		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 8008518

Facility Name: Gottlieb Memorial Hospital

Address: 701 West North Avenue (Number) Melrose Park (City) 60160 (Zip Code)

County: Cook

Telephone Number: (708)-450-4543 **Fax #** (708)-450-5058

HFS ID Number:

Date of Initial License for Current Owners: 6/10/1985

Type of Ownership:

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

IRS Exemption Code 501©(3)

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630)-530-7100 Ext 107
Email Address: Raj.Shah@srinc.org

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2010 to 06/30/2011 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) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630)-530-7100 Ext 107 Fax # 630-530-7106

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 N/A

	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	34	Skilled (SNF)	34	12,410	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	34	TOTALS	34	12,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	123	224	9,045	9,392	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	123	224	9,045	9,392	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.68%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/20/1985

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 9,392

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			6,505	6,505		6,505	343,560	350,065			1
2	Food Purchase											2
3	Housekeeping							98,137	98,137			3
4	Laundry							90,253	90,253			4
5	Heat and Other Utilities							175,661	175,661			5
6	Maintenance			2,119	2,119		2,119	136,602	138,721			6
7	Other (specify):* See Page 4A							114,919	114,919			7
8	**TOTAL General Services**			8,624	8,624		8,624	959,132	967,756			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,489,397	74,495	6,238	1,570,130		1,570,130		1,570,130			10
10a	Therapy											10a
11	Activities											11
12	Social Services							28,624	28,624			12
13	CNA Training											13
14	Program Transportation	55,080			55,080		55,080	4,221	59,301			14
15	Other (specify):* Unit Technicians	89,283			89,283		89,283		89,283			15
16	**TOTAL Health Care and Programs**	1,633,760	74,495	6,238	1,714,493		1,714,493	32,845	1,747,338			16
	C. General Administration											
17	Administrative	232,620		1,811	234,431		234,431	193,541	427,972			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		9,581	1,513	11,094		11,094		11,094			21
22	Employee Benefits & Payroll Taxes							623,798	623,798			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	232,620	9,581	3,324	245,525		245,525	817,339	1,062,864			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,866,380	84,076	18,186	1,968,642		1,968,642	1,809,316	3,777,958			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 Gottlieb Memorial Hospital #8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							456,224	456,224			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,649	16,649		16,649		16,649			35
36	Other (specify):* Tool/Equip			230	230		230	9,225	9,455			36
37	**TOTAL Ownership**			16,879	16,879		16,879	465,449	482,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							2,934,869	2,934,869			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							18,371	18,371			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**							2,953,240	2,953,240			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,866,380	84,076	35,065	1,985,521		1,985,521	5,228,005	7,213,526			45

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

Gottlieb Memorial Hospital
Medicaid Provider Number: 8008518
FYE 6/30/2011
Attchment to Line 7, Schedule V - Other General Service Cost

Description	Salary	Supplies	Other Exo	Total Exp
Cafeteria	4,386	6,242	177	10,805
Medical Records	10,489	118	3,504	14,110
Nursing Admin	61,580	763	5,136	67,479
Nursing Prof Develop	34,727	80	2,626	37,433
Sub Total	111,181	7,204	11,442	129,828
Less: Cafeteria Revenue				(14,909)
Net Expenses - Line 7				114,919

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	5,228,005			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 5,228,005		$	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))**	$ 5,228,005		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

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Hospital Overhead Cost Alloc - Dietary	$ 343,560	1	1
2	Hospital Overhead Cost Alloc - Housekeeping	98,137	3	2
3	Hospital Overhead Cost Alloc - Laundry	90,253	4	3
4	Hospital Overhead Cost Alloc - Heating & Other Utilitie	175,661	5	4
5	Hospital Overhead Cost Alloc - Cafeteria	10,805	7	5
6	Hospital Overhead Cost Alloc - Medical Records	14,110	7	6
7	Hospital Overhead Cost Alloc - Nursing Admin	67,479	7	7
8	Hospital Overhead Cost Alloc - Nursing Prof Deve.	37,434	7	8
9	Hospital Overhead Cost Alloc - Social Sevice	28,624	12	9
10	Hospital Overhead Cost Alloc - Transportation	4,221	14	10
11	Hospital Overhead Cost Alloc - Administration	193,583	17	11
12	Hospital Overhead Cost Alloc - Fringe Benefits	623,798	22	12
13	Hospital Overhead Cost Alloc - Depreciation	456,224	30	13
14	Hospital Overhead Cost Alloc - Property Insurance	9,225	36	14
15	Hospital Overhead Cost Alloc - State Assessment Fees	18,371	42	15
16	Hospital Overhead Cost Alloc - Maintenance	136,602	6	16
17				17
18	Cafeteria and Other Non Operating Rev	(14,909)	7	18
19	Other Non Op Rev	(42)	17	19
20				20
21	TCU Ancillary Revenue Centers Cost	2,934,869	39	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**	5,228,005		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	343,560	0	0	0	0	0	0	0	0	0	0	343,560	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	98,137	0	0	0	0	0	0	0	0	0	0	98,137	3
4	Laundry	90,253	0	0	0	0	0	0	0	0	0	0	90,253	4
5	Heat and Other Utilities	175,661	0	0	0	0	0	0	0	0	0	0	175,661	5
6	Maintenance	136,602	0	0	0	0	0	0	0	0	0	0	136,602	6
7	Other (specify):*	114,919	0	0	0	0	0	0	0	0	0	0	114,919	7
8	**TOTAL General Services**	959,132	0	0	0	0	0	0	0	0	0	0	959,132	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	28,624	0	0	0	0	0	0	0	0	0	0	28,624	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	4,221	0	0	0	0	0	0	0	0	0	0	4,221	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	32,845	0	0	0	0	0	0	0	0	0	0	32,845	16
	C. General Administration													
17	Administrative	193,541	0	0	0	0	0	0	0	0	0	0	193,541	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	623,798	0	0	0	0	0	0	0	0	0	0	623,798	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**	817,339	0	0	0	0	0	0	0	0	0	0	817,339	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,809,316	0	0	0	0	0	0	0	0	0	0	1,809,316	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	456,224	0	0	0	0	0	0	0	0	0	0	456,224	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	9,225	0	0	0	0	0	0	0	0	0	0	9,225	36
37	**TOTAL Ownership**	465,449	0	0	0	0	0	0	0	0	0	0	465,449	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	2,934,869	0	0	0	0	0	0	0	0	0	0	2,934,869	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	18,371	0	0	0	0	0	0	0	0	0	0	18,371	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	2,953,240	0	0	0	0	0	0	0	0	0	0	2,953,240	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,228,005	0	0	0	0	0	0	0	0	0	0	5,228,005	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Not Applicable								$		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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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 Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT **Silia Miglio**

TELEPHONE : 708.216.4135 FAX #: 708.216.8340

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,018 B. General Construction Type: Exterior Concrete Frame Concrete Number of Stories 6

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Hospital & Parkiing	1,458,000	1961	$ 61,937	1
2					2
3	TOTALS	1,458,000		$ 61,937	3

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	34			1961	$ 1,789,885	$ 17,894	50	$ 17,894	$	$ 1,789,885	4
5				1982	1,135,357	19,578	29	19,578		1,135,357	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1961	927,147					927,147	9
10	Building Improvements			1962	5,314	123		123		5,314	10
11	Building Improvements			1963	57,578	1,709		1,709		57,578	11
12	Building Improvements			1964	154	5		5		152	12
13	Building Improvements			1965	839,469	13,782		13,782		811,905	13
14	Building Improvements			1966	18,069	189		189		18,069	14
15	Building Improvements			1967	99,677	558		558		99,677	15
16	Building Improvements			1969	243,126	1,579		1,579		243,126	16
17	Building Improvements			1970	10,866					10,866	17
18	Building Improvements			1971	410,569	1,803		1,803		410,569	18
19	Building Improvements			1972	63,023	24		24		63,023	19
20	Building Improvements			1973	36,443					36,443	20
21	Building Improvements			1974	70,028	955		955		70,028	21
22	Building Improvements			1975	2,422					2,422	22
23	Building Improvements			1976	3,446,023	23,037		23,037		3,446,023	23
24	Building Improvements			1977	7,474,834	145,781		145,781		7,474,834	24
25	Building Improvements			1978	172,682	1,126		1,126		172,682	25
26	Building Improvements			1979	159,159	1,160		1,160		156,477	26
27	Building Improvements			1980	729,897	7,488		7,488		729,897	27
28	Building Improvements			1981	1,633,608					1,633,608	28
29	Building Improvements			1982	3,024,034	9,174		9,174		3,024,034	29
30	Building Improvements			1983	3,028,019	43,222		43,222		3,028,019	30
31	Building Improvements			1984	245,719					245,719	31
32	Building Improvements			1985	7,212,994	104,859		104,859		6,374,570	32
33	Building Improvements			1986	2,251,370					2,251,370	33
34	Building Improvements			1987	1,228,658					1,228,658	34
35	Building Improvements			1988	1,055,957					1,055,957	35
36	Building Improvements			1989	5,888,073					5,888,073	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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Building Improvements	1990	$ 5,443,853	$	5-20	$	$	$ 5,443,853	37
38	Building Improvements	1991	2,702,153	110,465	10-20	110,465		2,702,153	38
39	Building Improvements	1992	2,395,628	178,690	2-20	178,690		2,390,318	39
40	Building Improvements	1993	1,601,815	118,560	2-20	118,560		1,509,482	40
41	Building Improvements	1994	2,933,038	219,978	20	219,978		2,642,785	41
42	Building Improvements	1995	4,858,946	364,421	20	364,421		3,937,045	42
43	Building Improvements	1996	591,268	44,345	20	44,345		472,457	43
44	Architecture Fees	1996	39,853	2,989	20	2,989		32,294	44
45	Home Health Remodeling	1996	111,207	8,341	20	8,341		90,300	45
46	Miscellaneous Improvements	1996	25,040	1,878	20	1,878		19,869	46
47	Surgery Remodeling	1996	186,939	14,020	20	14,020		153,459	47
48	South Wing Remodeling	1996	30,902	2,318	20	2,318		24,360	48
49	Same Day Surgery Remodeling	1996	29,020	2,177	20	2,177		22,925	49
50	West Wing Remodeling	1996	25,593	1,919	20	1,919		20,129	50
51	Emergency Water Main	1996	470,298	35,272	20	35,272		379,685	51
52	POB Improvements	1996	2,052	154	20	154		1,667	52
53	Ultrasound Remodeling	1996	2,822	212	20	212		2,300	53
54	Medical Staff Office Remodeling	1996	7,800	585	20	585		6,305	54
55	Elevator Repairs	1996	595,784	44,684	20	44,684		468,710	55
56	Cath Lab Remodeling	1996	1,220	92	20	92		951	56
57	HVAC Improvements	1996	551,151	41,336	20	41,336		446,160	57
58	Absorbtion Machine	1996	1,524,624	114,347	20	114,347		1,241,990	58
59	Co-Generation System	1996	9,074	681	20	681		7,353	59
60	Signage	1996	118,241	8,868	20	8,868		92,382	60
61	Hospital Entrance	1997	249,954	18,747	20	18,747		187,558	61
62	Architecture Fees	1997	17,902	1,343	20	1,343		13,140	62
63	Labor Room Remodeling	1997	59,102	4,433	20	4,433		43,532	63
64	Miscellaneous Improvements	1997	2,090	157	20	157		1,550	64
65	Physical Therapy Remodeling	1997	637	48	20	48		481	65
66	Audiology Remodeling	1997	2,761	207	20	207		2,122	66
67	Same Day Surgery Remodeling	1997	698	52	20	52		530	67
68	Roof Repairs	1997	770	58	20	58		571	68
69	Eye Center Relocation	1997	54,139	4,060	20	4,060		41,365	69
70	TOTAL (lines 4 thru 69)		$ 67,906,528	$ 1,739,481		$ 1,739,481	$	$ 64,791,264	70

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 67,906,528	$ 1,739,481		$ 1,739,481	$	$ 64,791,264	1
2	Radiology Remodeling	1997	47,042	3,528	20	3,528		31,393	2
3	Emergency Room Remodeling	1997	12,863	965	20	965		8,638	3
4	South Wing Remodeling	1997	14,778	1,108	20	1,108		12,972	4
5	Data Processing Remodeling	1997	11,809	886	20	886		8,442	5
6	West Wing Remodeling	1997	8,210		20			8,210	6
7	Emergency Water Main	1997	2,900	218	20	218		2,035	7
8	POB Improvements	1997	39,906	2,993	20	2,993		29,529	8
9	Radiology Remodeling	1997	3,642	273	20	273		2,535	9
10	Retention Pond	1997	51,168	3,838	20	3,838		35,858	10
11	GI Lab Remodeling	1997	715	54	20	54		682	11
12	Cath Lab Remodeling	1997	29,968		20			29,968	12
13	CT Suite Remodeling	1997	1,230		20			1,230	13
14	Co-Generation System	1997	26,349		20			26,349	14
15	Signage	1997	2,703		20			2,703	15
16	Daycare Construction	1997	862,706	64,703	20	64,703		594,551	16
17	Hospital Entrance	1997	2,102,327	157,675	20	157,675		1,438,390	17
18	POB Addition	1997	245,437	18,408	20	18,408		180,894	18
19	Architecture Fees	1998	1,224,933	91,870	20	91,870		765,267	19
20	Labor Room Remodeling	1998	218,500	16,388	20	16,388		139,862	20
21	Miscellaneous Improvements	1998	45,301	3,398	20	3,398		28,711	21
22	Physical Therapy Remodeling	1998	205,829	15,437	20	15,437		125,451	22
23	Roof Repairs	1998	5,189	389	20	389		3,730	23
24	Eye Center Relocation	1998	741		20			741	24
25	Surgery Remodeling	1998	1,275		20			1,275	25
26	Emergency Room Remodeling	1998	2,680		20			2,680	26
27	Data Processing Remodeling	1998	6,781		20			6,781	27
28	West Wing Remodeling	1998	344,119	25,809	20	25,809		220,080	28
29	ICU Remodeling	1998	27,500	2,063	20	2,063		16,721	29
30	POB Improvements	1998	703,516	52,764	20	52,764		437,744	30
31	Radiology Remodeling	1998	161,977	12,148	20	12,148		104,931	31
32	Retention Pond	1998	8,952	671	20	671		5,778	32
33	Cath Lab Remodeling	1998	660	50	20	50		421	33
34	TOTAL (lines 1 thru 33)		$ 74,328,232	$ 2,215,114		$ 2,215,114	$	$ 69,065,816	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 74,328,232	$ 2,215,114		$ 2,215,114	$	$ 69,065,816	1
2	CT Suite Remodeling	1998	104,817	7,861	20	7,861		73,369	2
3	HVAC Improvements	1998	370,425	27,782	20	27,782		260,717	3
4	Co-Generation System	1998	5,910	443	20	443		4,285	4
5	Signage	1998	52,972	3,973	20	3,973		36,249	5
6	Daycare Construction	1998	920,137	69,010	20	69,010		658,308	6
7	Hospital Entrance	1998	39,015	2,926	20	2,926		27,728	7
8	POB Addition	1998	3,375,598	253,170	20	253,170		2,386,504	8
9	Architecture Fees	1999	230,457	17,284	20	17,284		154,328	9
10	Miscellaneous Improvements	1999	2,397	180	20	180		1,556	10
11	Fire Alarm Improvements	1999	97,371	7,303	20	7,303		63,211	11
12	Radiology Remodeling	1999	2,703	203	20	203		1,745	12
13	Emergency Room Remodeling	1999	195,419	14,656	20	14,656		124,819	13
14	South Wing Remodeling	1999	93,107	6,983	20	6,983		60,406	14
15	Physical Therapy Remodeling	1999	446,529	33,490	20	33,490		297,254	15
16	West Wing Remodeling	1999	563,059	42,229	20	42,229		352,966	16
17	Warehouse Improvements	1999	7,126	534	20	534		4,673	17
18	POB Improvements	1999	825,022	61,877	20	61,877		542,099	18
19	POB Addition	1999	1,209,362	90,702	20	90,702		791,023	19
20	Integrated Medicine	1999	34,842	2,613	20	2,613		22,553	20
21	Back to Work Remodeling	1999	802	60	20	60		541	21
22	Cashier Area Remodeling	1999	3,902	293	20	293		2,569	22
23	Home Health Remodeling	1999	25,475	1,911	20	1,911		16,131	23
24	Lab Remodeling	1999	2,129	160	20	160		1,428	24
25	CT Suite Remodeling	1999	2,242	168	20	168		1,485	25
26	Pharmacy Remodeling	1999	1,152	86	20	86		743	26
27	HVAC Improvements	1999	4,460	335	20	335		2,962	27
28	Co-Generation System	1999	640	48	20	48		405	28
29	Signage	1999	8,479	636	20	636		5,569	29
30	Daycare Construction	1999	24,254	1,819	20	1,819		15,811	30
31	Hospital Entrance	1999	1,923	144	20	144		1,259	31
32	Architecture Fees	2000	5,461,410	409,606	20	409,606		3,163,588	32
33	Miscellaneous Improvements	2000	25,044	1,878	20	1,878		14,670	33
34	TOTAL (lines 1 thru 33)		$ 88,466,412	$ 3,275,477		$ 3,275,477	$	$ 78,156,772	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 88,466,412	$ 3,275,477		$ 3,275,477	$	$ 78,156,772	1
2	Fire Alarm Improvements	2000	12,000	900	20	900		6,900	2
3	Labor Room Remodel	2000	900	68	20	68		518	3
4	Surgery Remodeling	2000	8,595	645	20	645		4,942	4
5	Radiology Remodeling	2000	6,504	488	20	488		3,740	5
6	Emergency Room Remodeling	2000	444,702	33,353	20	33,353		255,704	6
7	South Wing Remodeling	2000	172,378	12,928	20	12,928		99,117	7
8	Physical Therapy Remodeling	2000	10	1	20	1		6	8
9	West Wing Remodeling	2000	2,427	182	20	182		1,396	9
10	Warehouse Improvements	2000	9,357	702	20	702		5,380	10
11	POB Improvements	2000	415,372	31,153	20	31,153		238,839	11
12	Medical Staff Office Remodeling	2000	3,118	234	20	234		1,793	12
13	MRI Remodeling	2000	840	63	20	63		483	13
14	Architecture Fees	2001	3,333,020	249,977	20	249,977		1,916,487	14
15	Miscellaneous Improvements	2001	77,530	5,815	20	5,815		44,580	15
16	Fire Alarm Improvements	2001	7,871	590	20	590		4,526	16
17	Surgery Remodeling	2001	51,757	3,882	20	3,882		29,760	17
18	Radiology Remodeling	2001	25,457	1,909	20	1,909		14,638	18
19	Emergency Room Remodeling	2001	88,159	6,612	20	6,612		50,691	19
20	Physical Therapy Remodeling	2001	3,130	235	20	235		1,800	20
21	Adult Day Care Remodeling	2001	41,648	3,124	20	3,124		23,947	21
22	Coffee Shop	2001	78,411	5,881	20	5,881		45,086	22
23	PHO Project	2001	24,282	1,821	20	1,821		13,962	23
24	3 West Remodeling	2001	9,493	712	20	712		5,458	24
25	Home Health Remodeling	2001	35,700	2,678	20	2,678		20,528	25
26	POB Improvements	2001	297,944	22,346	20	22,346		171,318	26
27	West Wing Remodeling	2001	29,024	2,177	20	2,177		16,689	27
28	Pharmacy Remodeling	2001	23,294	1,747	20	1,747		13,394	28
29	Absorption Machine	2001	23,221	1,742	20	1,742		13,352	29
30	Medical Staff Office Remodeling	2001	360	27	20	27		207	30
31	South Wing Remodeling	2001	257,386	19,304	20	19,304		147,997	31
32	HVAC Improvements	2001	18,771	1,408	20	1,408		10,793	32
33	Hospital Entrance	2001	1,226	92	20	92		705	33
34	TOTAL (lines 1 thru 33)		$ 93,970,295	$ 412,791		$ 412,791	$	$ 81,321,506	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 93,970,295	$ 412,791		$ 412,791	$	$ 81,321,506	1
2	Roof Repairs	2001	15,190	1,139	20	1,139		8,058	2
3	Cafeteria Remodeling	2001	29,986	2,249	20	2,249		16,058	3
4	Miscellaneous Improvements	2002	35,713	2,678	20	2,678		18,182	4
5	Main Lobby Remodeling	2002	11,636	873	20	873		6,060	5
6	Surgery Remodeling	2002	231,396	17,355	20	17,355		113,383	6
7	Coffe Shop Construction	2002	40,990	3,074	20	3,074		21,179	7
8	PHO Project	2002	50,071	3,755	20	3,755		25,700	8
9	3 West Remodeling	2002	3,223	242	20	242		1,556	9
10	Pharmacy Remodeling	2002	124,144	9,311	20	9,311		63,446	10
11	POB Improvements	2002	776,904	58,268	20	58,268		390,551	11
12	Emergency Generator Project	2002	455,695	34,208	20	34,208		218,976	12
13	West Wing Remodeling	2002	750,146	57,665	20	57,665		375,305	13
14	Lab Remodeling	2002	589	44	20	44		299	14
15	CT Suite Construction	2002	98,770	7,408	20	7,408		50,004	15
16	Medical Staff Office Remodeling	2002	188,519	14,336	20	14,336		93,267	16
17	South Wing Remodeling	2002	63,834	4,788	20	4,788		32,040	17
18	HVAC Improvements	2002	57,325	4,299	20	4,299		29,574	18
19	Hospital Entrance Construction	2002	562	42	20	42		274	19
20	Cath Lab Remodeling	2002	157,692	11,905	20	11,905		77,355	20
21	Cafeteria Remodeling	2002	24,618	1,846	20	1,846		12,924	21
22	Miscellaneous Improvements	2003	2,622		20			2,622	22
23	Surgery Remodeling	2003	261,619	19,668	20	19,668		95,545	23
24	POB Improvements	2003	194,747	18,242	20	18,242		110,162	24
25	Emergency Generator Project	2003	116,721	11,428	20	11,428		70,862	25
26	E/R Decon Room	2003	12,328	925	20	925		5,706	26
27	Stand By Generator	2003	65,400	4,905	20	4,905		28,663	27
28	MRI Remodeling	2003	112,180	8,414	20	8,414		49,788	28
29	Medical Staff Office Remodeling	2003	16,083	1,270	20	1,270		7,860	29
30	HVAC Improvements	2003	20,500	1,538	20	1,538		9,738	30
31	2 West Remodeling	2003	12,362	942	20	942		5,952	31
32	Cath Lab Remodeling	2003	801,506	60,684	20	60,684		372,488	32
33	Cysto Project	2004	2,224	167	20	167		834	33
34	TOTAL (lines 1 thru 33)		$ 98,705,588	$ 776,460		$ 776,460	$	$ 83,635,918	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 98,705,588	$ 776,460		$ 776,460	$	$ 83,635,918	1
2	Various	2004	2,565,399	206,516	20	206,516		986,436	2
3	Various	2005	4,098,670	324,788	20	324,788		1,418,147	3
4	Various	2006	1,656,917	66,572	20	66,572		288,479	4
5	Various	2007	1,091,422	45,435	20	45,435		167,512	5
6	CMS Survey Arch	2008	2,799	140	20	140		490	6
7	CT Project	2008	249,675	12,484	20	12,484		43,693	7
8	HVAC Improvements	2008	28,880	1,925	20	1,925		6,739	8
9	Sprinkler Heads	2008	18,000	720	20	720		2,520	9
10	Signage	2008	435	44	10	44		152	10
11	POB Improvements	2008	12,946	863	15	863		3,021	11
12	POB Carpets	2008	4,050	810	5	810		2,835	12
13	Purchasing Project	2008	51,648	2,582	20	2,582		9,038	13
14	Radiology Improvements	2008	20,081	1,004	20	1,004		3,514	14
15	2 West Remodeling	2009	601,797	15,045	20	15,045		60,180	15
16	2 West HVAC	2009	28,426	948	15	948		3,790	16
17	2 West Locks	2009	12,674	634	10	634		2,535	17
18	2 West Decorating	2009	6,112	611	5	611		2,445	18
19	5 West Improvement	2009	568,552	14,214	20	14,214		56,855	19
20	5 West HVAC	2009	57,345	1,912	15	1,912		7,646	20
21	5 West Project	2009	10,133	507	10	507		2,027	21
22	6 West Project	2009	234,531	5,863	20	5,863		23,453	22
23	Wallpapering	2009	1,572	157	5	157		629	23
24	Miscellaneous Improvements	2009	55,366	2,768	10	2,768		11,073	24
25	Miscellaneous Improvements	2009	196,463	4,912	20	4,912		19,646	25
26	Chapel Project	2009	3,550	89	20	89		355	26
27	CT Project	2009	5	0	20	0		1	27
28	Suite 506 Improvement	2009	1,880	47	20	47		188	28
29	Suite 506 Improvement	2009	3,810	127	15	127		508	29
30	HVAC Improvements	2009	3,373	112	15	112		450	30
31	LDR Suite Project - Misc	2009	33,426	1,114	15	1,114		4,457	31
32	LDR Suite Project	2009	874,531	21,863	20	21,863		87,453	32
33	Loyola Misc Project	2009	31,393	785	20	785		3,139	33
34	TOTAL (lines 1 thru 33)		$ 111,231,449	$ 1,512,051		$ 1,512,051	$	$ 86,855,323	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 111,231,449	$ 1,512,051		$ 1,512,051	$	$ 86,855,323	1
2	Loyola Misc Project	2009	2,160	108	10	108		432	2
3	Miscellaneous Improvements	2009	1,940	49	20	49		194	3
4	Miscellaneous Improvements	2009	5,610	561	5	561		2,244	4
5	Morgue Project	2009	175,748	4,394	20	4,394		17,575	5
6	Morgue HVAC	2009	5,000	167	15	167		667	6
7	Morgue Locks	2009	642	32	10	32		128	7
8	Waiting Remodeling	2009	71,627	1,791	20	1,791		7,163	8
9	POB Misc	2009	15,013	1,501	5	1,501		6,005	9
10	POB Misc	2009	1,297	130	10	130		324	10
11	POB Misc	2009	8,070	404	20	404		1,009	11
12	Purchasing Project	2009	450	23	20	23		56	12
13	Sleep Lab Project	2009	10,886	544	20	544		1,361	13
14	Painting	2009	5,960	1,192	5	1,192		2,980	14
15	Suite 206 Paint	2009	17,778	3,556	5	3,556		8,889	15
16	Suite 206 Signs	2009	176	18	10	18		44	16
17	Suite 206 Improvement	2009	19,862	993	20	993		2,483	17
18	FIBER TERMINATION	2008	4,275	855	5	855		1,710	18
19	(20) NONOSA RESULT HIGH BACK SWIVEL TILT CHAIRS	2009	5,720	191	15	191		381	19
20	MISC FURNITURE FOR OFFICE AREA	2009	12,588	420	15	420		839	20
21	(12)KYOCERA PRINTERS - 50%	2009	7,350	735	5	735		1,470	21
22	TELEPHONE CONSOLE	2009	1,320	132	10	132		264	22
23	ATTENDANT TELEPHONE CONSOLE	2009	1,295	65	10	65		130	23
24	ATTENDANT TELEPHONE CONSOLE	2009	1,495	75	10	75		150	24
25	KRONOS TIME & MATERIAL TO REBUILD KRONOS APPLIC	2009	500	83	3	83		167	25
26	FATPIPE WARP REPLACEMENT UNIT	2009	4,500	450	5	450		900	26
27	DIALOGIC D 120 JCTLSEW	2009	5,639	1,128	5	1,128		2,256	27
28	SYMANTEC MAIL SECURITY	2009	3,908	651	3	651		1,303	28
29	(2)FUJITSU FI-6130 SCANNER	2009	1,786	179	5	179		357	29
30	(2)MFE FIREWALL ENTERPRISE 2100E APPLIANCE	2009	35,000	3,500	5	3,500		7,000	30
31	OPTIPLEX 760 SFF	2009	1,019	102	5	102		204	31
32	SERVERS,DRIVES,NETWORK DEVICES	2009	210,687	21,069	5	21,069		42,137	32
33	TAPE LIBRARY & TAPES FOR SERVERS	2009	5,758	576	5	576		1,152	33
34	TOTAL (lines 1 thru 33)		$ 111,876,507	$ 1,557,720		$ 1,557,720	$	$ 86,967,295	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 111,876,507	$ 1,557,720		$ 1,557,720	$	$ 86,967,295	1
2	POWER VAULT TL4000	2009	7,775	778	5	778		1,555	2
3	REPLACEMENT RCS	2009	8,230	823	5	823		1,646	3
4	WEB SERVER	2009	6,425	643	5	643		1,285	4
5	DELL VOSTRO 1520 LAPTOP	2009	1,328	221	3	221		443	5
6	VIZIO 32" VO32E 72OP LCD HDTV	2009	443	44	5	44		89	6
7	(4)BACK-UP ES 550VA 5-15P	2009	234	23	5	23		47	7
8	EXTREME NETWORK SUMMIT X450E-48P	2009	15,467	1,547	5	1,547		3,093	8
9	EXTREME NETWORK SUMMIT X450E-48P	2009	10,177	1,018	5	1,018		2,035	9
10	ADOBE ACROBAT PROFESSIONAL	2010	419	128	3	128		128	10
11	BD/SLIDING SCALE	2010	3,820	350	9	350		350	11
12	CHART RUNNER 3.6	2010	799	222	3	222		222	12
13									13
14	Reconciliation to SNF CY depreciation			(1,107,292)		(1,107,292)			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 111,931,624	$ 456,224		$ 456,224	$	$ 86,978,188	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 111,931,624	$ 456,224		$ 456,224	$	$ 86,978,188	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 111,931,624	$ 456,224		$ 456,224	$	$ 86,978,188	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$	$	$	$		$	71
72	Current Year Purchases	See						72
73	Fully Depreciated Assets	Previous						73
74		Schedules						74
75	TOTALS	$	$	$	$		$	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										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$	111,993,561	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	456,224	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	456,224	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	86,978,188	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:				$ N/A			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. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
(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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011 (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	$ 37,598,090	$ 37,598,090	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (2,000,500))	12,350,498	12,350,498	3
4	Supply Inventory (priced at)	2,759,414	2,759,414	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,167,018	3,167,018	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Affiliates	10,169,302	10,169,302	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 66,044,322	$ 66,044,322	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,894,899	4,894,899	13
14	Buildings, at Historical Cost	126,998,757	126,998,757	14
15	Leasehold Improvements, at Historical Cost	(93,314,236)	(93,314,236)	15
16	Equipment, at Historical Cost	52,070,859	52,070,859	16
17	Accumulated Depreciation (book methods)	(38,259,843)	(38,259,843)	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): Deferred Exp	632,349	632,349	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 53,022,785	$ 53,022,785	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 119,067,107	$ 119,067,107	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,252,106	$ 8,252,106	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,514,192	6,514,192	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,991,499	1,991,499	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Third Party Settlement	18,048,865	18,048,865	36
37	Reserve for self insurance	15,500,000	15,500,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 50,306,662	$ 50,306,662	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	Reserve for self insurance	2,165,000	2,165,000	43
44	Pension Funding	7,851,723	7,851,723	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,016,723	$ 10,016,723	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 60,323,385	$ 60,323,385	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 58,743,722	$ 58,743,722	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 119,067,107	$ 119,067,107	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 59,977,659	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 59,977,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,233,937)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,233,937)	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)**	$ 58,743,722	24 *

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

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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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 713,131,258	1
2	Discounts and Allowances for all Levels	(590,056,800)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 123,074,458	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please Refer to Page 19A for the details	6,238,279	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,238,279	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 129,312,737	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	130,546,674	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 130,546,674	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,233,937)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,233,937)	43

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

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

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

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

Dept #	Sub AC #	Description	Amount
814	159	GMH EMPLOYEE HEALTH CTR UNRELATED	(3,285)
923	179	GMH DAY CARE CENTER OTHER OPERATI	(526,481)
610	159	GMH COMMUNICATIONS UNRELATED BUS	(16,007)
956	172	GMH PATIENT ACCOUNTING TRANSCRIPT	(35)
998	175	GMH OTHER OPERATING REV OFFICE RE	(429,479)
609	179	GMH LIBRARY OTHER OPERATING REV	(200)
998	179	GMH OTHER OPERATING REV OTHER OPE	(125,294)
998	181	GMH OTHER OPERATING REV GAIN ON D	-
998	184	GAIN (LOSS)	(984)
632	187	GMH VOLUNTEER SERVICES UNRESTRICT	(284,937)
998	187	GMH OTHER OPERATING REV UNRESTRIC	(2,362)
999	188	GMH OTHER NON-OPER REV INCOME FRO	(4,433)
915	196	GMH INCIDENT MANAGEMENT ER PREPAR	(15,759)
998	198	GMH OTHER OPERATING REV GRANT REV	(100,000)
930	162	CAFETERIA SALES	(360,449)
930	170	GMH CAFETERIA VENDING COMMISSIONS	(8,410)
640	179	GMH NURSING ADMIN. OTHER OPERATIN	(83)
641	179	GMH NURSING PROF. DEVEL. OTHER OP	(948)
620	172	GMH MEDICAL RECORDS TRANSCRIPTION	(1,222)
781	172	GMH RADIOLOGY DIAGNOSTIC TRANSCRI	-
781	179	GMH RADIOLOGY DIAGNOSTIC OTHER OP	-
741	105	GMH CORE LAB REFERENCE LAB	(3,080,743)
744	105	GMH HISTOLOGY/CYTOLOGY REFERENCE	(621,781)
745	105	GMH MICROBIO/SEROLOGY REFERENCE L	(392,293)
705	179	GMH AUDIOLOGY OTHER OPERATING REV	(14,848)
683	179	GMH OB/GYNE UNIT OTHER OPERATING	(3,515)
732	187	GMH HOSPICE CARE UNRESTRICTED CON	(9,170)
602	165	GMH SNACK SHOP SNACK SHOP SALES	(63,550)
733	179	GMH ADULT DAY CARE OTHER OPERATIN	(172,011)
		Totals	(6,238,279)

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,784	2,028	$ 103,220	$ 50.90	1
2	Assistant Director of Nursing	1,347	1,918	81,470	42.48	2
3	Registered Nurses	26,266	30,272	1,012,449	33.45	3
4	Licensed Practical Nurses	3,586	4,327	101,093	23.36	4
5	CNAs & Orderlies	18,265	21,484	263,789	12.28	5
6	CNA Trainees					6
7	Licensed Therapist	1,505	1,765	32,602	18.47	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,606	1,715	26,058	15.19	10
11	Social Service Workers	1,842	2,127	55,196	25.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,489	8,557	190,503	22.26	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	63,690	74,193	$ 1,866,380 *	$ 25.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Unit Manager	Unit Manager		$ 101,993
Unit Supervisor	Unit Supervisor		74,766
Other Admin	Other Admin		55,861

TOTAL (agree to Schedule V, line 17, col. 1) $ 232,620
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
Cellular	$ 191
Conference	1,620

TOTAL (agree to Schedule V, line 17, col. 3) $ 1,811
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$

TOTAL (agree to Schedule V, line 19, column 3) $
(If total legal fees exceed $5,000, attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,213
Unemployment Compensation Insurance	4,577
FICA Taxes	136,306
Employee Health Insurance	196,244
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Ins	5,708
Life Ins	(230)
Pension	224,591
Tuition Reimbursement	2,562
Other	16,827

TOTAL (agree to Schedule V, line 22, col.8) $ 623,798

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

Description	Line #	Amount
		$

TOTAL $

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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? **No**
If YES, give association name and amount. **N/A**

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

(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? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line **N/A**

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

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

(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 fo
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 Departmen
during this cost report period. $ **18,371**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services fo
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. $ **14,490**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte and Touche**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees