FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0009175

Facility Name: Golden Good Shepherd Home

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

County: Adams

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2024 to 10/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) James G. Hull, CPA, Owner
(Firm Name & Address) WDM Computer Services, Inc., 1900 Harrison St, Quincy, IL 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	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	16,790	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 Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF				33		850		883	8
9	SNF/PED									9
10	ICF	1,123	3,819	428		4,681		829	10,880	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,123	3,819	428	33	4,681	850	829	11,763	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 70.06%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/06/63

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

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

Medicare Intermediary National Governmental Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 10/31/2025 Fiscal Year: 10/31/2025

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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	188,971	9,240	9,146	207,357		207,357		207,357			1
2	Food Purchase		134,555		134,555		134,555	(2,127)	132,428			2
3	Housekeeping	97,959	11,335	1,040	110,334		110,334		110,334			3
4	Laundry	41,082	9,391	68	50,541		50,541		50,541			4
5	Heat and Other Utilities			59,530	59,530		59,530		59,530			5
6	Maintenance	51,450	6,107	54,414	111,971		111,971		111,971			6
7	Other (specify):*											7
8	**TOTAL General Services**	379,462	170,628	124,198	674,288		674,288	(2,127)	672,161			8
	B. Health Care and Programs											
9	Medical Director			1,179	1,179		1,179		1,179			9
10	Nursing and Medical Records	1,289,275	83,566	175,706	1,548,547	(17,738)	1,530,809	(45)	1,530,764			10
10a	Therapy		36	122,938	122,974		122,974		122,974			10a
11	Activities	120,235	10,890	2,111	133,236	(561)	132,675		132,675			11
12	Social Services	82,357		989	83,346	561	83,907		83,907			12
13	CNA Training											13
14	Program Transportation		3,957		3,957		3,957		3,957			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,491,867	98,449	302,923	1,893,239	(17,738)	1,875,501	(45)	1,875,456			16
	C. General Administration											
17	Administrative	86,058			86,058		86,058		86,058			17
18	Directors Fees											18
19	Professional Services			107,993	107,993	1,240	109,233		109,233			19
20	Dues, Fees, Subscriptions & Promotions			21,780	21,780	(1,240)	20,540	(3,786)	16,754			20
21	Clerical & General Office Expenses	68,064	5,220	19,660	92,944		92,944		92,944			21
22	Employee Benefits & Payroll Taxes			211,489	211,489		211,489		211,489			22
23	Inservice Training & Education			2,629	2,629		2,629		2,629			23
24	Travel and Seminar			753	753		753		753			24
25	Other Admin. Staff Transportation		1,118		1,118		1,118		1,118			25
26	Insurance-Prop.Liab.Malpractice			66,372	66,372		66,372		66,372			26
27	Other (specify):*			24,875	24,875		24,875		24,875			27
28	**TOTAL General Administration**	154,122	6,338	455,551	616,011		616,011	(3,786)	612,225			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,025,451	275,415	882,672	3,183,538	(17,738)	3,165,800	(5,958)	3,159,842			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: 11/01/2024 Ending: 10/31/2025

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			83,348	83,348		83,348	32	83,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(30,760)	(30,760)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,619	6,619		6,619		6,619			35
36	Other (specify):*											36
37	**TOTAL Ownership**			89,967	89,967		89,967	(30,728)	59,239			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,570		8,570	17,738	26,308		26,308			39
40	Barber and Beauty Shops			3,595	3,595		3,595		3,595			40
41	Coffee and Gift Shops		263		263		263		263			41
42	Provider Participation Fee			111,523	111,523		111,523		111,523			42
43	Other (specify):*			31,121	31,121		31,121	(31,121)				43
44	**TOTAL Special Cost Centers**		8,833	146,239	155,072	17,738	172,810	(31,121)	141,689			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,025,451	284,248	1,118,878	3,428,577		3,428,577	(67,807)	3,360,770			45

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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	(1,957)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(45)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32	30		9
10	Interest and Other Investment Income	(30,760)	32		10
11	Discounts, Allowances, Rebates & Refunds	(170)	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	(31,121)	43		24
25	Fund Raising, Advertising and Promotional	(3,786)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,807)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,807)		37

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

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

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

Golden Good Shepherd Home

ID# 0009175

Report Period Beginning: 11/01/2024

Ending: 10/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,127)	0	0	0	0	0	0	0	0	0	0	(2,127)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,127)	0	0	0	0	0	0	0	0	0	0	(2,127)	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	(45)	0	0	0	0	0	0	0	0	0	0	(45)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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**	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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	(3,786)	0	0	0	0	0	0	0	0	0	0	(3,786)	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**	(3,786)	0	0	0	0	0	0	0	0	0	0	(3,786)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,958)	0	0	0	0	0	0	0	0	0	0	(5,958)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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	32	0	0	0	0	0	0	0	0	0	0	32	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,760)	0	0	0	0	0	0	0	0	0	0	(30,760)	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**	(30,728)	0	0	0	0	0	0	0	0	0	0	(30,728)	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):*	(31,121)	0	0	0	0	0	0	0	0	0	0	(31,121)	43
44	**TOTAL Special Cost Centers**	(31,121)	0	0	0	0	0	0	0	0	0	0	(31,121)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,807)	0	0	0	0	0	0	0	0	0	0	(67,807)	45

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Golden Good Shepherd Home

ID# **0009175**

Report Period Beginning: **11/01/2024**

Ending: **10/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
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
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STATE OF ILLINOIS **Ownership Listing-2**

Golden Good Shepherd Home

ID# **0009175**

Report Period Beginning: **11/01/2024**

Ending: **10/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
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148									148
149									149
150									150

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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: 11/01/2024 Ending: 10/31/2025

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 0/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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 Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 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 2025 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

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 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 2024 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 2024.

	(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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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).

F. List the bed capacity for the building if it differs from the licensed total. X

G. Have you properly capitalized all major repairs and equipment purchases? Yes

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

I. Are you presently operating under a sublease agreement? No

J. 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.

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	475,705	1963	$ 37,727	1
2					2
3	TOTALS	475,705		$ 37,727	3

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	42		1963	1963	$ 163,629	$	50	$	$	$ 163,629	4
5			1988	1988	208,384	5,210	40	5,210	0	193,623	5
6			1989	1989	84,694	2,117	40	2,117	(0)	77,460	6
7	4		2015	2015	354,549	9,091	39	9,091	0	96,213	7
8											8
	Improvement Type**										
9	Building Addidtion			1967	5,285		20			5,285	9
10	Building Addidtion			1973	25,841		20			25,841	10
11	Sprinkler System			1975	30,963		20			30,963	11
12	Building Addidtion			1975	18,103		20			18,103	12
13	Building Addidtion			1975	1,313		20			1,313	13
14	Building Addidtion			1976	15,380		20			15,380	14
15	Building Addidtion			1977	3,981		15			3,981	15
16	Doors			1978	900		20			900	16
17	Building Addidtion			1980	3,165		15			3,165	17
18	Parking Lot			1985	7,475		15			7,475	18
19	Building Addidtion			1983	4,174		15			4,174	19
20	Garage			1986	6,473		15			6,473	20
21	Landscaping			1988	620		10			620	21
22	Asphalt			1989	950		15			950	22
23	Building Addidtion			1990	655		20			652	23
24	Sprinkler System			1992	43,248		25			43,104	24
25	Floor & Foundation Improvements			1997	9,800	251	39	251	(0)	7,266	25
26	Parking Lot Expansion			1997	16,320	419	39	418	(1)	11,856	26
27	Owygen Room Venting			1998	2,880	72	40	72	(0)	1,996	27
28	Backflow Valve			1998	959		25			957	28
29	Laundry Door			1998	3,555		15			3,535	29
30	Backflow Preventor			1999	3,128		20			3,115	30
31	Ceiling			1999	4,657		20			4,637	31
32	Kitchen Floor			2000	1,167		10			1,157	32
33	New Roof Nursing Home			2001	38,956	999	39	999	0	24,140	33
34	Concrete Activity Room Entrance			2003	4,975		15			4,947	34
35	Remodel Kitchen			2004	5,085		15			5,057	35
36	Concrete Correction			2007	6,500		15			6,464	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire suppression System	2007	$ 2,369	$	10	$	$	$ 2,349	37
38	New Doors	2007	1,584		15			1,575	38
39	Parking lot Improvements	2007	6,868		15			6,830	39
40	Sprinkler	2010	107,879	4,315	25	4,315	(0)	67,245	40
41	Nurse Call System	2010	58,134	2,907	20	2,907	0	44,085	41
42	Concrete Pad	2011	1,900	127	15	127	0	1,816	42
43	Sprinkler Addition	2012	28,700	1,148	25	1,148	0	15,690	43
44	Shower Room-Materials & Labor	2013	12,814	644	20	645	1	8,271	44
45	Shower Room-Alarm System	2013	3,774	185	20	185		2,381	45
46	Shower Room-Floor Tile	2013	5,800	291	20	291		3,737	46
47	Shower Room-Plumbing	2013	19,153	956	20	956		12,276	47
48	Generator Electrical Switch	2014	22,000	1,105	20	1,100	(5)	12,979	48
49	80 KW Cummins Generator	2014	37,983	1,899	20	1,899	(0)	22,315	49
50	sprinkler system	2015	16,400	820	20	820	(0)	8,678	50
51	Landscaping	2015	4,588	306	15	306	0	3,084	51
52	Replaced Skinklers	2018	8,244	412	240	412	(0)	3,195	52
53	Hallways/Common Area Painting	2019	4,500	556	8	563	7	3,573	53
54	Dinning Rm, Act Room Flooring	2020	4,300	215	20	215	(0)	1,147	54
55	Driveway Improvements	2021	55,200	3,680	15	3,680	(0)	17,174	55
56	Replacement Windows -Entire Nursing Home	2023	135,000	6,720	20	6,750	30	20,751	56
57	Roof Replacement-Entire Roof	2023	84,606	4,230	20	4,230	(0)	9,871	57
58	PAINT ALL Hallways, Dining Room & Entryway	2024	8,198	1,026	8	1,026	(0)	1,271	58
59	FLOORING PROJECT - All Hallways and Dining Room	2024	18,022	901	20	901	(0)	976	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)		$ 1,725,780	$ 50,602		$ 50,634	$ 32	$ 1,045,697	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: 11/01/2024 Ending: 10/31/2025

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	$ 229,656	$ 23,643	$ 23,643	$	7	$ 117,644	71
72	Current Year Purchases	92,897	4,003	4,003		7	4,003	72
73	Fully Depreciated Assets	645,798				7	641,818	73
74								74
75	TOTALS	$ 968,351	$ 27,646	$ 27,646	$		$ 763,465	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	Ford Van	2012	$ 4,305	$	$	$	5	$ 4,305	76
77	Resident Transportation	2019 Coach Van	2019	62,918				5	61,869	77
78	Resident Transportation	2015 Grand Caravan	2024	25,500	5,100	5,100		5	6,375	78
79										79
80	TOTALS			$ 92,723	$ 5,100	$ 5,100	$		$ 72,549	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)	$ 2,824,581	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,348	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,380	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 32	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,881,711	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	Cottages	$ 683,249	$ 13,567	$ 531,381	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 683,249	$ 13,567	$ 531,381	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: 11/01/2024 Ending: 10/31/2025

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: [X] 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.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 6,619 Description: Oxygen rental $177.20, Dishwasher $1,080.00, Copier Rental $5,354.65, Maint Rent $6.99
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Golden Good Shepherd Home

STATE OF ILLINOIS
0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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	10a-3	hrs	$		$ 53,047	$		$ 53,047	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			16,781			16,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			60,609			60,609	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				26,307		26,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dental	10-3								12
13	Other (specify): Laboratory	10a-3				1,544			1,544	13
14	TOTAL			$		$ 131,980	$ 26,307		$ 158,287	14

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

STATE OF ILLINOIS

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2025 (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	$ 851,297	$ 850,897	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,247,456	1,247,456	3
4	Supply Inventory (priced at Lifo)	4,000	4,000	4
5	Short-Term Investments	228,807	228,807	5
6	Prepaid Insurance	474	474	6
7	Other Prepaid Expenses	(400)	(400)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,331,634	$ 2,331,234	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	1,071,264	1,730,813	14
15	Leasehold Improvements, at Historical Cost	605,203	605,203	15
16	Equipment, at Historical Cost	1,110,385	1,134,086	16
17	Accumulated Depreciation (book methods)	(1,881,711)	(2,413,092)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 945,696	$ 1,118,990	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,277,330	$ 3,450,224	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,916	$ 96,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,567	130,567	30
31	Accrued Taxes Payable (excluding real estate taxes)	962	962	31
32	Accrued Real Estate Taxes(Sch.IX-B)		6,085	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PAYROLL WITHHOLDINGS	17,550	17,550	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 245,995	$ 252,080	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)**	$ 245,995	$ 252,080	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,029,610	$ 3,198,144	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,275,605	$ 3,450,224	48

*(See instructions.)

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,021,398	1
2	Restatements (describe):		2
3	**Prior Period Adj**	125,437	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,146,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(21,033)	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 Income**	72,343	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 51,310	17
	B. Transfers (Itemize):		
18	**Rounding**	(1)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,198,144	24 *

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

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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	$ 3,245,950	1
2	Discounts and Allowances for all Levels	(34,672)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,211,278	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40,606	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 40,606	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	3,809	13
14	Non-Patient Meals	1,957	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	45	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,811	23
	D. Non-Operating Revenue		
24	Contributions	68,085	24
25	Interest and Other Investment Income***	30,760	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,845	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Incentive Income**	6,282	28
28a	**See List Attached**	44,721	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,003	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,407,544	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	674,288	31
32	Health Care	1,875,501	32
33	General Administration	616,011	33
	B. Capital Expense		
34	Ownership	89,967	34
	C. Ancillary Expense		
35	Special Cost Centers	61,287	35
36	Provider Participation Fee	111,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,428,577	40
41	**Income before Income Taxes (line 30 minus line 40)****	(21,033)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (21,033)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 177,215.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	738,379.00	45
46	MMAI-Medicaid is the Primary Payer	165,984.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,309,238.00	48
49	Medicare Part A	515,771.00	49
50	Other-(specify) VA	304,690.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify) Rounding	1.00	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,211,278	56

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,177	2,406	$ 116,014	$ 48.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,116	3,464	161,404	46.59	3
4	Licensed Practical Nurses	10,252	11,305	382,543	33.84	4
5	CNAs & Orderlies	20,597	21,540	569,446	26.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	978	1,097	33,824	30.83	9
10	Activity Assistants	4,600	4,996	86,411	17.30	10
11	Social Service Workers	2,604	2,929	82,357	28.12	11
12	Dietician					12
13	Food Service Supervisor	87	135	3,703	27.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,434	4,663	91,511	19.62	15
16	Dishwashers	5,298	5,592	93,757	16.77	16
17	Maintenance Workers	1,638	1,907	51,450	26.98	17
18	Housekeepers	4,757	5,353	97,959	18.30	18
19	Laundry	1,831	2,043	41,083	20.11	19
20	Administrator	1,785	2,091	86,057	41.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,331	2,767	68,064	24.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan	1,647	1,891	59,868	31.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,132	74,179	$ 2,025,451 *	$ 27.30	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	Contract	$ 7,500	1-3	35
36	Medical Director	Contract	1,179	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,087	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,550	11-3	44
45	Social Service Consultant	20	1,550	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	39	$ 15,865		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10-1	50
51	Licensed Practical Nurses	58	3,453	10-1	51
52	Certified Nurse Assistants/Aides	4,465	168,166	10-1	52
53	TOTAL (lines 50 - 52)	4,523	$ 171,619		53

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Smith	Administrator		$ 83,262
Britney Higdon	Administrator		2,796
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,058

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
American Health Tech	Support	$ 900
Denise Blackledge	Outside Clerical	1,710
MITC	Software	1,036
Office Ally	Billing Support	175
Point Click Care	Billing Software	28,519
Schmiedeskamp Robertson, Neu	Legal	2,944
TimeTrak	Time & Attendance	2,235
TrueBridge	Revenue Cycle Mngt	3,065
WayStar	Revenue Cycle Mngt	7,190
WDM	Accounting	61,460
Rounding		(1)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 109,233

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,667
Unemployment Compensation Insurance	24,450
FICA Taxes	151,094
Employee Health Insurance	12,112
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,165
TOTAL (agree to Schedule V, line 22, col.8)	$ 211,489

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	895
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	2,158
See List	17,402
Drug Tests	85
Less: Public Relations Expense	(3,786)
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,754

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
	753
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 753

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Golden Good Shepherd Home # 0009175 Report Period Beginning: 11/01/2024 Ending: 10/31/2025

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	2,158
	2,158 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
	Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	2,158
	2,158 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 16,245 Line 10-2

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 111,523
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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? n/a

(10) 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.

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

(12) Travel and Transportation

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

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

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

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. $

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

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

(15) 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.

Golden Good Shepherd
#0009175
11/01/24 to 10/31/25

Board Members

Carl Heinecke
2734 E 2100th Street
Golden, IL 62339

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

Linda Waite
706 Main St.
Golden, IL 62339

Nathan Buss
2836 N. 2300th AVE
Clayton, IL 62324

David Gronewold
2622 E 2600th St
Golden, IL 62339

Rick Walker
405 Alberts St
Golden, IL 62339

Paul Bruns
2773 N 2400th Ave
Golden, IL 62339

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

Golden Good Shepherd
#0009175
11/01/24 to 10/31/25

Reclasssifications

1 Reclassify $561 from Activity Outside Services to Social Services due to coding error.

2 Reclassify $1240.00 from Dues to Professional fees due to coding Timetrak error.

3 Reclassify $17738 for Nursing supplies to Pharmacy supplies due to coding error.

4 Reclassify $

5 Reclassify $

6 Reclassify $

7 Reclassify $

Golden Good Shepherd
#0009175
11/01/24 to 10/31/25

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	$0.00
REPAIRS & MAINT LAUNDRY	$0.00
REPAIRS & MAINT HSKING	$0.00
OUTSIDE SERVICES	$11,037.78
MOWING	$6,675.00
SNOW REMOVAL	$5,675.00
REPAIRS & MAINT BUILDINGS	$6,215.41
REPAIRS & MAINT EQUIPMENT	$1,571.98
REPAIRS & MAINT GROUNDS	$0.00
MUZAK	$0.00
CABLE TV	$10,364.44
Alarm	$2,406.32
REFUSE	$7,481.30
EXTERMITATOR	$1,886.85
REPAIRS & MAINT GEN/ADM	$1,100.00
TOTAL	$54,414.08

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	$19,660.50
TOTAL	$19,660.50

Schedule V. Line 14 ,Column 2

Auto Exp. & Service	$2,562.01
Auto Gas & Oil	$1,394.88
	$3,956.89

Schedule V. Line 36, Column3

Amortization of Loan	$0.00
Rounding	$0.00
	$0.00

Schedule V. Line 43, Column3

Bad Debt	$31,121.12
Contributions	$0.00
Rounding	$0.00
	$31,121.12

Schedule V. Line 27, Column 3

Misc Expenses	$24,827.27
Meals	$48.05
Rounding	$0.00
	$24,875.32

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	
Dietary Suppliments	$0.00
Admissions	$0.00
Activities Income	$746.25
Uniform Sales	$35.85
Education	$0.00
Personal Purchases	$389.26
Rebates	$170.00
Gain on sale of Asset	$39,606.00
Misc	$3,773.93
Rounding	
	$44,721.29

The following is a breakdown of Schedule XIX, Section F

Promotion/Public Relations	$3,786.06
Promo Advertising	$1,469.99
IL Prof Lic Fee	$123.25
Adobe	$106.25
Misc Dues	$1,140.12
CLIA License	$248.00
Google	$4.33
Fubo	$93.96
Canva	$74.95
Amazon Prime Membership	$44.97
Rounding	$1.00
Management MD	$3,773.18
Wells Billing	$6,536.25
Rounding	
	$17,402.31

Golden Good Shepherd

11/01/24 to 10/31/25

	Pvt Skilled/Ins	Pvt Int	Medicaid Int	Medicaid MLTSS	Medicaid MMAI	Medicare MMAI	Medicare SNF	Other	Total
November		477	120	330	60		81		1,068
December		478	122	311	62		66	2	1,041
January		498	57	339	31		74	34	1,033
February		414	51	302	31		105	34	937
March		383	83	280	31	18	56	44	895
April		392	69	285	30	7	19	84	886
May		399	134	310	31	8	71	93	1,046
June		359	105	313	29	-	67	59	932
July		309	101	340	31		23	77	881
August		345	93	341	31		96	131	1,037
September		345	94	327	30		92	116	1,004
October		282	94	341	31		100	155	1,003
	-	4,681	1,123	3,819	428		850		11,763