FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0012955

Facility Name: Good Sam Prophets Riverview

Address: 310 Mosher Drive (Number) Prophetstown (City) 61277 (Zip Code)

County: Whiteside

Telephone Number: 825-537-5175 **Fax #** 825-537-2628

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Kim Kouri **Telephone Number:** 605-362-3178
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 01/01/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JOSEPH HERDINA
(Title) VICE PRESIDENT OF FINANCE

Paid Preparer

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 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	20	Skilled (SNF)	70	21,050	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	0	4,500	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,326	7,568	2,932	19,826	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,326	7,568	2,932	19,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.60%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 [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 09/20/1967

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 2,499

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	183,455	13,299	4,002	200,756		200,756	(150)	200,606			1
2	Food Purchase		152,056		152,056		152,056	(4,315)	147,741			2
3	Housekeeping	52,788	13,622		66,410		66,410	(209)	66,201			3
4	Laundry	46,005	13,524		59,529		59,529	(214)	59,315			4
5	Heat and Other Utilities			74,327	74,327		74,327	(5,678)	68,649			5
6	Maintenance	60,441	1,774	53,940	116,155		116,155	(4,869)	111,286			6
7	Other (specify):*			816	816		816	(120)	696			7
8	TOTAL General Services	342,689	194,275	133,085	670,049		670,049	(15,555)	654,494			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	1,281,980	207,448	46,535	1,535,963		1,535,963	(105,886)	1,430,077			10
10a	Therapy		1,378	421,570	422,948		422,948	(100,690)	322,258			10a
11	Activities	64,410	5,994	1,493	71,897		71,897	(95)	71,802			11
12	Social Services	47,814	1,038	860	49,712		49,712	(16)	49,696			12
13	CNA Training											13
14	Program Transportation			2,860	2,860		2,860		2,860			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,394,204	215,858	490,318	2,100,380		2,100,380	(206,687)	1,893,693			16
	C. General Administration											
17	Administrative	55,962		219,250	275,212		275,212	41,482	316,694			17
18	Directors Fees											18
19	Professional Services			54	54		54		54			19
20	Dues, Fees, Subscriptions & Promotions			28,946	28,946		28,946	(22,098)	6,848			20
21	Clerical & General Office Expenses	105,271	126,415	49,603	281,289		281,289	(1,182)	280,107			21
22	Employee Benefits & Payroll Taxes			473,039	473,039		473,039	(24,686)	448,353			22
23	Inservice Training & Education			8,404	8,404		8,404	(2,236)	6,168			23
24	Travel and Seminar			10,959	10,959		10,959	(2,685)	8,274			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,996	28,996		28,996	(1,349)	27,647			26
27	Other (specify):*	3,636		168	3,804		3,804	(3,805)	(1)			27
28	TOTAL General Administration	164,869	126,415	819,419	1,110,703		1,110,703	(16,559)	1,094,144			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,901,762	536,548	1,442,822	3,881,132		3,881,132	(238,801)	3,642,331			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: 01/01/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			146,614	146,614		146,614		146,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,168	1,168		1,168		1,168			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,762	15,762		15,762		15,762			35
36	Other (specify):*											36
37	**TOTAL Ownership**			163,544	163,544		163,544		163,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		103	10,034	10,137		10,137		10,137			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,549	158,549		158,549		158,549			42
43	Other (specify):*	13,428		11,608	25,036		25,036	(25,913)	(877)			43
44	**TOTAL Special Cost Centers**	13,428	103	180,191	193,722		193,722	(25,913)	167,809			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,915,190	536,651	1,786,557	4,238,398		4,238,398	(264,714)	3,973,684			45

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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	(4,315)	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	1,835	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	(278,065)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (280,545)		$	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)	15,831		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,831		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (264,714)		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

Good Sam Prophets Riverview

ID# 0012955

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (150)	1	1
2	See Attached Schedule	(209)	3	2
3	See Attached Schedule	(214)	4	3
4	See Attached Schedule	(5,678)	5	4
5	See Attached Schedule	(4,869)	6	5
6	See Attached Schedule	(120)	7	6
7	See Attached Schedule	(105,886)	10	7
8	See Attached Schedule	(100,690)	10a	8
9	See Attached Schedule	(95)	11	9
10	See Attached Schedule	(16)	12	10
11	See Attached Schedule	(22,098)	20	11
12	See Attached Schedule	(3,017)	21	12
13	See Attached Schedule	(384)	22	13
14	See Attached Schedule	(2,236)	23	14
15	See Attached Schedule	(2,685)	24	15
16	See Attached Schedule	(3,805)	27	16
17	See Attached Schedule	(25,913)	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**	(278,065)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(150)	0	0	0	0	0	0	0	0	0	0	(150)	1
2	Food Purchase	(4,315)	0	0	0	0	0	0	0	0	0	0	(4,315)	2
3	Housekeeping	(209)	0	0	0	0	0	0	0	0	0	0	(209)	3
4	Laundry	(214)	0	0	0	0	0	0	0	0	0	0	(214)	4
5	Heat and Other Utilities	(5,678)	0	0	0	0	0	0	0	0	0	0	(5,678)	5
6	Maintenance	(4,869)	0	0	0	0	0	0	0	0	0	0	(4,869)	6
7	Other (specify):*	(120)	0	0	0	0	0	0	0	0	0	0	(120)	7
8	**TOTAL General Services**	(15,555)	0	0	0	0	0	0	0	0	0	0	(15,555)	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	(105,886)	0	0	0	0	0	0	0	0	0	0	(105,886)	10
10a	Therapy	(100,690)	0	0	0	0	0	0	0	0	0	0	(100,690)	10a
11	Activities	(95)	0	0	0	0	0	0	0	0	0	0	(95)	11
12	Social Services	(16)	0	0	0	0	0	0	0	0	0	0	(16)	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**	(206,687)	0	0	0	0	0	0	0	0	0	0	(206,687)	16
	C. General Administration													
17	Administrative	0	41,482	0	0	0	0	0	0	0	0	0	41,482	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	(22,098)	0	0	0	0	0	0	0	0	0	0	(22,098)	20
21	Clerical & General Office Expenses	(1,182)	0	0	0	0	0	0	0	0	0	0	(1,182)	21
22	Employee Benefits & Payroll Taxes	(384)	(24,302)	0	0	0	0	0	0	0	0	0	(24,686)	22
23	Inservice Training & Education	(2,236)	0	0	0	0	0	0	0	0	0	0	(2,236)	23
24	Travel and Seminar	(2,685)	0	0	0	0	0	0	0	0	0	0	(2,685)	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	(1,349)	0	0	0	0	0	0	0	0	0	(1,349)	26
27	Other (specify):*	(3,805)	0	0	0	0	0	0	0	0	0	0	(3,805)	27
28	**TOTAL General Administration**	(32,390)	15,831	0	0	0	0	0	0	0	0	0	(16,559)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(254,632)	15,831	0	0	0	0	0	0	0	0	0	(238,801)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(25,913)	0	0	0	0	0	0	0	0	0	0	(25,913)	43
44	**TOTAL Special Cost Centers**	(25,913)	0	0	0	0	0	0	0	0	0	0	(25,913)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(280,545)	15,831	0	0	0	0	0	0	0	0	0	(264,714)	45

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin/Accounting	$ 219,250	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 260,732	$ 41,482	1
2	V	22	Workers Compensation	107,906	The Evangelical Lutheran Good Samaritan Society	100.00%	79,995	(27,911)	2
3	V	22	Unemployment	156	The Evangelical Lutheran Good Samaritan Society	100.00%	354	198	3
4	V	26	Insurance	28,996	The Evangelical Lutheran Good Samaritan Society	100.00%	27,647	(1,349)	4
5	V	22	Group Health Insurance	182,405	The Evangelical Lutheran Good Samaritan Society	100.00%	185,816	3,411	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			$ 538,713			$ 554,544	$ * 15,831	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	John Holt	BOD President						2
3	H. theodore Grindal	BOD V-P						3
4	Gwen Wagstrom Halaas	BOD						4
5	Alan Gard	BOD						5
6	David Horazdovsky	BOD						6
7	Benjamin Anderson	BOD						7
8	Patricia Camero	BOD						8
9	Michael Deuth	BOD						9
10	Heather Krzmarsick	BOD						10
11	Connie March-Curtis	BOD						11
12	Guy Matson	BOD						12
13	John Racek	BOD						13
14	Jill Schumann	BOD						14
15	Dennis Stene	BOD						15
16	Sharon St. Mary	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1 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: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Good Sam Prophets Riverview **#** 0012955 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

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

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Sam 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,259 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land		1966	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1967	$ 347,118	$		$	$	$ 347,118	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	4,676					4,676	12
13				1978	2,854					2,854	13
14				1979	10,205					10,205	14
15				1980	2,114	9		9		2,079	15
16				1981	60,747	1,404		1,404		52,657	16
17				1982	10,416					10,416	17
18				1983	16,071					16,071	18
19				1984	8,772					8,772	19
20				1985	17,007					17,007	20
21				1986	3,134					3,134	21
22				1987	78,081					78,081	22
23				1988	47,917					47,917	23
24				1989	90,335					90,335	24
25				1990	805,403					805,403	25
26				1991	8,759					8,708	26
27				1992	28,408					28,408	27
28				1993	6,447					6,447	28
29				1994	44,592					44,592	29
30				1995	32,831	48		48		32,831	30
31				1996	40,289	710		710		38,317	31
32				1997	58,092	1,756		1,756		49,186	32
33				1998	26,516	320		320		25,669	33
34				1999	18,382	172		172		17,797	34
35				2000	16,758	48		48		16,543	35
36				2001	42,137	1,808		1,808		34,819	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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2002	$ 149,332	$ 9,674		$ 9,674	$	$ 138,902	37
38		2003	63,243	4,216		4,216		54,701	38
39		2004	68,785	361		361		65,741	39
40		2005	218,729	12,948		12,948		178,974	40
41		2006	205,969	13,774		13,774		132,146	41
42		2007	238,987	12,913		12,913		132,691	42
43		2008	70,978	2,695		2,695		56,694	43
44		2009	67,737	3,737		3,737		26,283	44
45		2010	98,266	6,278		6,278		41,846	45
46		2011	90,870	7,178		7,178		30,436	46
47	LOCKS FOR MED ROOM (2)	2012	585	78	90	78		305	47
48	FLOOR TILE	2012	700	35	240	35		131	48
49	VINYL FLOORING-HALLWAY	2012	35,326	3,533	120	3,533		10,888	49
50	AC COMPRESSOR & CONTACTOR	2013	4,786	319	180	319		745	50
51	HEAT EXCHANGER & SWITCH(2)	2013	2,450	245	120	245		531	51
52	IP VIDEO (SECURITY) SYSTEM	2013	17,890	1,789	120	1,789		3,876	52
53	BUILDING-SHOWER ROOM REMODEL	2013	4,676	187	300	187		390	53
54	CABINETS-SHOWER ROOM REMODEL	2013	534	36	180	36		74	54
55	TILE-SHOWER ROOM REMODEL	2013	4,111	206	240	206		428	55
56	DUCT WORK-SHOWER ROOM REMODEL	2013	386	19	240	19		40	56
57	PLUMBING-SHOWER ROOM REMODEL	2013	3,029	151	240	151		316	57
58	SHORETEL PHONE SYSTEM	2014	9,670	967	120	967		1,773	58
59	SNF TECKNOFLOR FLOORING	2013	34,333	3,433	120	3,433		6,867	59
60	HVAC DINING AREA HEAT EXCHANGE	2013	2,550	340	90	340		708	60
61	TECHNOFLOOR INSTALL PROJECT	2014	21,866	2,187	120	2,187		2,733	61
62	NURSE CALL LIGHT SYSTEM	2014	84,390	8,439	120	8,439		9,142	62
63	TRINITY BOILER INDUCER MOTOR	2015	1,440	96	120	96		96	63
64	BUILDING-100/200 SHOWER RM RMD	2015	16,899	394	300	394		394	64
65	TILE-100/200 SHOWER RM RMD	2015	9,053	264	240	264		264	65
66	PLBG-100/200 SHOWER RM RMD	2015	1,054	31	240	31		31	66
67	LANDSCAPING	2012	5,000	500	120	500		1,875	67
68	MULCH	2013	4,698	940	60	940		2,506	68
69	LANDSCAPING - MULCH	2015	6,047	454	120	454		454	69
70	TOTAL (lines 4 thru 69)		$ 3,407,255	$ 104,691		$ 104,691	$	$ 2,737,848	70

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,407,255	$ 104,691		$ 104,691	$	$ 2,737,848	1
2		1967	1,222					1,222	2
3	BOILER ROOM EXTERIOR DOOR	2012	4,310	216		216		700	3
4	STORM WINDOW BEAUTY SHOP	2012	773	52		52		172	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	TOTAL (lines 1 thru 33)		$ 3,413,560	$ 104,959		$ 104,959	$	$ 2,739,942	34

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 272,732	$ 26,728	$ 26,728	$		$ 168,995	71
72	Current Year Purchases	47,684	4,072	4,072			4,072	72
73	Fully Depreciated Assets	719,192	1,426	1,426			719,192	73
74								74
75	TOTALS	$ 1,039,608	$ 32,226	$ 32,226	$		$ 892,259	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	Van	2002 Olds	1992/2004	$ 52,835	$	$	$	6	$ 52,835	76
77	Van	1995 Chrylser	2008	3,000				3	3,000	77
78	Van	2010 Ford Transport	2012	19,000	4,750	4,750		4	19,000	78
79	Van	2006 Ford	2012	16,018	4,005	4,005		4	13,015	79
80	TOTALS			$ 90,853	$ 8,755	$ 8,755	$		$ 87,850	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)	$ 4,559,021	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 145,940	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,940	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)	$ 3,720,051	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	2,351,150	77,731	822,605	87
88	FFE	100,008	5,982	52,245	88
89					89
90					90
91	TOTALS	$ 2,451,158	$ 83,713	$ 874,850	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 59,227	92
93			93
94			94
95		$ 59,227	95

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 15,762 Description: General & Admin/Nursing Equipment Lease Rental
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	Line 10A, col 3	hrs	$	11,626	$ 174,385	$ 21	11,626	$ 174,406	1
2	Licensed Speech and Language Development Therapist	Line 10A, col 3	hrs		2,880	43,203		2,880	43,203	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, col 3	hrs		13,599	203,982		13,599	203,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	28,105	$ 421,570	$ 21	28,105	$ 421,591	14

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 61,355	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 38,707)	805,943		3
4	Supply Inventory (priced at)	9,984		4
5	Short-Term Investments	112,731		5
6	Prepaid Insurance	8,405		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,848		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,003,266	$	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	5,312,819		14
15	Leasehold Improvements, at Historical Cost	451,893		15
16	Equipment, at Historical Cost	1,230,470		16
17	Accumulated Depreciation (book methods)	(4,594,198)		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):	233,140		22
23	Other(specify):	42,452		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,691,576	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,694,842	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 189,392	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,078		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,014		30
31	Accrued Taxes Payable (excluding real estate taxes)	(6,022)		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	Security Deposits	23,035		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 362,497	$	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	Deffered Liabilities	1,579,959		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,579,959	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,942,456	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,752,386	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,694,842	$	48

***(See instructions.)**

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,282,590	1	
2	Restatements (describe):		2	
3	**Senior Living**	(47,341)	3	
4	**Apartments**	(454)	4	
5	**PY Adj**	3	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,234,798	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	73,519	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)**	$ 73,519	17	
	B. Transfers (Itemize):			
18	**Foundation Transfer**	(206)	18	
19	**Dnr Rest accounts**	3,396	19	
20	**SOA**	440,879	20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 444,069	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,752,386	24	*

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

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,705,316	1
2	Discounts and Allowances for all Levels	(1,316,518)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,388,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	38,526	5
6	Therapy	1,525,616	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,564,142	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	8,623	13
14	Non-Patient Meals	4,406	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,554	19
20	Radiology and X-Ray	2,511	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 257,305	23
	D. Non-Operating Revenue		
24	Contributions	18,052	24
25	Interest and Other Investment Income***	18,012	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,064	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	67,627	28
28a	Misc Oncome/PY Settlements	(2,019)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65,608	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,311,917	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	670,048	31
32	Health Care	2,100,380	32
33	General Administration	1,110,704	33
	B. Capital Expense		
34	Ownership	163,544	34
	C. Ancillary Expense		
35	Special Cost Centers	35,173	35
36	Provider Participation Fee	158,549	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,238,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,519	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 73,519	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,297,264	44
45	Private Pay - Net Inpatient Revenue	1,328,726	45
46	Medicare - Net Inpatient Revenue	1,156,510	46
47	Other-(specify)	211,271	47
48	Other-(specify)	(1,604,973)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,388,798	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: 01/01/2015 Ending: 12/31/2015

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	2,192	1,766	$ 63,471	$ 35.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,123	12,019	339,486	28.25	3
4	Licensed Practical Nurses	9,578	8,320	229,285	27.56	4
5	CNAs & Orderlies	49,585	45,218	629,521	13.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,835	1,603	26,546	16.56	9
10	Activity Assistants	3,253	3,048	36,876	12.10	10
11	Social Service Workers	2,102	1,908	47,081	24.68	11
12	Dietician					12
13	Food Service Supervisor	1,786	1,580	26,862	17.00	13
14	Head Cook	5,144	4,576	62,000	13.55	14
15	Cook Helpers/Assistants	9,468	8,447	99,337	11.76	15
16	Dishwashers					16
17	Maintenance Workers	3,770	3,041	62,556	20.57	17
18	Housekeepers	4,945	4,650	50,709	10.91	18
19	Laundry	4,343	3,849	45,544	11.83	19
20	Administrator	1,629	1,327	55,413	41.76	20
21	Assistant Administrator					21
22	Other Administrative	4,797	3,955	95,402	24.12	22
23	Office Manager	1,672	1,392	30,002	21.55	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	1,995	1,744	32,393	18.57	31
32	Other Health Care(specify)					32
33	Other(specify)	564	477	10,939	22.93	33
34	TOTAL (lines 1 - 33)	121,781	108,920	$ 1,943,423 *	$ 17.84	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	71	$ 2,973	Ln 1, Col 3	35
36	Medical Director		17,000	Ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,156	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	29	833	Ln 11, Col 3	44
45	Social Service Consultant	28	860	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	128	$ 24,822		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	801	$ 40,034	Ln 10, Col 3	50
51	Licensed Practical Nurses	20	800	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	60	1,801	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	881	$ 42,635		53

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cathy Smikle	Administrator	0	$ 55,962
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,962

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 219,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 219,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Fees	Fees	$ 54
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 54

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,906
Unemployment Compensation Insurance	309
FICA Taxes	142,471
Employee Health Insurance	182,405
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	38,622
Taxable gifts	970
Other	356
Page 5 adjustments	(24,686)
TOTAL (agree to Schedule V, line 22, col.8)	$ 448,353

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,792
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	6,374
Publications	3,780
Less: Public Relations Expense	( )
Non-allowable advertising	(22,098)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 4,892
In-State Travel	6,067
Seminar Expense	
Out of State Travel	(2,685)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,274

**See instructions.

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Good Sam Prophets Riverview # 0012955 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN-4379

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8.94

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 23,533 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 158,549
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. $ 4,315

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? 27%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

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

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

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