

Facility Name & ID Number Golden Good Shepherd Home

0009175 Report Period Beginning: 11/01/2019 Ending: 10/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,836	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,836	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	0	213	730	943	8
9	SNF/PED					9
10	ICF	5,316	6,171	0	11,487	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,316	6,384	730	12,430	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.83%

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)
N/A

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

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

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

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

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

Medicare Intermediary National Governmental Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 10/31/20 Fiscal Year: 10/31/20

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2019 Ending: 10/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	141,193	11,446	2,844	155,483		155,483		155,483		1
2	Food Purchase		91,896		91,896		91,896	(861)	91,035		2
3	Housekeeping	66,168	12,417	2,633	81,218		81,218		81,218		3
4	Laundry	21,943	1,495	45,763	69,201		69,201		69,201		4
5	Heat and Other Utilities			44,207	44,207		44,207		44,207		5
6	Maintenance	36,275	16,154	55,767	108,196		108,196		108,196		6
7	Other (specify):*										7
8	TOTAL General Services	265,579	133,408	151,214	550,201		550,201	(861)	549,340		8
	B. Health Care and Programs										
9	Medical Director			4,779	4,779		4,779		4,779		9
10	Nursing and Medical Records	966,861	67,849	5,180	1,039,890		1,039,890	(155)	1,039,735		10
10a	Therapy	78,185	236	195,388	273,809		273,809	(357)	273,452		10a
11	Activities	57,215	3,598	861	61,674	282	61,956	(77)	61,879		11
12	Social Services	30,315	102	1,425	31,842	(282)	31,560		31,560		12
13	CNA Training										13
14	Program Transportation		3,835		3,835		3,835		3,835		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,132,576	75,620	207,633	1,415,829		1,415,829	(589)	1,415,240		16
	C. General Administration										
17	Administrative	58,662			58,662		58,662		58,662		17
18	Directors Fees										18
19	Professional Services			61,814	61,814		61,814		61,814		19
20	Dues, Fees, Subscriptions & Promotions			27,986	27,986		27,986	(15,588)	12,398		20
21	Clerical & General Office Expenses	47,458	8,346	7,398	63,202		63,202		63,202		21
22	Employee Benefits & Payroll Taxes			165,967	165,967		165,967		165,967		22
23	Inservice Training & Education			5,827	5,827		5,827		5,827		23
24	Travel and Seminar			967	967		967		967		24
25	Other Admin. Staff Transportation		1,235		1,235		1,235		1,235		25
26	Insurance-Prop.Liab.Malpractice			59,299	59,299		59,299		59,299		26
27	Other (specify):*			1,482	1,482		1,482		1,482		27
28	TOTAL General Administration	106,120	9,581	330,740	446,441		446,441	(15,588)	430,853		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,504,275	218,609	689,587	2,412,471		2,412,471	(17,038)	2,395,433		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Golden Good Shepherd Home

#0009175

Report Period Beginning:

11/01/2019

Ending:

10/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			64,663	64,663		64,663	2	64,665		30
31	Amortization of Pre-Op. & Org.			3,471	3,471		3,471		3,471		31
32	Interest							(13,697)	(13,697)		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			5,928	5,928		5,928		5,928		35
36	Other (specify):*			294	294		294		294		36
37	TOTAL Ownership			74,356	74,356		74,356	(13,695)	60,661		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		28,789		28,789		28,789		28,789		39
40	Barber and Beauty Shops		4,815	125	4,940		4,940		4,940		40
41	Coffee and Gift Shops		4,157		4,157		4,157		4,157		41
42	Provider Participation Fee			96,273	96,273		96,273		96,273		42
43	Other (specify):*			95,986	95,986		95,986	(95,986)			43
44	TOTAL Special Cost Centers		37,761	192,384	230,145		230,145	(95,986)	134,159		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,504,275	256,370	956,327	2,716,972		2,716,972	(126,719)	2,590,253		45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(661)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(155)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2	30		9
10	Interest and Other Investment Income	(13,697)	32		10
11	Discounts, Allowances, Rebates & Refunds	(200)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,986)	43		24
25	Fund Raising, Advertising and Promotional	(15,513)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(509)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,719)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (126,719)		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	2	3	4
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/2019

Ending: 10/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Activities Income	\$ (77)	11	1
2	2019 Expenses	(357)	10a	2
3	Cottage Exp	(75)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(509)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019

Ending:

10/31/2020

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(861)	0	0	0	0	0	0	0	0	0	0	(861)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(861)	0	0	0	0	0	0	0	0	0	0	(861)	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	(155)	0	0	0	0	0	0	0	0	0	0	(155)	10
10a	Therapy	(357)	0	0	0	0	0	0	0	0	0	0	(357)	10a
11	Activities	(77)	0	0	0	0	0	0	0	0	0	0	(77)	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	(589)	0	0	0	0	0	0	0	0	0	0	(589)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,588)	0	0	0	0	0	0	0	0	0	0	(15,588)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(15,588)	0	0	0	0	0	0	0	0	0	0	(15,588)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,038)	0	0	0	0	0	0	0	0	0	0	(17,038)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019 Ending:

10/31/2020

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	2	0	0	0	0	0	0	0	0	0	0	2	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,697)	0	0	0	0	0	0	0	0	0	0	(13,697)	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	(13,695)	0	0	0	0	0	0	0	0	0	0	(13,695)	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):*	(95,986)	0	0	0	0	0	0	0	0	0	0	(95,986)	43
44	TOTAL Special Cost Centers	(95,986)	0	0	0	0	0	0	0	0	0	0	(95,986)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(126,719)	0	0	0	0	0	0	0	0	0	0	(126,719)	45

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

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

Facility Name & ID Number

Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019

Ending:

10/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2019 Ending: 10/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019

Ending: 0/31/2020

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

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

Facility Name & ID Number

Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019

Ending:

10/31/2020

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Brown County State Bank		X	Covid Relief		04/20/20	\$ 288,707	\$ 288,707	04/20/22	1.0000	\$ 1,556	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Brown County State Bank		X	Cash Flow	Interest	07/31/19	123,592		07/31/20	4.9500	1,915	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 412,299	\$ 288,707			\$ 3,471	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 412,299	\$ 288,707			\$ 3,471	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 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 2020 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:	2015	8
	2016	9
	2017	10
	2018	11
	2019	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Golden Good Shepherd Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009175

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Golden Good Shepherd Home

0009175 Report Period Beginning:

11/01/2019 Ending:

10/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Cottages

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Facility, 475,705, 1963, \$ 37,727, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 475,705, (blank), \$ 37,727, 3.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019 Ending:

10/31/2020

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1963	1963	\$ 163,629	\$	50	\$	\$	\$ 163,629	4
5		1988	1988	208,384	5,210	40	5,210		167,575	5
6		1989	1989	84,694	2,117	40	2,117		66,873	6
7	4	2015	2015	354,549	9,091	39	9,091		50,758	7
8										8
	Improvement Type**									
9	Building Addition	1967	1967	5,285		20			5,285	9
10	Building Addition	1973	1973	25,841		20			25,841	10
11	Sprinkler System	1975	1975	30,963		20			30,963	11
12	Building Addition	1975	1975	18,103		20			18,103	12
13	Building Addition	1975	1975	1,313		20			1,313	13
14	Building Addition	1976	1976	15,380		20			15,380	14
15	Building Addition	1977	1977	3,981		15			3,981	15
16	Doors	1978	1978	900		20			900	16
17	Building Addition	1980	1980	3,165		15			3,165	17
18	Parking Lot	1985	1985	7,475		15			7,475	18
19	Building Addition	1983	1983	4,174		15			4,174	19
20	Garage	1986	1986	6,473		15			6,473	20
21	Landscaping	1988	1988	620		10			620	21
22	Asphalt	1989	1989	950		15			950	22
23	Building Addition	1990	1990	655		20			652	23
24	Sprinkler System	1992	1992	43,248		25			43,104	24
25	Floor & Foundation Improvements	1997	1997	9,800	251	39	251		6,009	25
26	Parking Lot Expansion	1997	1997	16,320	418	39	418		9,764	26
27	Oxygen Room Venting	1998	1998	2,880	72	40	72		1,635	27
28	Backflow Valve	1998	1998	959	39	25	38	(1)	851	28
29	Laundry Door	1998	1998	3,555		15			3,535	29
30	Backflow Preventor	1999	1999	3,128		20			3,115	30
31	Ceiling	1999	1999	4,657		20			4,637	31
32	Kitchen Floor	2000	2000	1,167		10			1,157	32
33	New Roof Nursing Home	2001	2001	38,956	999	39	999		19,145	33
34	Concrete Activity Room Entrance	2003	2003	4,975		15			4,947	34
35	Remodel Kitchen	2004	2004	5,085		15			5,057	35
36	Concrete Correction	2007	2007	6,500	432	15	433		5,997	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire suppression System	2007	\$ 2,369	\$	10	\$	\$	\$ 2,349	37
38	New Doors	2007	1,584	106	15	106		1,434	38
39	Parking lot Improvements	2007	6,868	458	15	458		5,991	39
40	Sprinkler	2010	107,879	4,315	25	4,315		45,669	40
41	Nurse Call System	2010	58,134	2,907	20	2,907		29,551	41
42	Concrete Pad	2011	1,900	127	15	127		1,182	42
43	Sprinkler Addition	2012	28,700	1,148	25	1,148		9,950	43
44	Shower Room-Materials & Labor	2013	12,814	644	20	645	1	5,051	44
45	Shower Room-Alarm System	2013	3,774	185	20	185		1,456	45
46	Shower Room-Floor Tile	2013	5,800	291	20	291		2,282	46
47	Shower Room-Plumbing	2013	19,153	956	20	956		7,496	47
48	Generator Electrical Switch	2014	22,000	1,105	20	1,100	(5)	7,456	48
49	80 KW Cummins Generator	2014	37,983	1,899	20	1,899		12,819	49
50	sprinkler system	2015	16,400	820	20	820		4,578	50
51	Landscaping	2015	4,588	306	15	306		1,555	51
52	Replaced Skinklers	2018	8,244	412	240	412		1,134	52
53	Hallways/Common Area Painting	2019	4,500	557	8	563	6	791	53
54	Dinning Rm, Act Room Flooring	2020	4,300	72	20	72		72	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,424,754	\$ 34,937		\$ 34,939	\$ 1	\$ 823,879	70

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning:

11/01/2019

Ending:

10/31/2020

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	\$ 161,483	\$ 14,542	\$ 14,542	\$	9	\$ 91,928	71
72	Current Year Purchases	40,488	2,600	2,600		7	2,600	72
73	Fully Depreciated Assets	564,288				10	561,237	73
74								74
75	TOTALS	\$ 766,259	\$ 17,142	\$ 17,142	\$		\$ 655,765	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				\$	\$	\$	\$		\$	76
77	Resident Transportation	Ford Van	2012	4,305				5	4,305	77
78	Resident Transportation	2019 Coach Van	2019	62,918	12,584	12,584		5	20,973	78
79										79
80	TOTALS			\$ 67,223	\$ 12,584	\$ 12,584	\$		\$ 25,278	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,295,963	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,663	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,665	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,504,922	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	Cottatges	\$ 644,460	\$ 12,640	\$ 466,026	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 644,460	\$ 12,640	\$ 466,026	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/2019

Ending: 10/31/2020

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

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: _____ *

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: \$ 5,928

Description: Oxygen 2835.56, Dishwasher 828.00, Copier 2264.90,

(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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	968	\$ 75,483				968	\$ 75,483					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		185	14,411				185	14,411					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		1,206	94,235				1,206	94,235					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-2	# of prescrpts			3,231		28,789			32,020					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Dental</u>	10-3			1	149				1	149					12
13	Other (specify): <u>Laboratory</u>	10a-3				8,270					8,270					13
14	TOTAL			\$	2,359	\$ 195,779		\$ 28,789		2,359	\$ 224,568					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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 645,811	\$ 645,811	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	580,489	580,089	3
4	Supply Inventory (priced at <u>Fifo</u>)	4,000	4,000	4
5	Short-Term Investments	208,296	208,296	5
6	Prepaid Insurance	15,138	15,138	6
7	Other Prepaid Expenses	4,312	4,312	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,458,046	\$ 1,457,646	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,555	61,980	13
14	Buildings, at Historical Cost	1,363,971	1,984,731	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	894,264	917,965	16
17	Accumulated Depreciation (book methods)	(1,504,922)	(1,970,948)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Rounding</u>	1	1	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 793,869	\$ 993,729	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,251,915	\$ 2,451,375	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 43,283	\$ 43,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	288,707	288,707	29
30	Accrued Salaries Payable	84,574	84,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,931	1,931	31
32	Accrued Real Estate Taxes(Sch.IX-B)		6,721	32
33	Accrued Interest Payable	1,556	1,556	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	411	411	36
37	<u>Rounding</u>	1	1	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 420,463	\$ 427,184	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)	\$ 420,463	\$ 427,184	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,831,452	\$ 2,024,191	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,251,915	\$ 2,451,375	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,688,838	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,688,838	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	287,132	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Cottages Profit	48,221	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 335,353	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,024,191	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/2019

Ending: 10/31/2020

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.

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,502,800	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,502,800	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	72,355	6
7	Oxygen	704	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 73,059	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	592	12
13	Barber and Beauty Care	4,988	13
14	Non-Patient Meals	661	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	695	17
18	Sale of Supplies to Non-Patients	155	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	4,350	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,441	23
D. Non-Operating Revenue			
24	Contributions	55,582	24
25	Interest and Other Investment Income***	13,697	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69,279	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Grants Income	334,186	28
28a	See List Attached	13,339	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 347,525	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,004,104	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	550,201	31
32	Health Care	1,415,829	32
33	General Administration	446,441	33
B. Capital Expense			
34	Ownership	74,356	34
C. Ancillary Expense			
35	Special Cost Centers	133,872	35
36	Provider Participation Fee	96,273	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,716,972	40
41	Income before Income Taxes (line 30 minus line 40)**	287,132	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 287,132	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 798,722	44
45	Private Pay - Net Inpatient Revenue	1,242,954	45
46	Medicare - Net Inpatient Revenue	353,986	46
47	Other-(specify) Managed Care	107,138	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,502,800	49

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home

0009175

Report Period Beginning: 11/01/2019

Ending: 10/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,962	2,088	\$ 74,386	\$ 35.63	1
2	Assistant Director of Nursing	1,941	2,097	66,357	31.64	2
3	Registered Nurses	2,910	3,054	87,866	28.77	3
4	Licensed Practical Nurses	10,019	10,752	236,419	21.99	4
5	CNAs & Orderlies	28,328	30,080	450,480	14.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,686	4,112	78,185	19.01	8
9	Activity Director	1,849	2,035	29,181	14.34	9
10	Activity Assistants	2,435	2,624	28,034	10.68	10
11	Social Service Workers	1,706	1,947	30,315	15.57	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,616	1,776	32,399	18.24	14
15	Cook Helpers/Assistants	3,887	4,171	45,814	10.98	15
16	Dishwashers	5,532	5,746	62,980	10.96	16
17	Maintenance Workers	2,022	2,128	36,275	17.05	17
18	Housekeepers	5,337	5,776	66,168	11.46	18
19	Laundry	1,706	2,008	21,943	10.93	19
20	Administrator	1,933	2,088	58,662	28.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,844	3,030	47,458	15.66	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	267	267	3,448	12.91	31
32	Other Health C: <u>Care Plan Coord</u>	1,747	1,999	47,905	23.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,727	87,778	\$ 1,504,275 *	\$ 17.14	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	71	\$ 2,494	1-3	35
36	Medical Director	Contract	4,779	9-3	36
37	Medical Records Consultant	Contract	1,800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	41	2,633	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,143	11-3	44
45	Social Service Consultant	16	1,143	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	144	\$ 13,992		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Abby Wayman</u>	<u>Administrator</u>	<u>0</u>	\$ <u>58,662</u>	<u>Workers' Compensation Insurance</u>	\$ <u>29,780</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>12,114</u>	<u>Advertising: Employee Recruitment</u>	<u>4,925</u>	
				<u>FICA Taxes</u>	<u>114,621</u>	<u>Health Care Worker Background Check</u>	<u>396</u>	
				<u>Employee Health Insurance</u>		(Indicate # of checks performed <u>40</u>)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Illinois Healthcare Assoc</u>	<u>3,199</u>	
				<u>Employee Relations</u>	<u>5,120</u>	<u>COVID Test</u>	<u>325</u>	
				<u>Vacation Accrual Adjustment</u>	<u>4,332</u>	<u>Drug Test</u>		
				<u>Empoyee Benefits</u>		<u>Emp Physicals</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>58,662</u>			<u>See List Attached</u>	<u>17,077</u>	
B. Administrative - Other						<u>Less: Public Relations Expense</u>	<u>(10,894)</u>	
Description			Amount			<u>Non-allowable advertising</u>	<u>(4,619)</u>	
			\$			<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>165,967</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>12,398</u>	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Amount	
Vendor/Payee	Type	Amount	Amount	Description	Line #	Amount	Description	Amount
<u>Point Click Care</u>	<u>EMR Support</u>	<u>12,272</u>	\$	<u>n/a</u>		<u>0</u>	<u>Out-of-State Travel</u>	\$
<u>American Healthtech</u>	<u>EMR Support</u>	<u>11,666</u>					<u>In-State Travel</u>	
<u>Esolutions</u>	<u>Billing Support</u>	<u>1,357</u>						
<u>WDM Support Services</u>	<u>Data Processing</u>	<u>24,833</u>					<u>Seminar Expense</u>	<u>967</u>
<u>Rounding</u>								
<u>Roberts Neu Schmiedeskamp</u>	<u>Legal</u>	<u>4,291</u>						
<u>Rosie Connectivity</u>	<u>Software Support</u>	<u>135</u>						
<u>Gem City Account Service</u>	<u>Collections</u>	<u>4,060</u>						
<u>Health Tech</u>	<u>Transfer Software to PCC</u>	<u>3,200</u>					<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>61,814</u>	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>967</u>
(For legal fee disclosure, see page 39 of instructions)								

* 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. Illinois Healthcare Assoc \$3199
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? _____ 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. \$ 96,273
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 661
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? n/a
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 95
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Golden Good Shepherd
#0009175
11/01/19 to 10/31/20

Board Members

Kenneth Miller
308 Prairie Mills Road
Golden, IL 62339

Karen Dickhut
305 North Main
Camp Point, IL 62320

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

Jane Roberts
108 W. Prairie St.
Camp Point, IL 62320

Marge Moore
200 Prairie Mills Rd
Golden, IL 62339

Linda Waite
706 Main St.
Golden, IL 62339

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

Pam Flesner
2296 E. 2100th St.
Camp Point, IL 62320

Golden Good Shepherd
#0009175
11/01/19 to 10/31/20

Reclassifications

1 Reclassify \$282.00 from Social services outside services to Activity outside services in order to allocate Outcome Se

2 Reclassify \$

3 Reclassify \$

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

7 Reclassify \$

services bills properly.

Golden Good Shepherd
#0009175
11/01/19 to 10/31/20

Schedule V, Line 6, Column 3

REPAIRS & MAINT DIETARY	\$885.48
REPAIRS & MAINT LAUNDRY	\$678.24
REPAIRS & MAINT HSKING	\$0.00
OUTSIDE SERVICES	\$11,004.52
MOWING	\$4,717.50
SNOW REMOVAL	\$1,485.00
REPAIRS & MAINT BUILDINGS	\$2,690.64
REPAIRS & MAINT EQUIPMENT	\$4,890.78
REPAIRS & MAINT GROUNDS	\$0.00
MUZAK	\$0.00
CABLE TV	\$9,265.57
Alarm	\$1,882.24
REFUSE	\$12,689.52
EXTERMITATOR	\$1,609.85
REPAIRS & MAINT GENADM	\$3,967.14
TOTAL	<u>\$55,766.58</u>

Schedule V, Line 21, Column 3

TELEPHONE EXPENSE	\$7,397.84
TOTAL	<u>\$7,397.84</u>

Schedule V, Line 14, Column 2

Auto Exp. & Service	\$540.67
Auto Gas & Oil	\$3,294.49
	<u>\$3,835.16</u>

Schedule V, Line 36, Column 3

Amortization of Loan	\$294.26
Rounding	\$0.00
	<u>\$294.26</u>

Schedule V, Line 43, Column 3

Bad Debt	\$95,985.79
Contributions	\$0.00
Rounding	\$0.00
	<u>\$95,985.79</u>

Schedule V, Line 27, Column 3

Misc Expenses	\$1,416.17
Meals	\$66.25
Rounding	\$0.00
	<u>\$1,482.42</u>

Schedule XX, Question 12

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

Schedule XVII, Line 28a, Column 1

Transportation	\$490.00
Dietary Suppliments	\$1,920.30
Admissions	\$0.00
Activities Income	\$77.13
Uniform Sales	\$2,970.86
Education	\$0.00
Personal Purchases	\$6,434.87
Rebates	\$200.00
Gain on sale of Asset	\$0.00
Misc	\$1,245.15
Rounding	\$1.00
	<u>\$13,339.31</u>

The following is a breakdown of Schedule XIX, Section F

Promotion/Public Relations	\$4,618.66
Adverstising	\$10,894.33
Elitot Publishers	\$24.00
Subscriptions	\$217.55
INHAA	\$125.00
II Nursing Home Administrators Lic	\$102.25
Safe Deposit box	
Microsoft Subscriptions	\$14.86
AANAC	\$131.00
Sec of State-License Fee	\$10.00
CNASurety	
Relias-Subscription	\$782.69
Amazon Prime Membership	\$155.88
Fundraising Expense-Mailing	
Briggs Subscription	
Rounding	\$1.00
	<u>\$17,077.22</u>

Golden Good Shepherd

11/01/19 to 10/31/20

	Medicaid		Medicare		Pvt		
	SNF	ICF	SNF	ICF	SNF	ICF	
November	0	354	186	0	0	526	1066
December	0	421	132	0	41	541	1135
January	0	470	70	0	28	585	1153
February	0	464	42	0	29	528	1063
March	0	458	54	0	36	485	1033
April	0	439	56	0	30	506	1031
May	0	428	28	0	24	577	1057
June	0	417	29	0	25	570	1041
July	0	464	28	0	0	550	1042
August	0	491	72	0	0	473	1036
September	0	479	33	0	0	444	956
October	0	431	0	0	0	386	817
	0	5316	730	0	213	6171	12430

Caremark Med A.	Physical Therapy					Occupational Therapy					Speech Therapy					Total	Total			
	Hours	Dollars	Med B	Private	Med A	Hours	Dollars	Med B	Private	Med A	Hours	Dollars	Med B	Private	Total			Total		
Nov-19	92.52	\$7,216.56	22.83	\$1,780.74	0.00	\$0.00	84.18	\$6,566.04	9.33	\$727.74	0.00	\$0.00	13.75	\$1,072.50	2.75	\$214.50	0.00	\$0.00	268.75	20,962.50
Dec-19	72.08	\$5,622.24	38.12	\$2,973.36	28.42	\$2,216.76	77.25	\$6,025.50	17.92	\$1,397.76	24.75	\$1,930.50	12.92	\$1,007.76	11.00	\$858.00	0.00	\$0.00	338.50	26,403.00
Jan-20	41.52	\$3,238.56	49.22	\$3,839.16	28.75	\$2,242.50	46.33	\$3,613.74	21.17	\$1,651.26	28.16	\$2,196.48	3.00	\$234.00	2.00	\$156.00	0.00	\$0.00	266.00	20,748.00
Feb-20	34.60	\$2,698.80	29.92	\$2,333.76	23.75	\$1,852.50	34.25	\$2,671.50	9.67	\$754.26	23.83	\$1,858.74	3.00	\$234.00	0.00	\$0.00	2.00	\$156.00	211.25	16,477.50
Mar-20	45.67	\$3,562.26	23.75	\$1,852.50	31.50	\$2,457.00	50.43	\$3,933.54	15.50	\$1,209.00	34.33	\$2,677.74	0.00	\$0.00	4.33	\$337.74	9.00	\$702.00	267.75	20,884.50
Apr-20	36.58	\$2,853.24	7.25	\$565.50	18.08	\$1,410.24	31.00	\$2,418.00	16.42	\$1,280.76	21.50	\$1,677.00	8.25	\$643.50	13.25	\$1,033.50	5.50	\$429.00	201.75	15,736.50
May-20	12.03	\$938.34	7.33	\$571.74	10.33	\$805.74	11.67	\$910.26	11.00	\$858.00	11.75	\$916.50	3.75	\$292.50	2.00	\$156.00	2.50	\$195.00	112.75	8,794.50
Jun-20	17.13	\$1,336.14	31.43	\$2,451.54	19.67	\$1,534.26	16.17	\$1,261.26	37.50	\$2,925.00	19.50	\$1,521.00	4.75	\$370.50	18.50	\$1,443.00	4.00	\$312.00	213.25	16,633.50
Jul-20	16.00	\$1,248.00	25.97	\$2,025.66	3.33	\$259.74	17.67	\$1,378.26	36.50	\$2,847.00	0.00	\$0.00	7.00	\$546.00	12.50	\$975.00	0.00	\$0.00	153.00	11,934.00
Aug-20	39.73	\$3,098.94	24.15	\$1,883.70	4.92	\$383.76	48.08	\$3,750.24	29.25	\$2,281.50	0.00	\$0.00	12.58	\$981.24	5.16	\$402.48	0.00	\$0.00	209.75	16,360.50
Sep-20	24.17	\$1,885.26	5.17	\$403.26	0.00	\$0.00	20.83	\$1,624.74	5.02	\$391.56	0.00	\$0.00	2.50	\$195.00	3.00	\$234.00	0.00	\$0.00	92.49	7,214.22
Oct-20	0.00	\$0.00	16.75	\$1,306.50	5.63	\$439.14	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	0.00	\$0.00	25.38	1,979.64
	432.03	\$33,698.34	\$281.89	\$21,987.42	\$174.38	\$13,601.64	\$437.86	\$34,153.08	\$209.28	\$16,323.84	\$163.82	\$12,777.96	\$71.50	\$5,577.00	\$74.49	\$5,810.22	\$23.00	\$1,794.00	2,360.62	184,128.36

Consult	Consult	Consult							
Nov-19	28.40	\$2,215.20	14.99	\$1,169.22	0.00	\$0.00			
Dec-19	36.88	\$2,876.64	16.08	\$1,254.24	3.08	\$240.24			
Jan-20	25.76	\$2,009.28	19.84	\$1,547.52	0.25	\$19.50			
Feb-20	30.98	\$2,416.44	17.00	\$1,326.00	2.25	\$175.50			
Mar-20	30.58	\$2,385.24	20.74	\$1,617.72	1.92	\$149.76			
Apr-20	28.59	\$2,230.02	14.33	\$1,117.74	1.00	\$78.00			
May-20	29.56	\$2,305.68	10.83	\$844.74	0.00	\$0.00			
Jun-20	30.02	\$2,341.56	11.08	\$864.24	3.50	\$273.00			
Jul-20	23.20	\$1,809.60	9.33	\$727.74	1.50	\$117.00			
Aug-20	30.95	\$2,414.10	14.42	\$1,124.76	0.51	\$39.78			
Sep-20	21.92	\$1,709.76	8.13	\$634.14	1.75	\$136.50			
Oct-20	3.00	\$234.00	0.00	\$0.00	0.00	\$0.00			
	319.84	\$24,947.52	\$41,181.66	156.77	\$12,228.06	15.76	\$1,229.28	Total	
	1,208.14	\$94,234.92		967.73	\$75,482.94	184.75	14,410.50	\$184,128.36	

\$0.00
Cook -\$2,632.50
-\$2,632.50

Cook	Melanie's MDS	M. Young Dietician	Outcome Activity/SS
Nov-19	2.50	\$162.50	Nov-19 4.00 \$319.20
Dec-19	5.00	\$325.00	Dec-19 5.00 \$379.20
Jan-20	4.25	\$276.25	Jan-20 5.25 \$394.20
Feb-20	3.50	\$227.50	Feb-20 3.50 \$289.20
Mar-20	5.00	\$325.00	Mar-20 8.00 \$280.00
Apr-20	4.25	\$276.25	Apr-20
May-20	2.00	\$130.00	May-20
Jun-20	5.75	\$373.75	Jun-20
Jul-20	5.50	\$357.50	Jul-20 3.66 \$219.60
Aug-20	1.25	\$81.25	Aug-20 18.00 \$630.00
Sep-20	0.00	\$0.00	Sep-20 3.25 \$113.75
Oct-20	1.50	\$97.50	Oct-20 19.75 \$691.25
	40.50	\$2,632.50	0.00 \$1,800.00
			71.25 \$2,493.75
			31.49 \$2,285.40
			15.75 1,142.70

Golden Good Shepherd
 #0009175
 11/01/19 to 10/31/20

2020 In-Service Training

Date	Location	Sponsor	Workshop	Attendees	Registration cost
9/3/2020	GGSH	Polaris	PDPM Billing	Autumn, Abby	\$ 210.95
2/13/2020	GGSH	IHCA	MDS PDPM Sec G,GG	Jenny Roosa	\$ 55.00
2/13/2020	GGSH	IHCA	MDS PDPM Sec H J K M O	Jenny Roosa	\$ 55.00
12/6/2019	GGSH	Am Heart	CPR online		\$ 85.50
4/13/2020	GGSH	Quantum	CEUs	Nurses	\$ 240.00
7/23/2020	GGSH	PCC	Skin & Wound	Tiffany Engel	\$ 77.52
10/27/2020	GGSH		Med A Skills Course	Donna Hiland	\$ 19.00
10/22/2020	GGSH	Rosie Connectivity	How to Use Nurse Rosie	Nursing Staff	\$ 365.00
Various	GGSH	Relias	Relias Inservice Subscription		\$2,328.98
8/17/2020	JWCC		C.N.A. Classes	Natalie Wilson	\$1,009.75
8/18/2020	JWCC		C.N.A. Classes	Tristin Scott	\$ 733.25
8/24/2020	JWCC		C.N.A. Classes	Madison Scott	\$ 647.50
					\$5,827.45