		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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:

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: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
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 07/01/2011 to 06/30/2012 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: 07/01/2011 Ending: 06/30/2012

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	12,444	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	12,444	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	62	155	9,276	9,493	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62	155	9,276	9,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.29%

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 9,493

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: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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		7,438		7,438		7,438	317,259	324,697			1
2	Food Purchase							79,351	79,351			2
3	Housekeeping							175,591	175,591			3
4	Laundry							75,162	75,162			4
5	Heat and Other Utilities							137,144	137,144			5
6	Maintenance			1,552	1,552		1,552	59,412	60,964			6
7	Other (specify):* **Tech/Ward Clerk**	154,902			154,902		154,902	197,869	352,771			7
8	**TOTAL General Services**	154,902	7,438	1,552	163,892		163,892	1,041,788	1,205,680			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,449,324	86,144	10,610	1,546,078		1,546,078		1,546,078			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,449,324	86,144	10,610	1,546,078		1,546,078		1,546,078			16
	C. General Administration											
17	Administrative	238,818		1,484	240,302		240,302	485,670	725,972			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	(7)	9,727	444	10,164		10,164		10,164			21
22	Employee Benefits & Payroll Taxes							532,246	532,246			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							113,914	113,914			26
27	Other (specify):*											27
28	**TOTAL General Administration**	238,811	9,727	1,928	250,466		250,466	1,131,830	1,382,296			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,843,037	103,309	14,090	1,960,436		1,960,436	2,173,618	4,134,054			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:** 07/01/2011 **Ending:** 06/30/2012

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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							129,398	129,398			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											35
36	Other (specify):* **Equip Lease**			17,244	17,244		17,244		17,244			36
37	**TOTAL Ownership**			17,244	17,244		17,244	129,398	146,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							2,846,235	2,846,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							18,666	18,666			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**							2,864,901	2,864,901			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,843,037	103,309	31,334	1,977,680		1,977,680	5,167,917	7,145,597			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 Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	5,167,917			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 5,167,917		$	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 Organizatior 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))**	$ 5,167,917		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: 07/01/2011

Ending: 06/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Hospital Overhead Cost Alloc.-Dietary	$ 317,259	1	1
2	Hospital Overhead Cost Alloc.-Food Purchase	79,351	2	2
3	Hospital Overhead Cost Alloc.-Housekeeping	175,591	3	3
4	Hospital Overhead Cost Alloc.-Laundry	75,162	4	4
5	Hospital Overhead Cost Alloc.-Utilities	137,144	5	5
6	Hospital Overhead Cost Alloc.-Maintenance	59,412	6	6
7	Hospital Overhead Cost Alloc.-Cafeteria	13,591	7	7
8	Hospital Overhead Cost Alloc.-Medical records	0	7	8
9	Hospital Overhead Cost Alloc.-Medical Transcript	0	7	9
10	Hospital Overhead Cost Alloc.-Nursing Admin	82,290	7	10
11	Hospital Overhead Cost Alloc.-Nursing Prof Develp.	88,646	7	11
12	Hospital Overhead Cost Alloc.-Transportation	13,342	7	12
13	Hospital Overhead Cost Alloc.-Social Service	0	12	13
14	Hospital Overhead Cost Alloc.-Administration	485,670	17	14
15	Hospital Overhead Cost Alloc.-Employee Bene.	532,246	22	15
16	Hospital Overhead Cost Alloc.-Insurance	113,914	26	16
17	Hospital Overhead Cost Alloc.-Depreciation	129,398	30	17
18	Hospital Overhead Cost Alloc.-Prov Partici. Fees	18,666	42	18
19				19
20	TCU Ancillary Services Cost	2,846,235	39	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**	5,167,917		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	317,259	0	0	0	0	0	0	0	0	0	0	317,259	1
2	Food Purchase	79,351	0	0	0	0	0	0	0	0	0	0	79,351	2
3	Housekeeping	175,591	0	0	0	0	0	0	0	0	0	0	175,591	3
4	Laundry	75,162	0	0	0	0	0	0	0	0	0	0	75,162	4
5	Heat and Other Utilities	137,144	0	0	0	0	0	0	0	0	0	0	137,144	5
6	Maintenance	59,412	0	0	0	0	0	0	0	0	0	0	59,412	6
7	Other (specify):*	197,869	0	0	0	0	0	0	0	0	0	0	197,869	7
8	**TOTAL General Services**	1,041,788	0	0	0	0	0	0	0	0	0	0	1,041,788	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	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**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	485,670	0	0	0	0	0	0	0	0	0	0	485,670	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	532,246	0	0	0	0	0	0	0	0	0	0	532,246	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	113,914	0	0	0	0	0	0	0	0	0	0	113,914	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	1,131,830	0	0	0	0	0	0	0	0	0	0	1,131,830	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	2,173,618	0	0	0	0	0	0	0	0	0	0	2,173,618	29

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	129,398	0	0	0	0	0	0	0	0	0	0	129,398	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	129,398	0	0	0	0	0	0	0	0	0	0	129,398	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	2,846,235	0	0	0	0	0	0	0	0	0	0	2,846,235	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	18,666	0	0	0	0	0	0	0	0	0	0	18,666	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	2,864,901	0	0	0	0	0	0	0	0	0	0	2,864,901	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,167,917	0	0	0	0	0	0	0	0	0	0	5,167,917	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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
N/A						

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: 07/01/2011 Ending: 06/30/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		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: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic 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: 07/01/2011 Ending: 06/30/2012

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	N/A						$	$			$	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. **$** N/A **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:** 07/01/2011 **Ending:** 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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 (		$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.**

2011 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 07/01/2011 Ending: 06/30/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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 & Parking	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:** 07/01/2011 **Ending:** 06/30/2012

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	$ 2,717,032	$	50	$	$	$ 2,717,032	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1962	5,314	-		-		5,314	9
10	Various			1963	57,578	-		-		57,578	10
11	Various			1964	154	-		-		152	11
12	Various			1965	839,469	13,782		13,782		825,687	12
13	Various			1966	18,069	-		-		18,069	13
14	Various			1967	99,677	-		-		99,677	14
15	Various			1969	243,126	-		-		243,126	15
16	Various			1970	10,866	-		-		10,866	16
17	Various			1971	410,569	-		-		410,569	17
18	Various			1972	63,023	-		-		63,023	18
19	Various			1973	36,443	-		-		36,443	19
20	Various			1974	70,028	-		-		70,028	20
21	Various			1975	2,422	-		-		2,422	21
22	Various			1976	3,446,023	-		-		3,446,023	22
23	Various			1977	7,474,834	-		-		7,474,834	23
24	Various			1978	172,682	-		-		172,682	24
25	Various			1979	159,159	1,160		1,160		157,637	25
26	Various			1980	729,897	-		-		729,897	26
27	Various			1981	1,633,608	-		-		1,633,608	27
28	Various			1982	4,159,391	-		-		4,159,391	28
29	Various			1983	3,028,019	-		-		3,028,019	29
30	Various			1984	245,719	-		-		245,719	30
31	Various			1985	7,212,994	104,859		104,859		6,479,429	31
32	Various			1986	2,251,370	-		-		2,251,370	32
33	Various			1987	1,228,658	-		-		1,228,658	33
34	Various			1988	1,055,957	-		-		1,055,957	34
35											35
36											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:** 07/01/2011 **Ending:** 06/30/2012

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	Various	1989	$ 5,888,073	$ -		$ -	$	$ 5,888,073	37
38	Various	1990	5,443,853	-		-		5,443,853	38
39	Various	1991	2,702,153	-		-		2,702,153	39
40	Various	1992	2,395,628	-		-		2,390,318	40
41	Various	1993	1,601,815	-		-		1,509,482	41
42	Various	1994	2,933,038	219,978		219,978		2,862,763	42
43	Various	1995	4,858,946	364,421		364,421		4,301,466	43
44	Various	1996	4,322,888	324,217		324,217		3,807,515	44
45	Various	1997	3,851,805	283,697		283,697		2,988,926	45
46	Various	1998	7,826,827	586,151		586,151		5,893,484	46
47	Various	1999	3,782,851	283,714		283,714		2,749,252	47
48	Various	2000	6,562,656	492,199		492,199		4,289,273	48
49	Various	2001	4,472,858	335,464		335,464		2,905,498	49
50	Various	2002	3,071,826	232,098		232,098		1,762,174	50
51	Various	2003	1,616,067	128,016		128,016		887,401	51
52	Various	2004	2,567,622	203,241		203,241		1,190,511	52
53	Various	2005	4,098,669	324,788		324,788		1,742,934	53
54	Various	2006	1,656,917	66,572		66,572		355,050	54
55	Various	2007	1,091,422	40,123		40,123		207,635	55
56	Various	2008	392,789	21,427		21,427		95,139	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 108,510,784**	**$ 4,025,907**		**$ 4,025,907**	**$**	**$ 90,596,111**	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:** 07/01/2011 **Ending:** 06/30/2012

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**		**$ 108,510,784**	**$ 4,025,907**		**$ 4,025,907**	**$**	**$ 90,596,111**	1
2	EXTREME NETWORK SUMMIT X450E-48P	2009	10,177	1,018	5	1,018		3,053	2
3	EXTREME NETWORK SUMMIT X450E-48P	2009	15,467	1,547	5	1,547		4,640	3
4	(4)BACK-UP ES 550VA 5-15P	2009	234	23	5	23		70	4
5	VIZIO 32" VO32E 72OP LCD HDTV	2009	443	44	5	44		133	5
6	DELL VOSTRO 1520 LAPTOP	2009	1,328	221	3	221		664	6
7	WEB SERVER	2009	6,425	643	5	643		1,928	7
8	REPLACEMENT RCS	2009	8,230	823	5	823		2,469	8
9	POWER VAULT TL4000	2009	7,775	778	5	778		2,333	9
10	TAPE LIBRARY & TAPES FOR SERVERS	2009	5,758	576	5	576		1,728	10
11	SERVERS,DRIVES,NETWORK DEVICES	2009	210,687	21,069	5	21,069		63,206	11
12	OPTIPLEX 760 SFF	2009	1,019	102	5	102		306	12
13	(2)MFE FIREWALL ENTERPRISE 2100E APPLIANCE	2009	35,000	3,500	5	3,500		10,500	13
14	(2)FUJITSU FI-6130 SCANNER	2009	1,786	179	5	179		536	14
15	SYMANTEC MAIL SECURITY	2009	3,908	651	3	651		1,954	15
16	DIALOGIC D 120 JCTLSEW	2009	5,639	1,128	5	1,128		3,383	16
17	FATPIPE WARP REPLACEMENT UNIT	2009	4,500	450	5	450		1,350	17
18	KRONOS TIME & MATERIAL TO REBUILD KRONOS APPLIC	2009	500	83	3	83		250	18
19	ATTENDANT TELEPHONE CONSOLE	2009	1,495	75	10	75		224	19
20	ATTENDANT TELEPHONE CONSOLE	2009	1,295	65	10	65		194	20
21	TELEPHONE CONSOLE	2009	1,320	132	10	132		396	21
22	(12)KYOCERA PRINTERS - 50%	2009	7,350	735	5	735		2,205	22
23	MISC FURNITURE FOR OFFICE AREA	2009	12,588	420	15	420		1,259	23
24	(20) NONOSA RESULT HIGH BACK SWIVEL TILT CHAIRS	2009	5,720	191	15	191		572	24
25	Suite 206 Improvement	2009	19,862	993	20	993		3,476	25
26	Suite 206 Signs	2009	176	18	10	18		62	26
27	Suite 206 Paint	2009	17,778	3,556	5	3,556		12,445	27
28	Painting	2009	5,960	1,192	5	1,192		4,172	28
29	Sleep Lab Project	2009	10,886	544	20	544		1,905	29
30	Purchasing Project	2009	450	23	20	23		79	30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 108,914,539**	**$ 4,066,683**		**$ 4,066,683**	**$**	**$ 90,721,601**	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:** 07/01/2011 **Ending:** 06/30/2012

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**		**$ 108,914,539**	**$ 4,066,683**		**$ 4,066,683**	**$**	**$ 90,721,601**	1
2	POB Misc	2009	8,070	404	20	404		1,412	2
3	POB Misc	2009	1,297	130	10	130		454	3
4	POB Misc	2009	15,013	1,501	5	1,501		7,507	4
5	Waiting Remodeling	2009	71,627	1,791	20	1,791		8,953	5
6	Morgue Locks	2009	642	32	10	32		160	6
7	Morgue HVAC	2009	5,000	167	15	167		833	7
8	Morgue Project	2009	175,748	4,394	20	4,394		21,968	8
9	Miscellaneous Improvements	2009	5,610	561	5	561		2,805	9
10	Miscellaneous Improvements	2009	1,940	49	20	49		243	10
11	Loyola Misc Project	2009	2,160	108	10	108		540	11
12	Loyola Misc Project	2009	31,393	785	20	785		3,924	12
13	LDR Suite Project	2009	874,531	21,863	20	21,863		109,316	13
14	LDR Suite Project - Misc	2009	33,426	1,114	15	1,114		5,571	14
15	HVAC Improvements	2009	3,373	112	15	112		562	15
16	Suite 506 Improvement	2009	3,810	127	15	127		635	16
17	Suite 506 Improvement	2009	1,880	47	20	47		235	17
18	CT Project	2009	5	0	20	0		1	18
19	Chapel Project	2009	3,550	89	20	89		444	19
20	Miscellaneous Improvements	2009	196,463	4,912	20	4,912		24,558	20
21	Miscellaneous Improvements	2009	55,366	2,768	10	2,768		13,841	21
22	Wallpapering	2009	1,572	157	5	157		786	22
23	6 West Project	2009	234,531	5,863	20	5,863		29,316	23
24	5 West Project	2009	10,133	507	10	507		2,533	24
25	5 West HVAC	2009	57,345	1,912	15	1,912		9,558	25
26	5 West Improvement	2009	568,552	14,214	20	14,214		71,069	26
27	2 West Decorating	2009	6,112	611	5	611		3,056	27
28	2 West Locks	2009	12,674	634	10	634		3,168	28
29	2 West HVAC	2009	28,426	948	15	948		4,738	29
30	2 West Remodeling	2009	601,797	15,045	20	15,045		75,225	30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 111,926,585**	**$ 4,147,526**		**$ 4,147,526**	**$**	**$ 91,125,013**	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:** 07/01/2011 **Ending:** 06/30/2012

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**		**$ 111,926,585**	**$ 4,147,526**		**$ 4,147,526**	**$**	**$ 91,125,013**	1
2									2
3	CHART RUNNER 3.6	**2010**	799	222	3	222		666	3
4	BD/SLIDING SCALE	**2010**	3820	350	9	350		1050	4
5	ADOBE ACROBAT PROFESSIONAL	**2010**	419	128	3	128		384	5
6									6
7	**Recocile to TCU current year dep exp**	**2012**		-4018828		**(4,018,828)**			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	**TOTAL (lines 1 thru 33)**		**$ 111,931,623**	**$ 129,398**		**$ 129,398**	**$**	**$ 91,127,113**	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: 07/01/2011 Ending: 06/30/2012

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	$ See	$	$	$		$	71
72	Current Year Purchases	Previous						72
73	Fully Depreciated Assets	Schedules						73
74								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)	$	111,993,560	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	129,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	129,398	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)	$	91,127,113	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: 07/01/2011 Ending: 06/30/2012

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

00
00

		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

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.	/2013	$
13.	/2014	$
14.	/2015	$

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 by the length of the lease _____. N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ 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: 07/01/2011 Ending: 06/30/2012

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.

Hospital hires trained Nurses' Aides

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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:** 07/01/2011 **Ending:** 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2012 **(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	$ 24,747,552	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,799,000)	19,650,020		3
4	Supply Inventory (priced a)	2,874,627		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	445,325		7
8	Accounts Receivable (owners or related parties)	21,462,049		8
9	Other(specify): **self ins. Fund**	63,107		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 69,242,680	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cos	82,915,082		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cos			16
17	Accumulated Depreciation (book methods)			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 (spe **Other long term**	436,174		22
23	Other(specify): **investment in unconsolidated**	101,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 83,452,756	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 152,695,436	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 18,200,346	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,880,090		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Payable to third party payors**	13,880,130		36
37	**current portion of long term debt**	120,340		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 39,080,906	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,433,840		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**self ins reserve**	16,768,000		43
44	**accrued pension and other**	16,910,268		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 39,112,108	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 78,193,014	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,502,422	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 152,695,436	$	48

***(See instructions.)**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 76,287,493	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 76,287,493	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,785,071)	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 Equipmen		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,785,071)	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)**	$ 74,502,422	24	*

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 701,702,190	1
2	Discounts and Allowances for all Level	(576,170,479)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 125,531,711	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	**Other Rev**	6,261,350	28
28a	**investment earnings**	(262,125)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,999,225	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 131,530,936	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	133,316,007	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)***	$ 133,316,007	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,785,071)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,785,071)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$	49

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

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

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

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

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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	1,555	1,930	$ 94,779	$ 49.11	1
2	Assistant Director of Nursing	1,717	2,211	87,735	39.68	2
3	Registered Nurses	25,800	30,187	998,801	33.09	3
4	Licensed Practical Nurses	3,607	4,380	104,759	23.92	4
5	CNAs & Orderlies	18,215	21,418	262,797	12.27	5
6	CNA Trainees					6
7	Licensed Therapist	1,589	1,850	34,702	18.76	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,151	1,394	20,646	14.81	10
11	Social Service Workers	1,873	2,160	57,029	26.40	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	6,832	8,011	181,789	22.69	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)	62,339	73,541	$ 1,843,037 *	$ 25.06	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
Admistrative Manager			$ 92,338
Supervisors			85,558
Other Administrative			60,921
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 238,818

B. Administrative - Other

Description	Amount
Mobile Devices	$ 169
Conferences	1,314
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,484
(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	$ 46,381
Unemployment Compensation Insurance	3,338
FICA Taxes	140,313
Employee Health Insurance	235,547
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	97,184
Tuition Refund	1,248
Lif Ins Prem.	1,047
Disability Ins	6,015
Other Asst Prog	1,173
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,246

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.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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 th
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 expens
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 procedure
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 ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer
during this cost report period. $ **18,666**
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
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 t
the Department, in addition to the daily rate, been properly classifie
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 f
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, attac
a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **No** Indicate the amount $ **N/A**

(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
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 adjuste
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 & Touche**

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

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