		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. **IDPH License ID Number:** 0007344

Facility Name: Good Sam Soc Mt Carroll

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

County: Carroll

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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

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

STATE OF ILLINOIS

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,352	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	8,917	8,812	2,562	20,291	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,917	8,812	2,562	20,291	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.00%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 2,332

Medicare Intermediary ____________

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	208,083	11,166	6,641	225,890		225,890	(139)	225,751			1
2	Food Purchase		138,081		138,081		138,081	(13,746)	124,335			2
3	Housekeeping	57,350	10,965		68,315		68,315	(145)	68,170			3
4	Laundry	30,973	8,544		39,517		39,517	(113)	39,404			4
5	Heat and Other Utilities			86,986	86,986		86,986	(3,284)	83,702			5
6	Maintenance	59,062		44,500	103,562		103,562	(5,006)	98,556			6
7	Other (specify):*	7,257		277	7,534		7,534	(253)	7,281			7
8	**TOTAL General Services**	362,725	168,756	138,404	669,885		669,885	(22,686)	647,199			8
	B. Health Care and Programs											
9	Medical Director			1,600	1,600		1,600		1,600			9
10	Nursing and Medical Records	1,388,964	203,477	50,755	1,643,196		1,643,196	(109,713)	1,533,483			10
10a	Therapy		216	357,547	357,763		357,763	(60,898)	296,865			10a
11	Activities	66,584	2,260	2,921	71,765		71,765	(30)	71,735			11
12	Social Services	36,060	15	1,716	37,791		37,791		37,791			12
13	CNA Training											13
14	Program Transportation			2,152	2,152		2,152		2,152			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,491,608	205,968	416,691	2,114,267		2,114,267	(170,641)	1,943,626			16
	C. General Administration											
17	Administrative	66,985		220,967	287,952		287,952	22,294	310,246			17
18	Directors Fees											18
19	Professional Services			5,768	5,768		5,768		5,768			19
20	Dues, Fees, Subscriptions & Promotions			19,934	19,934		19,934	(13,643)	6,291			20
21	Clerical & General Office Expenses	132,994	135,468	23,398	291,860		291,860	(307)	291,553			21
22	Employee Benefits & Payroll Taxes			446,599	446,599		446,599	(1,243)	445,356			22
23	Inservice Training & Education			7,585	7,585		7,585	(61)	7,524			23
24	Travel and Seminar			3,578	3,578		3,578	(1,860)	1,718			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,056	30,056		30,056	40,379	70,435			26
27	Other (specify):*	13,909		101	14,010		14,010	(14,012)	(2)			27
28	**TOTAL General Administration**	213,888	135,468	757,986	1,107,342		1,107,342	31,547	1,138,889			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,068,221	510,192	1,313,081	3,891,494		3,891,494	(161,780)	3,729,714			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Sam Soc Mt Carroll #0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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			208,358	208,358		208,358	(7,227)	201,131			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			250	250		250		250			35
36	Other (specify):*											36
37	**TOTAL Ownership**			208,608	208,608		208,608	(7,227)	201,381			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,100	154,100		154,100		154,100			42
43	Other (specify):*			7,374	7,374		7,374	(7,374)				43
44	**TOTAL Special Cost Centers**			161,474	161,474		161,474	(7,374)	154,100			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,068,221	510,192	1,683,163	4,261,576		4,261,576	(176,381)	4,085,195			45

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	(13,746)	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	1,686	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	(233,895)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (245,955)		$	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)	69,574		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 69,574		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (176,381)		37

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

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

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

STATE OF ILLINOIS

Good Sam Soc Mt Carroll

ID# 0007344

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (139)	1	1
2	See Attached Schedule	(145)	3	2
3	See Attached Schedule	(113)	4	3
4	See Attached Schedule	(3,284)	5	4
5	See Attached Schedule	(5,006)	6	5
6	See Attached Schedule	(253)	7	6
7	See Attached Schedule	(109,713)	10	7
8	See Attached Schedule	(60,898)	10a	8
9	See Attached Schedule	(30)	11	9
10	See Attached Schedule	(7,000)	17	10
11	See Attached Schedule	(13,643)	20	11
12	See Attached Schedule	(1,993)	21	12
13	See Attached Schedule	(1,144)	22	13
14	See Attached Schedule	(61)	23	14
15	See Attached Schedule	(1,860)	24	15
16	See Attached Schedule	(14,012)	27	16
17	See Attached Schedule	(7,374)	43	17
18	See Attached Schedule	(7,227)	30	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**	(233,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses A. General Services	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)	
1	Dietary	(139)	0	0	0	0	0	0	0	0	0	0	(139)	1
2	Food Purchase	(13,746)	0	0	0	0	0	0	0	0	0	0	(13,746)	2
3	Housekeeping	(145)	0	0	0	0	0	0	0	0	0	0	(145)	3
4	Laundry	(113)	0	0	0	0	0	0	0	0	0	0	(113)	4
5	Heat and Other Utilities	(3,284)	0	0	0	0	0	0	0	0	0	0	(3,284)	5
6	Maintenance	(5,006)	0	0	0	0	0	0	0	0	0	0	(5,006)	6
7	Other (specify):*	(253)	0	0	0	0	0	0	0	0	0	0	(253)	7
8	**TOTAL General Services**	(22,686)	0	0	0	0	0	0	0	0	0	0	(22,686)	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	(109,713)	0	0	0	0	0	0	0	0	0	0	(109,713)	10
10a	Therapy	(60,898)	0	0	0	0	0	0	0	0	0	0	(60,898)	10a
11	Activities	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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**	(170,641)	0	0	0	0	0	0	0	0	0	0	(170,641)	16
	C. General Administration													
17	Administrative	(7,000)	29,294	0	0	0	0	0	0	0	0	0	22,294	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,643)	0	0	0	0	0	0	0	0	0	0	(13,643)	20
21	Clerical & General Office Expenses	(307)	0	0	0	0	0	0	0	0	0	0	(307)	21
22	Employee Benefits & Payroll Taxes	(1,144)	(99)	0	0	0	0	0	0	0	0	0	(1,243)	22
23	Inservice Training & Education	(61)	0	0	0	0	0	0	0	0	0	0	(61)	23
24	Travel and Seminar	(1,860)	0	0	0	0	0	0	0	0	0	0	(1,860)	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	40,379	0	0	0	0	0	0	0	0	0	40,379	26
27	Other (specify):*	(14,012)	0	0	0	0	0	0	0	0	0	0	(14,012)	27
28	**TOTAL General Administration**	(38,027)	69,574	0	0	0	0	0	0	0	0	0	31,547	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(231,354)	69,574	0	0	0	0	0	0	0	0	0	(161,780)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,227)	0	0	0	0	0	0	0	0	0	0	(7,227)	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**	(7,227)	0	0	0	0	0	0	0	0	0	0	(7,227)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(7,374)	0	0	0	0	0	0	0	0	0	0	(7,374)	43
44	**TOTAL Special Cost Centers**	(7,374)	0	0	0	0	0	0	0	0	0	0	(7,374)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(245,955)	69,574	0	0	0	0	0	0	0	0	0	(176,381)	45

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Good Samaritan Society	100					

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	$ 220,967	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 250,261	$ 29,294	1
2	V	22	Workers Compensation	39,975	The Evangelical Lutheran Good Samaritan Society	100.00%	67,879	27,904	2
3	V	22	Unemployment	30,056	The Evangelical Lutheran Good Samaritan Society	100.00%	3,162	(26,894)	3
4	V	26	Insurance	2,473	The Evangelical Lutheran Good Samaritan Society	100.00%	42,852	40,379	4
5	V	22	Group Health Insurance	201,330	The Evangelical Lutheran Good Samaritan Society	100.00%	200,221	(1,109)	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			$ 494,801			$ 564,375	$ * 69,574	14

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	H. Theodore Grindal	BOD - President						2
3	Gwn Halaas	BOD - VP						3
4	Alan Gard	BOD						4
5	Dale Thompson	BOD						5
6	David Horazdovsky	BOD						6
7	Benjamin Anderson	BOD						7
8	Patricia Camero	BOD						8
9	Michael Deuth	BOD						9
10	Health Hrzmarzick	BOD						10
11	Lee Laaveg	BOD						11
12	Connie March-Curtis	BOD						12
13	John Racek	BOD						13
14	Dina Robinson	BOD						14
15	Jill Schumann	BOD						15
16	Dennis Stene	BOD						16
17	Sharon St. Mary	BOD						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		**8**
	2012		**9**
	2013		**10**
	2014		**11**
	2015		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Sam Soc Mt Carroll COUNTY Carroll

FACILITY IDPH LICENSE NUMBER 0007344

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land		1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1970	$ 388,819	$		$	$	$ 388,819	4
5				1991	805,551					805,551	5
6				2010	192,900	7,716		7,716		45,010	6
7											7
8											8
	Improvement Type**										
9				1970	3,703					3,703	9
10				1971	262					262	10
11				1975	1,986					1,986	11
12				1976	2,090					2,090	12
13				1977	185					185	13
14				1979	6,037					6,037	14
15				1980	1,559					1,559	15
16				1981	33,937					33,627	16
17				1982	29,188					29,188	17
18				1983	8,193					8,193	18
19				1984	1,224					1,224	19
20				1986	4,163					4,163	20
21				1987	15,273					15,273	21
22				1988	6,707					6,707	22
23				1989	5,010					5,010	23
24				1990	6,322					6,322	24
25				1991	98,155					95,713	25
26				1992	10,350					10,350	26
27				1993	4,260					4,260	27
28				1994	66,654					66,654	28
29				1995	36,466					36,466	29
30				1996	78,462	2,535		2,535		78,462	30
31				1997	24,046	749		749		23,423	31
32				1998	16,770	520		520		16,021	32
33				1999	37,004	736		736		34,940	33
34				2000	88,586	921		921		74,969	34
35				2002	51,858	2,201		2,201		50,019	35
36				2003	58,269	2,822		2,822		40,169	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2004	$ 13,568	$ 441		$ 441	$	$ 11,246	37
38		2005	109,024	3,225		3,225		66,424	38
39		2006	385,284	18,024		18,024		196,094	39
40		2007	29,076	1,192		1,192		25,157	40
41		2008	155,962	10,460		10,460		93,472	41
42		2009	128,025	7,936		7,936		58,834	42
43		2010	177,513	10,680		10,680		105,839	43
44		2011	15,113	1,384		1,384		7,831	44
45		2012	264,943	24,665		24,665		108,552	45
46	SHORETEL PHONE SYSTEM	2013	36,398	3,640	120	3,640		14,256	46
47	FIRE DOORS IN KIT/DIN ROOM WIN	2013	3,517	352	120	352		1,377	47
48	GENERATOR REPAIRS	2013	2,629	526	60	526		1,972	48
49	REPLACE ROOFTOP UNITS	2013	91,850	9,185	120	9,185		32,913	49
50	BLDG-200 WING SPA ROOM RMDL	2014	18,284	731	300	731		2,011	50
51	ELECT-200 WING SPA ROOM RMDL	2014	4,500	300	180	300		825	51
52	PLBG-200 WING SPA ROOM RMDL	2014	2,200	110	240	110		303	52
53	BLDG-SNF NEW FLOORING	2014	633	25	300	25		65	53
54	VINYL-SNF NEW FLOORING	2014	6,262	626	120	626		1,618	54
55	NEW GARAGE IDOT BUS	2014	23,498	940	300	940		2,193	55
56	BUILDING-REMODEL DINING ROOM	2014	8,905	356	300	356		831	56
57	FIRE PUMP REPAIR, INSPECTION	2014	2,434	243	120	243		507	57
58	PARKING LOT/BUS SLAB/SHED	2015	20,897	1,393	180	1,393		1,858	58
59	ELECTRIC-EMERGENCY LIGHTING	2015	2,489	166	180	166		263	59
60	EMERGENCY LIGHTING	2015	3,270	218	180	218		345	60
61	PAINT-RES RM/ENTRANCE/KITCHEN	2016	18,060	3,311	60	3,311		3,311	61
62	HVAC - CARRIER MODEL HIM OFFIC	2015	1,975	132	180	132		198	62
63	LIFE SAFTEY - ELEC/WIRING	2015	16,390	820	240	820		1,024	63
64	REMSTAR AUTO HUMIDIFIER	2015	792	53	180	53		57	64
65	FRONT DR - 600LB SMALL 301LOCK	2016	1,309	80	180	80		80	65
66	HVAC - TEK MAR PANELS	2015	3,817	254	180	254		297	66
67	ASBESTOS ABATE-RESIDENT HALLS	2016	13,800	345	120	345		345	67
68	CARPET-SNF HALLS	2016	18,428	921	60	921		921	68
69	CARPET-OFFICES	2016	8,021	267	60	267		267	69
70	TOTAL (lines 4 thru 69)		$ 3,672,852	$ 121,200		$ 121,200	$	$ 2,637,639	70

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 3,672,852	$ 121,200		$ 121,200	$	$ 2,637,639	1
2	CHAIN LINK FENCE AT GENERATOR	2013	584	39	180	39		136	2
3	CONCRETE PARKING LOT & SIDEWLK	2014	4,000	200	240	200		500	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	TOTAL (lines 1 thru 33)		$ 3,677,436	$ 121,439		$ 121,439	$	$ 2,638,275	34

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 406,047	$ 39,264	$ 39,264	$		$ 221,748	71
72	Current Year Purchases	85,409	10,534	10,534			10,534	72
73	Fully Depreciated Assets	774,787	6,005	6,005			774,787	73
74								74
75	TOTALS	$ 1,266,243	$ 55,803	$ 55,803	$		$ 1,007,069	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Home	2002 Oldsmobile	2005	$ 15,173	$	$	$	4	$ 15,173	76
77	Nursing Home	2005 Chevrolet Pickup	2009	14,272				4	14,272	77
78	Nursing Home	2016 Dodge Caravan	2015	39,750	9,937	9,937		4	13,250	78
79	Nursing Home	2016 Ford Starcraft	2015	55,806	13,952	13,952		4	15,114	79
80	TOTALS			$ 125,001	$ 23,889	$ 23,889	$		$ 57,809	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)	$ 5,074,400	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,131	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,131	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)	$ 3,703,153	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 28,200	92
93			93
94			94
95		$ 28,200	95

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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: $ 250 Description: General & Admin/Nursing Equipment Rental Lease
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.

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	$	10,561	$ 159,760	$	10,561	$ 159,760	1
2	Licensed Speech and Language Development Therapist	Line 10A, col 3	hrs		1,150	17,256		1,150	17,256	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, col 3	hrs		12,035	180,531		12,035	180,531	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			$	23,746	$ 357,547	$	23,746	$ 357,547	14

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 63,403	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 16,210)	679,088		3
4	Supply Inventory (priced at)	5,409		4
5	Short-Term Investments	70,514		5
6	Prepaid Insurance	9,517		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,936		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 830,867	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	3,304,220		14
15	Leasehold Improvements, at Historical Cost	373,214		15
16	Equipment, at Historical Cost	1,391,245		16
17	Accumulated Depreciation (book methods)	(3,703,154)		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):	89,012		22
23	Other(specify):	19,306		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,479,563	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,310,430	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,527	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,245		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,368		30
31	Accrued Taxes Payable (excluding real estate taxes)	19		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 340,159	$	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)**	$ 340,159	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,970,271	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,310,430	$	48

***(See instructions.)**

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,868,529	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,868,529	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	203,453	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)**	$ 203,453	17
	B. Transfers (Itemize):		
18	Dnr Restricted accounts	(3,940)	18
19	Society Business account	(97,771)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (101,711)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,970,271	24 *

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

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,111,735	1
2	Discounts and Allowances for all Levels	(1,482,937)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,628,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	486	5
6	Therapy	1,369,090	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,369,576	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	7,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	60	14
15	Telephone, Television and Radio	14,742	15
16	Rental of Facility Space		16
17	Sale of Drugs	279,603	17
18	Sale of Supplies to Non-Patients	99	18
19	Laboratory	7,008	19
20	Radiology and X-Ray	3,331	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 311,843	23
	D. Non-Operating Revenue		
24	Contributions	100,511	24
25	Interest and Other Investment Income***	28,324	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 128,835	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing/Medical Supplies	81,244	28
28a	Misc Income/PY Settlements	(55,272)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,465,024	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	669,884	31
32	Health Care	2,114,267	32
33	General Administration	1,107,338	33
	B. Capital Expense		
34	Ownership	208,608	34
	C. Ancillary Expense		
35	Special Cost Centers	7,374	35
36	Provider Participation Fee	154,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,261,571	40
41	**Income before Income Taxes (line 30 minus line 40)****	203,453	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 203,453	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,164,354	44
45	Private Pay - Net Inpatient Revenue	1,696,126	45
46	Medicare - Net Inpatient Revenue	1,165,593	46
47	Other-(specify)	212,078	47
48	Other-(specify)	(1,609,353)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,628,798	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 Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,774	2,106	$ 61,676	$ 29.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,374	17,425	468,372	26.88	3
4	Licensed Practical Nurses	5,048	5,477	125,176	22.85	4
5	CNAs & Orderlies	48,423	55,096	719,758	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	2,089	34,386	16.46	9
10	Activity Assistants	3,017	3,612	32,048	8.87	10
11	Social Service Workers	1,806	1,941	35,372	18.22	11
12	Dietician					12
13	Food Service Supervisor	1,865	2,123	40,073	18.88	13
14	Head Cook	4,931	5,741	61,474	10.71	14
15	Cook Helpers/Assistants	10,604	11,698	107,017	9.15	15
16	Dishwashers					16
17	Maintenance Workers	3,245	3,515	56,893	16.19	17
18	Housekeepers	5,107	5,751	56,670	9.85	18
19	Laundry	3,024	3,431	30,957	9.02	19
20	Administrator	1,870	2,089	66,985	32.07	20
21	Assistant Administrator					21
22	Other Administrative	1,905	2,471	97,491	39.45	22
23	Office Manager	3,084	3,691	80,129	21.71	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	1,701	1,980	37,310	18.84	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	735	843	14,034	16.65	33
34	TOTAL (lines 1 - 33)	115,350	131,079	$ 2,125,821 *	$ 16.22	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$	Ln 1, col 3	35
36	Medical Director		1,600	Ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	4,400	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	57	1,716	Ln 11, col 3	44
45	Social Service Consultant	57	1,716	Ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	202	$ 9,432		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	763	$ 38,162	Ln 10, col 3	50
51	Licensed Practical Nurses	8	327	Ln 10, col 3	51
52	Certified Nurse Assistants/Aides	206	6,169	Ln 10, col 3	52
53	TOTAL (lines 50 - 52)	977	$ 44,658		53

Facility Name & ID Number Good Sam Soc Mt Carroll # 0007344 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LuAnn Brewington	Administrator	0	$ 66,985
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 66,985

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 220,967
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 220,967

C. Professional Services

Vendor/Payee	Type	Amount
Gallup Services	Survey results	$ 5,768
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 5,768

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,975
Unemployment Compensation Insurance	2,618
FICA Taxes	155,816
Employee Health Insurance	201,330
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	45,335
Taxable Gifts	1,151
Other	374
Adjustments Per 5a tab	(1,243)
TOTAL (agree to Schedule V, line 22, col.8)	$ 445,356

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,672
Health Care Worker Background Check	
(Indicate # of checks performed ______)	
Patient Background Checks	
Dues	5,838
Publications	2,424
Less: Public Relations Expense	( )
Non-allowable advertising	(13,643)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,291

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,680
In-State Travel	35
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,715

**See instructions.

Facility Name & ID Number **Good Sam Soc Mt Carroll** **# 0007344** **Report Period Beginning: 01/01/2016 Ending: 12/31/2016**

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?
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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,805** Line **10**

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

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **154,100**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ____ Has any meal income been offset against related costs? **YES** Indicate the amount. $ ____

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients?

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