		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: 0007344

Facility Name: GOOD SAM SOC - MT CARROLL

Address: 1006 N Lowden Rd (Number) Mount Caroll (City) 60153-0008 (Zip Code)

County: Carroll

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code

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 - MT CARROLL # 0007344 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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	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	6,972	7,851	2,604	17,427	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,972	7,851	2,604	17,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.31%

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)
MEALS ON WHEELS

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 2,192

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 - MT CARROLL # 0007344 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	182,047	12,217	8,114	202,378		202,378	(155)	202,223			1
2	Food Purchase		111,311		111,311		111,311	(6,004)	105,307			2
3	Housekeeping	44,682	10,473		55,155		55,155	(137)	55,018			3
4	Laundry	29,521	5,345		34,866		34,866	(70)	34,796			4
5	Heat and Other Utilities			87,047	87,047		87,047		87,047			5
6	Maintenance	45,093	4,628	62,380	112,101		112,101	(2,834)	109,267			6
7	Other (specify):*			345	345		345	(23)	322			7
8	TOTAL General Services	301,343	143,974	157,886	603,203		603,203	(9,223)	593,980			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	1,171,344	177,107	342,982	1,691,433		1,691,433	(117,072)	1,574,361			10
10a	Therapy		3,043	366,180	369,223		369,223	(82,801)	286,422			10a
11	Activities	56,831	2,880	454	60,165		60,165	(34)	60,131			11
12	Social Services	37,918		789	38,707		38,707		38,707			12
13	CNA Training											13
14	Program Transportation			2,418	2,418		2,418		2,418			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,266,093	183,030	715,023	2,164,146		2,164,146	(199,907)	1,964,239			16
	C. General Administration											
17	Administrative	85,389		203,171	288,560		288,560	23,502	312,062			17
18	Directors Fees											18
19	Professional Services			3,904	3,904		3,904		3,904			19
20	Dues, Fees, Subscriptions & Promotions			23,055	23,055		23,055	(17,014)	6,041			20
21	Clerical & General Office Expenses	88,680	78,696	33,480	200,856		200,856	(9,263)	191,593			21
22	Employee Benefits & Payroll Taxes			391,766	391,766		391,766	(23,995)	367,771			22
23	Inservice Training & Education			5,374	5,374		5,374	(1,721)	3,653			23
24	Travel and Seminar			10,438	10,438		10,438	(3,628)	6,810			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,394	56,394		56,394	41,077	97,471			26
27	Other (specify):*	11,490		1	11,491		11,491	(11,515)	(24)			27
28	TOTAL General Administration	185,559	78,696	727,583	991,838		991,838	(2,557)	989,281			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,752,995	405,700	1,600,492	3,759,187		3,759,187	(211,687)	3,547,500			29

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL #0007344 Report Period Beginning: 01/01/2018 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			204,718	204,718		204,718	(1,187)	203,531			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,041	27,041		27,041		27,041			35
36	Other (specify):*											36
37	**TOTAL Ownership**			231,759	231,759		231,759	(1,187)	230,572			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			139,072	139,072		139,072		139,072			42
43	Other (specify):*			6,746	6,746		6,746	(6,746)				43
44	**TOTAL Special Cost Centers**			145,818	145,818		145,818	(6,746)	139,072			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,752,995	405,700	1,978,069	4,136,764		4,136,764	(219,620)	3,917,144			45

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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	(9,700)	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	1,239	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	(256,438)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (264,899)		$	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)	41,571		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 41,571		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (223,328)		37

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

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

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

GOOD SAM SOC - MT CARROLL

ID# 0007344

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	See Attached Schedule	$ (155)	1	1
2	See Attached Schedule	(137)	3	2
3	See Attached Schedule	(70)	4	3
4	See Attached Schedule	(2,834)	6	4
5	See Attached Schedule	(23)	7	5
6	See Attached Schedule	(117,072)	10	6
7	See Attached Schedule	(82,801)	10a	7
8	See Attached Schedule	(34)	11	8
9	See Attached Schedule	(17,014)	20	9
10	See Attached Schedule	(10,502)	21	10
11	See Attached Schedule	(999)	22	11
12	See Attached Schedule	(1,721)	23	12
13	See Attached Schedule	(3,628)	24	13
14	See Attached Schedule	(11,515)	27	14
15	See Attached Schedule	(1,187)	30	15
16	See Attached Schedule	(6,746)	43	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**	(256,438)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 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	(155)	0	0	0	0	0	0	0	0	0	0	(155)	1
2	Food Purchase	(9,700)	0	0	0	0	0	0	0	0	0	0	(9,700)	2
3	Housekeeping	(137)	0	0	0	0	0	0	0	0	0	0	(137)	3
4	Laundry	(70)	0	0	0	0	0	0	0	0	0	0	(70)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,834)	0	0	0	0	0	0	0	0	0	0	(2,834)	6
7	Other (specify):*	(23)	0	0	0	0	0	0	0	0	0	0	(23)	7
8	TOTAL General Services	(12,919)	0	0	0	0	0	0	0	0	0	0	(12,919)	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	(117,072)	0	0	0	0	0	0	0	0	0	0	(117,072)	10
10a	Therapy	(82,801)	0	0	0	0	0	0	0	0	0	0	(82,801)	10a
11	Activities	(34)	0	0	0	0	0	0	0	0	0	0	(34)	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	(199,907)	0	0	0	0	0	0	0	0	0	0	(199,907)	16
	C. General Administration													
17	Administrative	0	23,502	0	0	0	0	0	0	0	0	0	23,502	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	(17,014)	0	0	0	0	0	0	0	0	0	0	(17,014)	20
21	Clerical & General Office Expenses	(9,263)	0	0	0	0	0	0	0	0	0	0	(9,263)	21
22	Employee Benefits & Payroll Taxes	(999)	(22,996)	0	0	0	0	0	0	0	0	0	(23,995)	22
23	Inservice Training & Education	(1,721)	0	0	0	0	0	0	0	0	0	0	(1,721)	23
24	Travel and Seminar	(3,628)	0	0	0	0	0	0	0	0	0	0	(3,628)	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	41,065	0	0	0	0	0	0	0	0	0	41,065	26
27	Other (specify):*	(11,515)	0	0	0	0	0	0	0	0	0	0	(11,515)	27
28	TOTAL General Administration	(44,140)	41,571	0	0	0	0	0	0	0	0	0	(2,569)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(256,966)	41,571	0	0	0	0	0	0	0	0	0	(215,395)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(1,187)	0	0	0	0	0	0	0	0	0	0	(1,187)	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**	(1,187)	0	0	0	0	0	0	0	0	0	0	(1,187)	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):*	(6,746)	0	0	0	0	0	0	0	0	0	0	(6,746)	43
44	**TOTAL Special Cost Centers**	(6,746)	0	0	0	0	0	0	0	0	0	0	(6,746)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(264,899)	41,571	0	0	0	0	0	0	0	0	0	(223,328)	45

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 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	$ 203,171	The Evangelical Lutheran Good Samaritan Society	100.00%	$ 226,673	$ 23,502	1
2	V	22	Workers Compensation	23,765	The Evangelical Lutheran Good Samaritan Society	100.00%	36,660	12,895	2
3	V	22	Unemployment	56,394	The Evangelical Lutheran Good Samaritan Society	100.00%	7,300	(49,094)	3
4	V	26	Insurance	6,249	The Evangelical Lutheran Good Samaritan Society	100.00%	47,314	41,065	4
5	V	22	Group Health Insurance	183,449	The Evangelical Lutheran Good Samaritan Society	100.00%	196,652	13,203	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			$ 473,028			$ 514,599	$ * 41,571	14

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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 - MT CARROLL # 0007344 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 - MT CARROLL # 0007344 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 - MT CARROLL # 0007344 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 - MT CARROLL # 0007344 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 - MT CARROLL COUNTY Carroll

FACILITY IDPH LICENSE NUMBER 0007344

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 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 - MT CARROLL # 0007344 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		1968	$ 5,720	1
2					2
3	TOTALS			$ 5,720	3

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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				1970	$ 388,819	$		$	$	$ 388,819	4
5				1991	805,551					805,551	5
6				2010	192,900	7,716		7,716		68,158	6
7											7
8				1970	3,703					3,703	8
	Improvement Type**										
9				1971	262					262	9
10				1975	1,986					1,986	10
11				1976	2,090					2,090	11
12				1977	185					185	12
13				1979	5,570					5,570	13
14				1980	1,559					1,559	14
15				1981	33,937					33,627	15
16				1982	29,188					29,188	16
17				1983	8,193					8,193	17
18				1984	1,224					1,224	18
19				1986	4,163					4,163	19
20				1987	15,273					15,273	20
21				1988	6,707					6,707	21
22				1989	5,010					5,010	22
23				1990	6,322					6,322	23
24				1991	98,155					95,713	24
25				1992	10,350					10,350	25
26				1993	4,260					4,260	26
27				1994	62,344					62,344	27
28				1995	36,466					36,466	28
29				1996	78,462					78,462	29
30				1997	20,996					20,996	30
31				1998	16,770	229		229		16,770	31
32				1999	37,004	736		736		36,412	32
33				2000	88,586	921		921		76,811	33
34				2002	51,858	28		28		51,749	34
35				2003	58,269	2,815		2,815		45,806	35
36				2004	7,703	441		441		6,263	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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		2005	$ 109,024	$ 3,225		$ 3,225	$	$ 72,875	37
38		2006	385,284	17,135		17,135		230,570	38
39		2007	29,076	654		654		26,824	39
40		2008	155,962	9,699		9,699		113,631	40
41		2009	128,025	7,936		7,936		74,705	41
42		2010	177,516	10,680		10,680		119,483	42
43		2011	15,113	1,384		1,384		10,599	43
44		2012	264,943	24,665		24,665		157,882	44
45		2013	134,978	13,347		13,347		77,742	45
46		2014	70,714	3,532		3,532		15,918	46
47	PARKING LOT/BUS SLAB/SHED	2015	20,897	1,393		1,393		4,644	47
48	ELECTRIC-EMERGENCY LIGHTING	2015	2,489	166		166		595	48
49	EMERGENCY LIGHTING	2015	3,270	218		218		781	49
50	PAINT-RES RM/ENTRANCE/KITCHEN	2016	18,060	3,612		3,612		10,535	50
51	HVAC - CARRIER MODEL HIM OFFIC	2015	1,975	132		132		461	51
52	LIFE SAFTEY - ELEC/WIRING	2015	16,390	820		820		2,663	52
53	REMSTAR AUTO HUMIDIFIER	2015	792	53		53		163	53
54	FRONT DR - 600LB SMALL 301LOCK	2016	1,309	87		87		254	54
55	HVAC - TEK MAR PANELS	2015	3,817	254		254		806	55
56	ASBESTOS ABATE-RESIDENT HALLS	2016	13,800	1,380		1,380		3,105	56
57	CARPET-SNF HALLS	2016	18,428	3,686		3,686		8,293	57
58	CARPET-OFFICES	2016	8,021	1,604		1,604		3,476	58
59	CLOSET DOORS	2017	34,920	2,328		2,328		4,656	59
60	GE ZONELINE PTAC HEAT PUMP	2016	647	43		43		86	60
61	GENERATOR REPAIR	2016	1,321	132		132		330	61
62	RADIATOR FOR GENERATOR	2016	9,224	922		922		2,306	62
63	VINYL FLOOR	2016	3,510	351		351		702	63
64	LED LIGHT FIXTURES	2017	10,007	1,001		1,001		1,751	64
65	PULL STATION-EMPLOYEE BREAK RM	2017	1,190	119		119		208	65
66	DOOR REPAIRS	2017	1,642	219		219		383	66
67	KITCHEN DRAINS	2017	17,820	891		891		1,114	67
68	REMODEL BATHROOM/ADD SHOWER	2017	1,500	100		100		133	68
69	SECURITY CAMERA	2017	657	131		131		252	69
70	TOTAL (lines 4 thru 69)		$ 3,746,183	$ 124,785		$ 124,785	$	$ 2,877,914	70

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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		$ 3,746,183	$ 124,785		$ 124,785	$	$ 2,877,914	1
2	GUTTERS	2016	2,795	280	120	280		699	2
3	ELECTRIC-RESIDENT SHOWER ROOMS	2017	3,476	232	180	232		270	3
4	SCREENED-IN PORCH	2018	9,190	306	180	306		306	4
5	CALL SYSTEM	2018	5,703	428	120	428		428	5
6	GENERATOR REPAIR	2018	6,882	172	120	172		172	6
7	TILE	2017	665	33	240	33		42	7
8	WATER SOFTENER	2018	5,345	223	120	223		223	8
9	ROOF REPAIR	2018	2,820	118	120	118		118	9
10	CONCRETE SIDEWALKS	2016	3,190	213	180	213		443	10
11	PRIAVCY FENCE WHITE VINYL	2016	7,794	779	120	779		1,689	11
12									12
13	PY Depreciation						(1,187)		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,794,043	$ 127,569		$ 127,569	$ (1,187)	$ 2,882,304	34

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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	$ 445,052	$ 45,849	$ 45,849	$		$ 251,341	71
72	Current Year Purchases	18,517	1,217	1,217			1,217	72
73	Fully Depreciated Assets	798,002	3,103	3,103			798,002	73
74								74
75	TOTALS	$ 1,261,571	$ 50,169	$ 50,169	$		$ 1,050,560	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	2005 Chevrolet Pickup	2005	$ 14,272	$	$	$		$ 14,272	76
77	Nursing Home	2016 Dodge Caravan	2016	39,750	9,938	9,938			33,125	77
78	Nursing Home	2016 Ford Starcraft	2016	55,806	13,952	13,952			43,017	78
79										79
80	TOTALS			$ 109,828	$ 23,890	$ 23,890	$		$ 90,414	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,171,162	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,628	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,628	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,187)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,023,278	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	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 GOOD SAM SOC - MT CARROLL # 0007344 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: $ 27,041 Description: General & Admin/Nursing Equipment Rental Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 10a, Col 3	hrs	$	10,008	$ 150,124	$ 199	10,008	$ 150,323	1
2	Licensed Speech and Language Development Therapist	Line 10a, Col 3	hrs		2,879	43,191		2,879	43,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a, Col 3	hrs		11,469	172,033		11,469	172,033	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			$	24,356	$ 365,348	$ 199	24,356	$ 365,547	14

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

STATE OF ILLINOIS

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 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	$ 86,849	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 127,508)	364,829		3
4	Supply Inventory (priced at)	8,781		4
5	Short-Term Investments	48,786		5
6	Prepaid Insurance	1,327		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(2,214)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 508,358	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,720		13
14	Buildings, at Historical Cost	3,419,225		14
15	Leasehold Improvements, at Historical Cost	374,817		15
16	Equipment, at Historical Cost	1,371,400		16
17	Accumulated Depreciation (book methods)	(4,025,183)		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):	12,699		22
23	Other(specify):	12,004		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,170,682	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,679,040	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,863	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,389		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,532		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,749		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,533	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 347,533	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,331,507	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,679,040	$	48

*(See instructions.)

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 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**	$ 1,733,112	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,733,112	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(239,495)	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)**	$ (239,495)	17
	B. Transfers (Itemize):		
18	**Dnr Restricted Assets**	3,909	18
19	**SOA Accounts**	(166,019)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (162,110)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,331,507	24 *

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 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	$ 3,735,043	1
2	Discounts and Allowances for all Levels	(1,625,921)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,109,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,496,273	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,496,273	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	120	13
14	Non-Patient Meals	9,700	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	315,848	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,218	19
20	Radiology and X-Ray	1,766	20
21	Other Medical Services	3,255	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 335,907	23
	D. Non-Operating Revenue		
24	Contributions	(24,588)	24
25	Interest and Other Investment Income***	25,017	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 429	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nursing & Medical Supplies	57,501	28
28a	Misc Income/PY Settlements	(101,963)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (44,462)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,897,269	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	603,204	31
32	Health Care	2,164,146	32
33	General Administration	991,837	33
	B. Capital Expense		
34	Ownership	231,759	34
	C. Ancillary Expense		
35	Special Cost Centers	6,746	35
36	Provider Participation Fee	139,072	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,136,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	(239,495)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (239,495)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 846,651	44
45	Private Pay - Net Inpatient Revenue	1,574,187	45
46	Medicare - Net Inpatient Revenue	1,061,309	46
47	Other-(specify)	337,767	47
48	Other-(specify)	(1,710,792)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,109,122	49

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

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

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

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

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 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	1,485	1,619	$ 58,060	$ 35.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,550	19,270	549,157	28.50	3
4	Licensed Practical Nurses	1,545	1,785	41,580	23.29	4
5	CNAs & Orderlies	32,356	36,715	485,865	13.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,558	1,845	29,944	16.23	9
10	Activity Assistants	2,688	2,969	27,351	9.21	10
11	Social Service Workers	1,823	2,088	36,748	17.60	11
12	Dietician					12
13	Food Service Supervisor	1,967	2,126	40,168	18.89	13
14	Head Cook	4,544	5,291	54,394	10.28	14
15	Cook Helpers/Assistants	8,490	9,197	83,685	9.10	15
16	Dishwashers					16
17	Maintenance Workers	2,572	2,962	46,754	15.78	17
18	Housekeepers	4,374	5,192	49,098	9.46	18
19	Laundry	2,983	3,281	29,048	8.85	19
20	Administrator	1,755	2,083	85,389	40.99	20
21	Assistant Administrator					21
22	Other Administrative	1,469	2,124	51,522	24.26	22
23	Office Manager	2,053	2,239	41,118	18.36	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	1,594	1,949	38,561	19.79	31
32	Other Health Care(specify)					32
33	Other(specify)	603	744	12,291	16.52	33
34	TOTAL (lines 1 - 33)	91,409	103,479	$ 1,760,733 *	$ 17.02	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		$		35
36	Medical Director		2,200	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	57	2,874	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				44
45	Social Service Consultant	26	789	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	83	$ 5,863		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	469	$ 23,426	Ln 10, Col 3	50
51	Licensed Practical Nurses	1,242	49,666	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	8,694	260,828	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	10,405	$ 333,920		53

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LuAnn Brewington	Administrator	100	$ 85,389
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,389

B. Administrative - Other

Description	Amount
Admin/Accounting	$ 203,171
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 203,171

C. Professional Services

Vendor/Payee	Type	Amount
Gallup	Survey Services	$ 3,904
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 3,904

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,765
Unemployment Compensation Insurance	6,415
FICA Taxes	128,395
Employee Health Insurance	183,449
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	38,203
Taxable Gifts	10,321
Other	1,218
Offset (page 5a)	(23,995)
TOTAL (agree to Schedule V, line 22, col.8)	$ 367,771

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	14,729
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues	57,263
Publications	2,603
Less: Public Relations Expense	( )
Non-allowable advertising	(17,014)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,581

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,810
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,810

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GOOD SAM SOC - MT CARROLL # 0007344 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN-4379, $3,431**

(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? **12.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,355** 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. $ **139,072**
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. $ **6,004** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,004**

(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? **28%**
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