FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0009175

Facility Name: Golden Good Shepherd Home, Inc

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

County: Adams

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 c 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/16 to 10/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	46	Skilled (SNF)	46	16,836	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,836	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	611	726	1,337	8
9	SNF/PED					9
10	ICF	4,142	6,726	0	10,868	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,142	7,337	726	12,205	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.49%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/09/63

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided _____

Medicare Intermediary Natioanl Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	148,582	6,780	5,176	160,538		160,538		160,538			1
2	Food Purchase		123,725		123,725		123,725	(2,915)	120,810			2
3	Housekeeping	79,467	14,784		94,251		94,251		94,251			3
4	Laundry	19,858	4,895	32,140	56,893		56,893		56,893			4
5	Heat and Other Utilities			47,407	47,407		47,407		47,407			5
6	Maintenance	37,059	10,220	31,498	78,777		78,777		78,777			6
7	Other (specify):*											7
8	TOTAL General Services	284,966	160,404	116,221	561,591		561,591	(2,915)	558,676			8
	B. Health Care and Programs											
9	Medical Director			1,191	1,191		1,191		1,191			9
10	Nursing and Medical Records	758,584	59,820	4,571	822,975		822,975		822,975			10
10a	Therapy	63,998	635	196,717	261,350		261,350		261,350			10a
11	Activities	72,410	4,291	3,348	80,049	(1,301)	78,748	(43)	78,705			11
12	Social Services	29,686	84	454	30,224	1,301	31,525		31,525			12
13	CNA Training											13
14	Program Transportation		4,084		4,084		4,084		4,084			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	924,678	68,914	206,281	1,199,873		1,199,873	(43)	1,199,830			16
	C. General Administration											
17	Administrative	55,552			55,552		55,552		55,552			17
18	Directors Fees											18
19	Professional Services			32,547	32,547	6,808	39,355		39,355			19
20	Dues, Fees, Subscriptions & Promotions			27,488	27,488	(56)	27,432	(17,274)	10,158			20
21	Clerical & General Office Expenses	28,767	7,182	8,649	44,598		44,598		44,598			21
22	Employee Benefits & Payroll Taxes			137,421	137,421		137,421		137,421			22
23	Inservice Training & Education			9,570	9,570	(7,547)	2,023		2,023			23
24	Travel and Seminar			2,365	2,365	695	3,060	(669)	2,391			24
25	Other Admin. Staff Transportation		293		293		293		293			25
26	Insurance-Prop.Liab.Malpractice			47,991	47,991	100	48,091		48,091			26
27	Other (specify):*			3,805	3,805		3,805		3,805			27
28	TOTAL General Administration	84,319	7,475	269,836	361,630		361,630	(17,943)	343,687			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,293,963	236,793	592,338	2,123,094		2,123,094	(20,901)	2,102,193			29

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

Facility Name & ID Number Golden Good Shepherd Home, Inc #0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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			70,878	70,878		70,878	(7)	70,871			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,082	11,082		11,082	(56)	11,026			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,671	13,671		13,671		13,671			35
36	Other (specify):*			589	589		589		589			36
37	TOTAL Ownership			96,220	96,220		96,220	(63)	96,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,888		46,888		46,888		46,888			39
40	Barber and Beauty Shops		10	7,492	7,502		7,502		7,502			40
41	Coffee and Gift Shops		2,551		2,551		2,551		2,551			41
42	Provider Participation Fee			94,861	94,861		94,861		94,861			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		49,449	102,353	151,802		151,802		151,802			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,293,963	286,242	790,911	2,371,116		2,371,116	(20,964)	2,350,152			45

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	(2,246)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(43)	2		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7)	30		9
10	Interest and Other Investment Income	(56)	32		10
11	Discounts, Allowances, Rebates & Refunds	(626)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				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	(17,274)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(712)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,964)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (20,964)		37

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

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

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

Golden Good Shepherd Home, Inc

ID# 0009175

Report Period Beginning: 11/01/16

Ending: 10/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activities Income	$ (43)	11	1
2	2016 Expenses	(669)	24	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
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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**	(712)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,915)	0	0	0	0	0	0	0	0	0	0	(2,915)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,915)	0	0	0	0	0	0	0	0	0	0	(2,915)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(43)	0	0	0	0	0	0	0	0	0	0	(43)	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**	(43)	0	0	0	0	0	0	0	0	0	0	(43)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(17,274)	0	0	0	0	0	0	0	0	0	0	(17,274)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(669)	0	0	0	0	0	0	0	0	0	0	(669)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,943)	0	0	0	0	0	0	0	0	0	0	(17,943)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,901)	0	0	0	0	0	0	0	0	0	0	(20,901)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Golden Good Shepherd Home, Inc **#** 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

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)	0	0	0	0	0	0	0	0	0	0	(7)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56)	0	0	0	0	0	0	0	0	0	0	(56)	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**	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,964)	0	0	0	0	0	0	0	0	0	0	(20,964)	45

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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 [X] NO

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Financial		X	EMR Wing	$1,417.58	02/14/14	$ 55,881	$ 5,554	01/14/18	10.0110	$ 1,238	1
2	Brown County State Bank		X	New Wing	$5,000.00	04/29/15	243,900	115,947	04/29/20	3.2500	4,668	2
3												3
4												4
5												5
	Working Capital											
6	Brown County State Bank		X	Cash Flow	Interest	12/18/14	40,000	150,000	12/18/17	2.9500	5,176	6
7												7
8												8
9	TOTAL Facility Related				$6,417.58		$ 339,781	$ 271,501			$ 11,082	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 339,781	$ 271,501			$ 11,082	15

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc **#** 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golden Good Shepherd Home, Inc COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009175

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,748 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

Cottages

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	42			1963	$ 163,629	$	50	$	$	$ 163,629	4
5			1963	1988	208,384	5,210	40	5,210		151,946	5
6			1988	1989	84,694	2,117	40	2,117		60,521	6
7	4		1989	2015	354,549	9,091	39	9,091		23,485	7
8			2015								8
	Improvement Type**										
9	Building Addidtion			1967	5,285		20			5,285	9
10	Building Addidtion			1973	25,841		20			25,841	10
11	Sprinkler System			1975	30,963		20			30,963	11
12	Building Addidtion			1975	18,103		20			18,103	12
13	Building Addidtion			1975	1,313		20			1,313	13
14	Building Addidtion			1976	15,380		20			15,380	14
15	Building Addidtion			1977	3,981		15			3,981	15
16	Doors			1978	900		20			900	16
17	Building Addidtion			1980	3,165		15			3,165	17
18	Parking Lot			1985	7,475		15			7,475	18
19	Building Addidtion			1983	4,174		15			4,174	19
20	Garage			1986	6,473		15			6,473	20
21	Landscaping			1988	620		10			620	21
22	Asphalt			1989	950		15			950	22
23	Building Addidtion			1990	655		20			653	23
24	Sprinkler System			1992	43,248	865	25	865	(0)	43,104	24
25	Floor & Foundation Improvements			1997	9,800	251	39	251		5,255	25
26	Parking Lot Expansion			1997	16,320	418	39	418		8,508	26
27	Owygen Room Venting			1998	2,880	72	40	72		1,418	27
28	Backflow Valve			1998	959	39	25	38	(1)	735	28
29	Laundry Door			1998	3,555		15			3,535	29
30	Backflow Preventor			1999	3,128	157	20	156	(1)	2,918	30
31	Ceiling			1999	4,657	233	20	233		4,210	31
32	Kitchen Floor			2000	1,167		10			1,157	32
33	New Roof Nursing Home			2001	38,956	999	39	999		16,149	33
34	Concrete Activity Room Entrance			2003	4,975	332	15	332		4,809	34
35	Remodel Kitchen			2004	5,085	341	15	339	(2)	4,659	35
36	Concrete Correction			2007	6,500	432	15	433		4,701	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	Fire suppression System	2007	$ 2,369	$ 39	10	$ 39	$	$ 2,349	37
38	New Doors	2007	1,584	106	15	106		1,118	38
39	Parking lot Improvements	2007	6,868	458	15	458		4,617	39
40	Sprinkler	2010	107,879	4,315	25	4,315		32,724	40
41	Nurse Call System	2010	58,134	2,907	20	2,907		20,831	41
42	Concrete Pad	2011	1,900	127	15	127		802	42
43	Sprinkler Addition	2012	28,700	1,148	25	1,148		6,506	43
44	Shower Room-Materials & Labor	2013	12,814	644	20	645	1	3,119	44
45	Shower Room-Alarm System	2013	3,774	185	20	185		901	45
46	Shower Room-Floor Tile	2013	5,800	291	20	291		1,409	46
47	Shower Room-Plumbing	2013	19,153	956	20	956		4,628	47
48	Generator Electrical Switch	2014	22,000	1,105	20	1,100	(5)	4,142	48
49	80 KW Cummins Generator	2014	37,983	1,899	20	1,899		7,122	49
50	sprinkler system	2015	16,400	820	20	820		2,118	50
51	Landscaping	2015	4,588	306	15	306		637	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,407,710	$ 35,863		$ 35,856	$ (8)	$ 719,038	70

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	$ 285,206	$ 34,036	$ 34,036	$	8	$ 181,814	71
72	Current Year Purchases	8,756	249	249		8	249	72
73	Fully Depreciated Assets	403,249					401,878	73
74								74
75	TOTALS	$ 697,211	$ 34,285	$ 34,285	$		$ 583,941	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	95 Ford Bus	2006	$ 5,000	$	$	$	5	$ 5,000	76
77	Resident Transportation	Ford Van	2012	4,305	730	730		5	4,305	77
78										78
79										79
80	TOTALS			$ 9,305	$ 730	$ 730	$		$ 9,305	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,151,953	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,878	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,871	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,312,284	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	Cattages	$ 356,147	$ 5,468	$ 265,118	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 356,147	$ 5,468	$ 265,118	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 13,671 Description: Oxygen $5551.14, Dishwasher $828.00, Equip $4259.22, Copier $2311.87, Computer $720.98
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	966	$ 77,260	$ 437	966	$ 77,697	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		83	6,660		83	6,660	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,238	99,020	198	1,238	99,218	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				46,888		46,888	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Endoscopic Procedure	10a-3				395			395	13
14	TOTAL			$	2,287	$ 183,335	$ 47,523	2,287	$ 230,858	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.

STATE OF ILLINOIS

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/17 (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	$ 13,065	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,127)	392,441		3
4	Supply Inventory (priced at Fifo)	4,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,421		6
7	Other Prepaid Expenses	2,322		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 425,249	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	205,223		12
13	Land	40,555		13
14	Buildings, at Historical Cost	1,659,041		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	811,331		16
17	Accumulated Depreciation (book methods)	(1,577,475)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): organization costs	1,472		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,140,147	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,565,396	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,968	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable	78,202		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,570		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,434		32
33	Accrued Interest Payable	4,449		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Group Insurance	(643)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 310,980	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,554		39
40	Mortgage Payable	115,947		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)**	$ 121,501	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 432,481	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,132,915	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,565,396	$	48

***(See instructions.)**

Facility Name & ID Number Golden Good Shepherd Home, Inc **#** 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,181,956	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(980)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,180,976	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(81,733)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Cottages**	33,672	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (48,061)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,132,915	24 *

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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	$ 2,288,342	1
2	Discounts and Allowances for all Levels	(136,839)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,151,503	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,632	6
7	Oxygen	274	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 34,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,322	12
13	Barber and Beauty Care	7,286	13
14	Non-Patient Meals	2,246	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	4,740	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,594	23
	D. Non-Operating Revenue		
24	Contributions	54,274	24
25	Interest and Other Investment Income***	56	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,330	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Attached	33,047	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 33,047	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,289,380	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	561,591	31
32	Health Care	1,199,873	32
33	General Administration	361,630	33
	B. Capital Expense		
34	Ownership	96,220	34
	C. Ancillary Expense		
35	Special Cost Centers	56,941	35
36	Provider Participation Fee	94,861	36
	D. Other Expenses (specify):		
37	Rounding	(3)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,371,113	40
41	**Income before Income Taxes (line 30 minus line 40)****	(81,733)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (81,733)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 438,918	44
45	Private Pay - Net Inpatient Revenue	1,319,625	45
46	Medicare - Net Inpatient Revenue	239,573	46
47	Other-(specify) Managed Care	153,387	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,151,503	49

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,410	1,590	$ 46,657	$ 29.34	1
2	Assistant Director of Nursing	1,916	2,121	48,908	23.06	2
3	Registered Nurses	4,860	5,142	124,077	24.13	3
4	Licensed Practical Nurses	7,632	8,166	152,320	18.65	4
5	CNAs & Orderlies	25,711	27,424	324,055	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,427	3,895	63,998	16.43	8
9	Activity Director	1,876	2,054	24,649	12.00	9
10	Activity Assistants	4,677	5,031	47,761	9.49	10
11	Social Service Workers	1,840	2,043	29,686	14.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,029	2,147	36,971	17.22	14
15	Cook Helpers/Assistants	5,420	5,778	59,191	10.24	15
16	Dishwashers	5,522	5,682	52,420	9.23	16
17	Maintenance Workers	1,896	2,095	37,059	17.69	17
18	Housekeepers	7,275	7,925	79,467	10.03	18
19	Laundry	1,707	1,972	19,858	10.07	19
20	Administrator	1,923	2,175	55,552	25.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,803	2,019	28,767	14.25	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					31
32	Other Health C: Care Plan	1,818	2,073	46,435	22.40	32
33	Other(specify) Med Records	1,254	1,357	16,132	11.89	33
34	TOTAL (lines 1 - 33)	83,996	90,689	$ 1,293,963 *	$ 14.27	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	125	$ 4,387	1-3	35
36	Medical Director	Contract	1,191	9-3	36
37	Medical Records Consultant	Contract	2,500	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	43	2,779	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,755	11-3	44
45	Social Service Consultant	21	1,755	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	210	$ 14,367		49

C. CONTRACT NURSES

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

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 Report Period Beginning: 11/01/16 Ending: 10/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Marlow	Administrator	0	$ 25,224
Abby Wayman	Administrator	0	30,328
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,552

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Pro One	Design Work	$ 447
YoloCare	Website Hosting	417
Carla Schneider	Administrator Consultant	2,129
American Healthtech	EMR Support	10,945
Relias	Training Software	4,629
Ability	Billing Support	2,386
WDM Support Services	Data Processing	18,127
Rounding		0
Roberts Neu Schmiedeskamp	Legal	225
Dianne Kircher	A/R Consultant	50
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 39,355

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,915
Unemployment Compensation Insurance	7,471
FICA Taxes	98,847
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,938
Vacation Acrual Adjustment	(7,750)
TOTAL (agree to Schedule V, line 22, col.8)	$ 137,421

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

Description	Line #	Amount
n/a		$ 0
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,154
Health Care Worker Background Check	1,631
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Healthcare Assoc	
IHCA	3,036
Drug Test	129
Emp Physicals	320
See List Attached	18,172
Less: Public Relations Expense	(2,087)
Non-allowable advertising	(15,187)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,158

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See list attached	2,391
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,391

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Golden Good Shepherd Home, Inc # 0009175 **Report Period Beginning:** 11/01/16 **Ending:** 10/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3036.00**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,235** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **94,861**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,246**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **90**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

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

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

	Physical Therapy						Occupational Therapy						Speech Therapy							
Caremark	Med A. Hours	Dollars	Med B		Private		Med A Hours	Dollars	Med B		Private		Med A Hours	Dollars	Med B		Private		Total	Total	Cook	
Nov-14	46.08	$3,686.40	29.75	$2,380.00	0.00	$0.00	47.17	$3,773.60	15.33	$1,226.40	0.00	$0.00	6.00	$480.00	0.00	$0.00	0.00	$0.00	230.50	$18,440.00		$178.75
Dec-14	25.92	$2,073.60	12.25	$980.00	11.00	$880.00	29.67	$2,373.60	5.67	$453.60	13.58	$1,086.40	0.00	$0.00	2.50	$200.00	0.00	$0.00	149.50	$11,960.00		$211.25
Jan-15	22.58	$1,806.40	23.33	$1,866.40	16.08	$1,286.40	10.08	$806.40	5.67	$453.60	17.92	$1,433.60	0.00	$0.00	2.00	$160.00	1.92	$153.60	154.75	$12,380.00		$295.50
Feb-15	50.50	$4,040.00	6.08	$486.40	6.67	$533.60	50.08	$4,006.40	2.25	$180.00	7.42	$593.60	4.00	$320.00	2.33	$186.40	2.25	$180.00	182.25	$14,580.00		$195.00
Mar-15	72.75	$5,820.00	0.00	$0.00	0.00	$0.00	70.33	$5,626.40	0.00	$0.00	0.00	$0.00	5.58	$446.40	0.00	$0.00	0.00	$0.00	201.25	$16,100.00		$227.50
Apr-15	65.25	$5,220.00	0.00	$0.00	17.42	$1,393.60	50.17	$4,013.60	0.00	$0.00	19.08	$1,526.40	5.00	$400.00	0.00	$0.00	0.00	$0.00	218.25	$17,460.00		$455.00
May-15	30.92	$2,473.60	6.33	$506.40	20.08	$1,606.40	16.08	$1,286.40	2.75	$220.00	4.17	$333.60	3.00	$240.00	0.00	$0.00	0.00	$0.00	126.00	$10,080.00		$422.50
Jun-15	17.75	$1,420.00	15.17	$1,213.60	56.58	$4,526.40	23.08	$1,846.40	12.33	$986.40	48.08	$3,846.40	0.00	$0.00	1.25	$100.00	1.00	$80.00	237.75	$19,020.00		$308.75
Jul-15	34.10	$2,728.00	5.67	$453.60	6.92	$553.60	24.08	$1,926.40	5.25	$420.00	1.47	$117.60	6.25	$500.00	0.00	$0.00	1.00	$80.00	125.00	$10,000.00		$211.25
Aug-15	76.08	$6,086.40	13.25	$1,060.00	9.67	$773.60	38.47	$3,077.60	0.00	$0.00	12.08	$966.40	4.33	$346.40	3.38	$270.40	0.00	$0.00	232.25	$18,580.00		$390.00
Sep-15	26.50	$2,120.00	26.92	$2,153.60	28.17	$2,253.60	23.58	$1,886.40	22.58	$1,806.40	29.83	$2,386.40	3.57	$285.60	3.00	$240.00	0.00	$0.00	225.50	$18,040.00		$341.25
Oct-15	29.62	$2,369.60	20.72	$1,657.60	24.22	$1,937.60	32.58	$2,606.40	18.25	$1,460.00	22.83	$1,826.40	0.75	$60.00	2.00	$160.00	0.00	$0.00	203.75	$16,300.00		
	498.05	$39,844.00	$159.47	$12,757.60	$196.81	$15,744.80	$415.37	$33,229.60	$90.08	$7,206.40	$176.46	$14,116.80	$38.48	$3,078.40	$16.46	$1,316.80	$6.17	$493.60	2,286.75	182,940.00	0.00	$3,236.75
	Consult						Consult						Consult									
Nov-14	44.67	$3,573.60					37.75	$3,020.00					3.75	$300.00								
Dec-14	29.83	$2,386.40					19.08	$1,526.40					0.00	$0.00								
Jan-15	30.26	$2,420.80					24.33	$1,946.40					0.58	$46.40								
Feb-15	27.25	$2,180.00					19.00	$1,520.00					4.42	$353.60								
Mar-15	35.50	$2,840.00					12.67	$1,013.60					4.42	$353.60								
Apr-15	34.33	$2,746.40					25.25	$2,020.00					1.75	$140.00								
May-15	22.67	$1,813.60					18.75	$1,500.00					1.25	$100.00								
Jun-15	28.00	$2,240.00					33.51	$2,680.80					1.00	$80.00								
Jul-15	24.81	$1,984.80					14.95	$1,196.00					0.50	$40.00								
Aug-15	44.50	$3,560.00					28.20	$2,256.00					2.29	$183.20								
Sep-15	34.66	$2,772.80					25.01	$2,000.80					1.68	$134.40								
Oct-15	26.94	$2,155.20					25.34	$2,027.20					0.50	$40.00								
	383.42	$30,673.60		$49,197.15			283.84	$22,707.20					22.14	$1,771.20								
	1,237.75	$99,020.00					965.75	$77,260.00					83.25	6,660.00								

706	$52,888.80
7065	$12,757.60
707	$36,152.35
716	$3,158.40
7161	$1,316.80
717	$2,579.80
755	$44,232.80
756	$7,206.40
757	$25,820.80
	$186,113.75
Cook	-$2,778.75
	$183,335.00

	Cook			Melanie's MDS			M. Young Dietician			Outcome	Activity/SS
Nov-15	2.75	$178.75	Nov-15			Nov-16	12.25	$428.75	Nov-15	2.75	$244.20
Dec-15	3.50	$227.50	Dec-15		$500.00	Dec-16			Dec-15	3.00	$259.20
Jan-16	4.50	$292.50	Jan-16			Jan-17	20.00	$700.00	Jan-16	3.25	$274.20
Feb-16	5.00	$325.00	Feb-16			Feb-17			Feb-16	3.67	$299.40
Mar-16	1.75	$113.75	Mar-16		$500.00	Mar-17	18.00	$630.00	Mar-16	4.00	$319.20
Apr-16	4.25	$276.25	Apr-16			Apr-17	15.50	$542.50	Apr-16	3.08	$264.00
May-16	3.50	$227.50	May-16			May-17	9.00	$315.00	May-16	3.00	$259.20
Jun-16	7.00	$455.00	Jun-16		$500.00	Jun-17	12.75	$446.25	Jun-16	4.50	$349.20
Jul-16	4.25	$276.25	Jul-16			Jul-17			Jul-16	4.00	$319.20
Aug-16	2.50	$162.50	Aug-16			Aug-17	14.75	$516.25	Aug-16	3.25	$274.20
Sep-16	2.00	$130.00	Sep-16		$500.00	Sep-17	15.50	$542.50	Sep-16	5.00	$379.20
Oct-16	1.75	$113.75	Oct-16		$500.00	Oct-17	7.50	$265.50	Oct-16	3.17	$269.40
	42.75	$2,778.75		0.00	$2,500.00		125.25	$4,386.75		42.67	$3,510.60
										21.34	1,755.30

Golden Good Shepherd
#0009175
11/01/16 to 10/31/17

Board Members

Kenneth Miller
308 Prairie Mills Road
Golden, IL 62339

Karen Dickhut
305 North Main
Camp Point, IL 62320

Curtis Post
2553 E. 2903rd Lane
Clayton, IL 62324

Jane Roberts
412 Kiwanis Rd #3
Carthage, IL 62321

Cara Hoskins
208 West 5th St.
Golden, IL 62339

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

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

Joyce Emmerick
PO Box 201
Golden, IL 62339

Golden Good Shepherd
#0009175
11/01/16 to 10/31/17

Reclasssifications

1 Reclassify $100.00 from Dues to Insurance expense for coding error of Bond.

2 Reclassify $1301 to Social Service Contract to split contract between Activities a

3 Reclassify $2129.00 from Inservice Training to Consultants for coding error for Ad

4 Reclassify $4628.50 from Inservice Training to Professional Services for coding er

5 Reclassify $50.00 from Inservice Training to Consultants for coding error for Dian

6 Reclassify $44.85 from Inservice Training to Dues & Subscriptions for coding error

7 Reclassify $695.00 from Inservice Training to Seminars for coding error of Career

nd SS.

ministrator Consultant

ror for Relias Software.

ne Kircher.

of MDS User Manual Subscription.

Track Seminar.

Golden Good Shepherd
#0009175
11/01/16 to 10/31/17

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	$1,469.31
REPAIRS & MAINT LAUNDRY	$150.68
REPAIRS & MAINT HSKING	$0.00
OUTSIDE SERVICES	$4,523.80
MOWING	$5,180.00
SNOW REMOVAL	$180.00
REPAIRS & MAINT BUILDINGS	$742.75
REPAIRS & MAINT EQUIPMENT	$3,847.90
REPAIRS & MAINT GROUNDS	$0.00
MUZAK	$0.00
CABLE TV	$2,326.90
Alarm	$2,494.46
REFUSE	$5,025.30
EXTERMITATOR	$1,312.56
REPAIRS & MAINT GEN/ADM	$4,243.90
TOTAL	$31,497.56

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	$8,649.16
TOTAL	$8,649.16

Schedule V. Line 14 ,Column 2

Auto Exp. & Service	$1,993.90
Auto Gas & Oil	$2,089.84
	$4,083.74

Schedule V. Line 36, Column3

Amortization of Loan	$588.72
Rounding	$0.00
	$588.72

Schedule V. Line 43, Column3

Bad Debt	$0.00
Contributions	$0.00
Rounding	$0.00
	$0.00

Schedule V. Line 27, Column 3

Misc Expenses	$3,717.18
Meals	$87.53
Rounding	$0.00
	$3,804.71

Schedule XX. Question 12

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

Schedule XVII, Line 28a, Column 1

Transportation	$4,446.28
Management Fee	$15,650.07
Dietary Suppliments	$2,641.60
Admissions	$0.00
Activities Income	$43.00
Uniform Sales	$31.49
Education	$0.00
Sales to employees	$43.12
Personal Purchases	$511.73
Rebates	$625.60
Gain on sale of Asset	$0.00
Discounts	$0.00
Doors Program	$0.00
Misc	$9,053.36
Rounding	$1.00
	$33,047.25

The following is a breakdown of Schedule XIX, Section F

Promotion/Public Relations	$2,086.82
Adverstising	$15,186.99

Elliot Publishers	$24.00
Sams-Membership	$100.00
Brown County State Bank-Safe Deposit	$10.00
Sec State Annual Fee	$35.00
Sec State Close Partnership fee	$25.00
Quincy Herald Whig	$159.55
Quincy Chamber Membership	$241.00
Van Sticker	$10.00
Nursing Home Admin License	$100.00
CLIA License	$150.00
MDS User Manual Subscription	$44.85
Rounding	-$1.00
	$18,172.21

Golden Good Shepherd

11/01/16 to 10/31/17

	Medicaid		Medicare		Pvt		
	SNF	ICF	SNF	ICF	SNF	ICF	
November	0	346	70	0	30	593	1039
December	0	341	36	0	49	614	1040
January	0	321	13	0	57	632	1023
February	0	286	87	0	19	553	945
March	0	338	76	0	62	558	1034
April	0	330	64	0	97	564	1055
May	0	341	41	0	42	576	1000
June	0	340	38	0	80	549	1007
July	0	387	50	0	31	589	1057
August	0	353	113	0	32	535	1033
September	0	359	62	0	60	497	978
October	0	400	76	0	52	466	994
	0	4142	726	0	611	6726	12205

Golden Good Shepherd
#0009175
11/01/16 to 10/31/17

Schedule V. Line 23, Column 3

Check Date	When Attended	Vendor Name	Name of In-Service	Amount
4/27/2017	Apr-17	Quincy Fire Specialists	All Staff Fire Training	$120.00
6/5/2017	Jun-17	IHCA	Quapi Training	$55.00
7/5/2017	Jul-17	IHCA	Quapi Training	$55.00
6/23/2017	6/23/2017	Alex Ussery	CPR Training	$840.00
7/20/2017	7/20/2017	Alex Ussery	CPR Training	$120.00
8/23/2017	8/23/2017	IDFPR	Administrator Testing	$703.00
6/5/2017		Nabweb	Administrator Testing	$130.00
				$2,023.00

Golden Good Shepherd
#0009175
11/01/16 to 10/31/17

2017 Conferences

Date	Location	Sponsor	Attendees	Registration cost	Mileage	Meals	Hotel	Parking/Taxi	
10/4/2016	Quincy, IL	Educational Services		$ 10.00					
11/2/2016	Springfield, IL	Illinois Nursing Home	Marlow	$ 250.00	$ 118.80	$ 5.03			
1/11/2017	Springfield, IL	IHCA	Marlow	$ 155.00	$ 105.93	$ 13.95		$ 3.00	
1/20/2017	Quincy, IL	Adams CTY Health	Marlow	$ 128.11					
2/15/2017	Springfield, IL	IHCA - QAPI	Marlow	$ 55.00					
2/28/2017	Quincy, IL	Sanitation Classes	Laning		$ 64.80				
4/5/2017	Springfield, IL	American Red Cross	Scogins	$ 110.00	$ 118.80				
5/23/2017	Springfield, IL	IHCA	Wayman	$ 275.00	$ 126.90				
8/22/2017	Lincoln, IL	Disaster Plan Training	Wayman	free	$ 155.52				
9/12/2017	Quincy, IL	Career Track	Wayman	$ 695.00					
			Whitaker						
			Laning						
			Clark						
									Totals
				$ 1,678.11	$ 690.75	$ 18.98	$ -	$ 3.00	$ 2,390.84