		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0012955

Facility Name: GOOD SAM SOC - PROPHETS RIVERVIEW

Address: 310 Mosher Drive (Number) Prophetstown (City) 61277-1002 (Zip Code)

County: Whiteside

Telephone Number: 825-537-5175 **Fax #** 825-53-2628

HFS ID Number:

Date of Initial License for Current Owners: 09/20/1967

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 None

	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	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,338	7,199	1,464	14,001	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,338	7,199	1,464	14,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.80%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/20/1967

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified and days of care provided 1,146

Medicare Intermediary Noridian Administrative Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/01/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIE # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	134,090	9,258	5,658	149,006		149,006	(114)	148,892			1
2	Food Purchase		101,489		101,489		101,489	(2,833)	98,656			2
3	Housekeeping	32,404	10,517		42,921		42,921	(134)	42,787			3
4	Laundry	32,299	6,760		39,059		39,059	(92)	38,967			4
5	Heat and Other Utilities			72,698	72,698		72,698		72,698			5
6	Maintenance	51,451	10,138	52,884	114,473		114,473	(9,628)	104,845			6
7	Other (specify):*			172	172		172	(55)	117			7
8	**TOTAL General Services**	250,244	138,162	131,412	519,818		519,818	(12,856)	506,962			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	992,663	98,011	93,647	1,184,321		1,184,321	(53,909)	1,130,412			10
10a	Therapy		597	308,629	309,226		309,226	(109,706)	199,520			10a
11	Activities	45,362	5,019	8,797	59,178		59,178	(69)	59,109			11
12	Social Services	32,190		3,911	36,101		36,101		36,101			12
13	CNA Training											13
14	Program Transportation			3,035	3,035		3,035		3,035			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,070,215	103,627	432,419	1,606,261		1,606,261	(163,684)	1,442,577			16
	C. General Administration											
17	Administrative	103,571		143,640	247,211		247,211	38,513	285,724			17
18	Directors Fees											18
19	Professional Services			3,816	3,816		3,816		3,816			19
20	Dues, Fees, Subscriptions & Promotions			12,718	12,718		12,718	(7,179)	5,539			20
21	Clerical & General Office Expenses	63,394	54,412	56,310	174,116		174,116	(10,643)	163,473			21
22	Employee Benefits & Payroll Taxes			356,217	356,217		356,217	(51,551)	304,666			22
23	Inservice Training & Education			4,094	4,094		4,094		4,094			23
24	Travel and Seminar			5,387	5,387		5,387	(4,433)	954			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,575	53,575		53,575	37,449	91,024			26
27	Other (specify):*	2,664		4	2,668		2,668	(2,670)	(2)			27
28	**TOTAL General Administration**	169,629	54,412	635,761	859,802		859,802	(514)	859,288			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,490,088	296,201	1,199,592	2,985,881		2,985,881	(177,054)	2,808,827			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 - PROPHETS RIVERVIEW #0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			175,127	175,127		175,127	(20,474)	154,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,984)	(1,984)		(1,984)		(1,984)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,874	25,874		25,874		25,874			35
36	Other (specify):*											36
37	**TOTAL Ownership**			199,017	199,017		199,017	(20,474)	178,543			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			121,633	121,633		121,633		121,633			42
43	Other (specify):*			9,314	9,314		9,314	(4,642)	4,672			43
44	**TOTAL Special Cost Centers**			130,947	130,947		130,947	(4,642)	126,305			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,490,088	296,201	1,529,556	3,315,845		3,315,845	(202,170)	3,113,675			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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(2,833)	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	1,137	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	(225,121)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,817)		$	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)	24,635		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 24,635		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (202,182)		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 - PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (114)	1	1
2	See Attached Schedule	(134)	3	2
3	See Attached Schedule	(92)	4	3
4	See Attached Schedule	(9,628)	6	4
5	See Attached Schedule	(55)	7	5
6	See Attached Schedule	(53,909)	10	6
7	See Attached Schedule	(109,706)	10a	7
8	See Attached Schedule	(69)	11	8
9	See Attached Schedule	(7,179)	20	9
10	See Attached Schedule	(11,780)	21	10
11	See Attached Schedule	(236)	22	11
12	See Attached Schedule	(4,433)	24	12
13	See Attached Schedule	(2,670)	27	13
14	See Attached Schedule	(20,474)	30	14
15	See Attached Schedule	(4,642)	43	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(225,121)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(114)	0	0	0	0	0	0	0	0	0	0	(114)	1
2	Food Purchase	(2,833)	0	0	0	0	0	0	0	0	0	0	(2,833)	2
3	Housekeeping	(134)	0	0	0	0	0	0	0	0	0	0	(134)	3
4	Laundry	(92)	0	0	0	0	0	0	0	0	0	0	(92)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(9,628)	0	0	0	0	0	0	0	0	0	0	(9,628)	6
7	Other (specify):*	(55)	0	0	0	0	0	0	0	0	0	0	(55)	7
8	TOTAL General Services	(12,856)	0	0	0	0	0	0	0	0	0	0	(12,856)	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	(53,909)	0	0	0	0	0	0	0	0	0	0	(53,909)	10
10a	Therapy	(109,706)	0	0	0	0	0	0	0	0	0	0	(109,706)	10a
11	Activities	(69)	0	0	0	0	0	0	0	0	0	0	(69)	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	(163,684)	0	0	0	0	0	0	0	0	0	0	(163,684)	16
	C. General Administration													
17	Administrative	0	38,513	0	0	0	0	0	0	0	0	0	38,513	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	(7,179)	0	0	0	0	0	0	0	0	0	0	(7,179)	20
21	Clerical & General Office Expenses	(10,643)	0	0	0	0	0	0	0	0	0	0	(10,643)	21
22	Employee Benefits & Payroll Taxes	(236)	(51,315)	0	0	0	0	0	0	0	0	0	(51,551)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,433)	0	0	0	0	0	0	0	0	0	0	(4,433)	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	37,437	0	0	0	0	0	0	0	0	0	37,437	26
27	Other (specify):*	(2,670)	0	0	0	0	0	0	0	0	0	0	(2,670)	27
28	TOTAL General Administration	(25,161)	24,635	0	0	0	0	0	0	0	0	0	(526)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(201,701)	24,635	0	0	0	0	0	0	0	0	0	(177,066)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

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	(20,474)	0	0	0	0	0	0	0	0	0	0	(20,474)	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**	(20,474)	0	0	0	0	0	0	0	0	0	0	(20,474)	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):*	(4,642)	0	0	0	0	0	0	0	0	0	0	(4,642)	43
44	**TOTAL Special Cost Centers**	(4,642)	0	0	0	0	0	0	0	0	0	0	(4,642)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(226,817)	24,635	0	0	0	0	0	0	0	0	0	(202,182)	45

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Admin/Accounting	$ 143,640	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 182,153	$ 38,513	1
2	V	22	Workers Compensation	69,616	The Evangelical Lutheran Good Samaritan Society	100.00%	51,222	(18,394)	2
3	V	22	Unemployment	53,575	The Evangelical Lutheran Good Samaritan Society	100.00%	10,220	(43,355)	3
4	V	26	Insurance	8,793	The Evangelical Lutheran Good Samaritan Society	100.00%	46,230	37,437	4
5	V	22	Group Health Insurance	144,982	The Evangelical Lutheran Good Samaritan Society	100.00%	155,416	10,434	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			$ 420,606			$ 445,241	$ * 24,635	14

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Dr Gwen Halaas	0	BOD					1
2	Dale Thompson	0	BOD					2
3	Alan Gard	0	BOD					3
4	Jill Schumann	0	BOD					4
5	Randy Bury	0	BOD					5
6	Kelby Krabbenhoft	0	BOD					6
7	Patricia Camero	0	BOD					7
8	Heather Krzmarzick	0	BOD					8
9	Lee Laaveg	0	BOD					9
10	John Racek	0	BOD					10
11	Dina Robinson	0	BOD					11
12	Lisa Melby	0	BOD					12
13	Timothy Phillippe	0	BOD					13
14	Norval Beckneberg	0	BOD					14
15	Rebecca Bollig	0	BOD					15
16	Scott Petersen	0	BOD					16
17	Javier Espinosa	0	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 - PROPHETS RIVERVII # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 - PROPHETS RIVERVIE # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:		
2013		8
2014		9
2015		10
2016		11
2017		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GOOD SAM SOC - PROPHETS RIVERVIEW COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,848 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1967	$ 321,110	$		$	$	$ 321,110	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1973	669					669	9
10				1974	483					483	10
11				1975	33,671					33,671	11
12				1977	3,561					3,561	12
13				1978	2,854					2,854	13
14				1979	10,205					10,205	14
15				1980	1,654	9		9		1,645	15
16				1981	60,747	1,404		1,404		56,870	16
17				1982	10,416					10,416	17
18				1983	850					850	18
19				1984	8,091					8,091	19
20				1985	10,418					10,418	20
21				1986	2,284					2,284	21
22				1987	78,081					78,081	22
23				1988	36,635					36,635	23
24				1989	90,335					90,335	24
25				1990	792,306					792,306	25
26				1991	4,175					4,151	26
27				1992	24,125					24,125	27
28				1993	3,293					3,293	28
29				1994	40,485					40,485	29
30				1995	16,185					16,185	30
31				1996	36,794	240		240		35,811	31
32				1997	45,715	1,339		1,339		41,476	32
33				1998	20,385	207		207		20,385	33
34				1999	17,314	172		172		17,243	34
35				2000	14,454	48		48		14,383	35
36				2001	40,084	1,242		1,242		36,762	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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2002	$ 145,904	$ 93		$ 93	$	$ 145,356	37
38		2003	62,734	109		109		62,734	38
39		2004	68,785	361		361		66,824	39
40		2005	196,858	7,849		7,849		180,648	40
41		2006	206,296	9,974		9,974		165,010	41
42		2007	238,987	6,386		6,386		160,533	42
43		2008	71,789	1,834		1,834		63,649	43
44		2009	74,816	4,412		4,412		38,373	44
45		2010	90,659	5,380		5,380		54,046	45
46		2011	90,870	5,842		5,842		48,407	46
47		2012	45,921	4,362		4,362		26,985	47
48		2013	79,444	7,039		7,039		38,849	48
49		2014	205,605	18,748		18,748		80,663	49
50	TRINITY BOILER INDUCER MOTOR	2015	1,440	144		144		528	50
51	BUILDING-100/200 SHOWER RM RMD	2015	16,899	676		676		2,422	51
52	TILE-100/200 SHOWER RM RMD	2015	9,053	453		453		1,622	52
53	PLBG-100/200 SHOWER RM RMD	2015	1,054	53		53		189	53
54	BLDG-INTERIOR WALL REPAIR/PAIN	2016	49,259	1,970		1,970		5,254	54
55	PAINT-INTER WALL REPAIR/PAIN	2016	16,075	3,215		3,215		8,573	55
56	BLDG-REMODEL DISHWASHING ROOM	2016	10,305	412		412		1,099	56
57	DOUBLE HUNG WINDOWS	2016	43,635	2,182		2,182		5,818	57
58	PUSH BUTTON DIGITAL ACCESS	2016	853	57		57		161	58
59	HEAT EXCHANGE- S 300 WING RTU	2016	3,800	507		507		1,478	59
60	RESIDENT RM BLINDS (37)	2016	1,416	283		283		755	60
61	WATER HEATER	2016	8,400	840		840		2,030	61
62	BLINDS-DINING ROOM ADDITION	2017	3,859	772		772		1,543	62
63	BUILDING-DINING ROOM ADDITION	2017	194,127	7,765		7,765		15,530	63
64	CABINETS-DINING ROOM ADDITION	2017	12,966	864		864		1,729	64
65	CARPET-DINING ROOM ADDITION	2017	13,900	2,780		2,780		5,560	65
66	DOORS-DINING ROOM ADDITION	2017	3,750	250		250		500	66
67	ELECTRIC-DINING ROOM ADDITION	2017	14,500	967		967		1,933	67
68	HVAC-DINING ROOM ADDITION	2017	12,000	800		800		1,600	68
69	INSULATION-DINING ROOM ADD	2017	9,310	466		466		931	69
70	TOTAL (lines 4 thru 69)		$ 3,732,648	$ 102,505		$ 102,505	$	$ 2,906,113	70

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 3,732,648	$ 102,505		$ 102,505	$	$ 2,906,113	1
2	PAINT-DINING ROOM ADD	2017	7,698	1,540		1,540		3,079	2
3	PLUMBING-DINING ROOM ADD	2017	1,500	75		75		150	3
4	ROOF-DINING ROOM ADD	2017	9,160	458		458		916	4
5	SPRINKLER-DINING ROOM ADD	2017	4,950	198		198		396	5
6	WINDOWS-DINING ROOM ADD	2017	5,000	333		333		667	6
7	PLUMBING REPAIRS	2016	2,940	392		392		915	7
8	WINDOWS(9)-OFFICE/BEAUTY SHOP	2015	4,365	291		291		873	8
9	CISCO 24 PORT SWITCH	2015	1,126	225		225		807	9
10	PAINT	2017	10,167	2,033		2,033		2,372	10
11	SHOWER HEAD	2018	835	42		42		42	11
12	MOP SINK	2018	8,324	185		185		185	12
13	WATER HEATER	2018	10,500	438		438		438	13
14	FIRE ALARM PANEL	2015	3,189	319		319		1,010	14
15	HEAT EXCHANGE REPAIR	2015	3,800	507		507		1,562	15
16	WATER HEATER REPAIR	2015	917	183		183		596	16
17	LANDSCAPING - MULCH	2015	6,047	605		605		2,268	17
18									18
19	Adjust PY Depreciation						(20,474)		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)		$ 3,813,166	$ 110,329		$ 110,329	$ (20,474)	$ 2,922,389	34

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 344,027	$ 36,446	$ 36,446	$		$ 187,361	71
72	Current Year Purchases	28,697	3,215	3,215			3,215	72
73	Fully Depreciated Assets	482,259	2,012	2,012			482,259	73
74								74
75	TOTALS	$ 854,983	$ 41,673	$ 41,673	$		$ 672,835	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Home]	Older Assets	Many	$ 52,836	$	$	$	4	$ 52,836	76
77	Nursing Home]	1995 Chrylser Van	2008	3,000				3	3,000	77
78	Nursing Home]	2010 Ford Transport	2012	19,000				4	19,000	78
79	Nursing Home]	2006 Ford Van	2012	16,018				4	16,018	79
80	TOTALS			$ 90,854	$	$	$		$ 90,854	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,774,003	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,002	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,002	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,474)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,686,078	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$	$	$	86
87	Building & Land Improvements	2,353,484	78,727	1,051,219	87
88	FFE	107,146	6,453	75,449	88
89					89
90					90
91	TOTALS	$ 2,460,630	$ 85,180	$ 1,126,668	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 14,374	92
93			93
94			94
95		$ 14,374	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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 25,874 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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	7,654	$ 114,813	$ 107	7,654	$ 114,920	1
2	Licensed Speech and Language Development Therapist	Line 10A, Col 3	hrs		1,845	27,675		1,845	27,675	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10A, Col 3	hrs		10,958	164,372		10,958	164,372	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			$	20,457	$ 306,860	$ 107	20,457	$ 306,967	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 GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 99,263	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 554,860)	275,714		3
4	Supply Inventory (priced at)	11,274		4
5	Short-Term Investments	36,095		5
6	Prepaid Insurance	2,683		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(4,895)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 420,134	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	5,728,242		14
15	Leasehold Improvements, at Historical Cost	438,410		15
16	Equipment, at Historical Cost	1,052,982		16
17	Accumulated Depreciation (book methods)	(4,815,483)		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):	32,623		22
23	Other(specify):	157,985		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,609,759	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,029,893	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,102	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,210		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,262		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,720		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,188		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	11,528		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 265,010	$	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	Deferred Liabilities	1,747,309		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,747,309	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,012,319	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,017,574	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,029,893	$	48

*(See instructions.)

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,544,505	1
2	Restatements (describe):		2
3	Senior Living	(139,450)	3
4	Apartments	14,285	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,419,340	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(619,190)	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)**	$ (619,190)	17
	B. Transfers (Itemize):		
18	Dnr Restricted Accounts	(6,865)	18
19	SOA Accounts	228,365	19
20	Intra Co Transfer	875	20
21	Audit Adjustment	(4,951)	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 217,424	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,017,574	24 *

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

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 2,935,056	1
2	Discounts and Allowances for all Levels	(1,056,738)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,878,318	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	20,335	5
6	Therapy	1,115,393	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,135,728	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,227	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs	122,543	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,755	19
20	Radiology and X-Ray	3,202	20
21	Other Medical Services	3,185	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 136,962	23
	D. Non-Operating Revenue		
24	Contributions	11,935	24
25	Interest and Other Investment Income***	14,749	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,684	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	26,716	28
28a	Misc Income/PY Settlements	(507,752)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (481,036)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,696,656	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	519,819	31
32	Health Care	1,606,261	32
33	General Administration	859,802	33
	B. Capital Expense		
34	Ownership	199,017	34
	C. Ancillary Expense		
35	Special Cost Centers	9,314	35
36	Provider Participation Fee	121,633	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,315,846	40
41	**Income before Income Taxes (line 30 minus line 40)****	(619,190)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (619,190)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 724,125	44
45	Private Pay - Net Inpatient Revenue	1,406,085	45
46	Medicare - Net Inpatient Revenue	558,623	46
47	Other-(specify)	185,257	47
48	Other-(specify)	(995,772)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,878,318	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 - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,072	2,122	$ 70,308	$ 33.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,561	9,948	316,657	31.83	3
4	Licensed Practical Nurses	6,967	7,477	221,688	29.65	4
5	CNAs & Orderlies	25,566	28,426	393,803	13.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,544	1,764	27,203	15.42	9
10	Activity Assistants	1,475	1,985	22,979	11.58	10
11	Social Service Workers	1,359	1,604	34,690	21.63	11
12	Dietician					12
13	Food Service Supervisor	1,397	1,580	23,940	15.15	13
14	Head Cook	3,965	4,458	54,774	12.29	14
15	Cook Helpers/Assistants	5,029	5,724	59,623	10.42	15
16	Dishwashers					16
17	Maintenance Workers	3,102	3,453	54,015	15.64	17
18	Housekeepers	2,999	3,178	32,440	10.21	18
19	Laundry	2,382	2,590	31,147	12.03	19
20	Administrator	1,780	2,106	92,166	43.76	20
21	Assistant Administrator					21
22	Other Administrative	2,115	2,797	61,901	22.13	22
23	Office Manager	1,176	1,356	20,475	15.10	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	1,249	1,374	22,834	16.62	31
32	Other Health Care(specify)					32
33	Other(specify) Med Records	136	157	2,664	16.97	33
34	TOTAL (lines 1 - 33)	72,874	82,099	$ 1,543,307 *	$ 18.80	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	123	$ 5,176	Ln 1, Col 3	35
36	Medical Director		14,400	Ln 10, col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,431	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	18	525	Ln 11, col 3	44
45	Social Service Consultant	130	3,911	Ln 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	307	$ 25,443		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	488	$ 24,423	Ln 10, col 3	50
51	Licensed Practical Nurses	1,080	43,207	Ln 10, col 3	51
52	Certified Nurse Assistants/Aides	746	22,379	Ln 10, col 3	52
53	TOTAL (lines 50 - 52)	2,314	$ 90,009		53

Facility Name & ID Number GOOD SAM SOC - PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gail Blcoker	Administrator	100	$ 56,569
Benjamin Ornelas	Administrator	100	47,002
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,571

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 143,640
TOTAL (agree to Schedule V, line 17, col. 3)	$ 143,640
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gallup	Survey Services	$ 3,816
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 3,816

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,616
Unemployment Compensation Insurance	8,920
FICA Taxes	114,200
Employee Health Insurance	144,982
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	10,226
Taxable Gifts	4,284
Other	3,989
Offset (Page 5a)	(51,551)
TOTAL (agree to Schedule V, line 22, col.8)	$ 304,666

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,642
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	4,311
Publications	3,765
Less: Public Relations Expense	( )
Non-allowable advertising	(7,179)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,539

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	954
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 954

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN-4379, $4,620**

(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? **10.833**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,211** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **121,633**
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. $ **2,833** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,833**

(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? **11%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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