FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 W North Ave (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
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: Patrick Szajkovics **Telephone Number:** (630) 530-7100, Ext. 111
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 July 1, 2012 to June 30, 2013 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) 10/30/2013 (Date)
(Print Name and Title) Patrick Szajkovics, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100, Ext. 111 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: July 1, 2012 Ending: June 30, 2013

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	267	11	9,827	10,105	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	267	11	9,827	10,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.43%

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 5/20/1985

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 8,752

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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		6,832		6,832		6,832	347,077	353,909			1
2	Food Purchase							119,927	119,927			2
3	Housekeeping							278,123	278,123			3
4	Laundry							103,990	103,990			4
5	Heat and Other Utilities							365,152	365,152			5
6	Maintenance		2,754	683	3,437		3,437	2,347	5,784			6
7	Other (specify):* Patient Transport							13,782	13,782			7
8	TOTAL General Services		9,586	683	10,269		10,269	1,230,398	1,240,667			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,690,093	111,150	37,860	1,839,103		1,839,103	238,721	2,077,824			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	1,690,093	111,150	37,860	1,839,103		1,839,103	238,721	2,077,824			16
	C. General Administration											
17	Administrative	194,297		1,475	195,772		195,772	546,094	741,866			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	118,106	9,549	654	128,309		128,309		128,309			21
22	Employee Benefits & Payroll Taxes			10,992	10,992		10,992	630,946	641,938			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	312,403	9,549	13,121	335,073		335,073	1,177,040	1,512,113			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,002,496	130,285	51,664	2,184,445		2,184,445	2,646,159	4,830,604			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: July 1, 2012 Ending: June 30, 2013

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							126,589	126,589			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**			18,528	18,528		18,528		18,528			36
37	**TOTAL Ownership**			18,528	18,528		18,528	126,589	145,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							36,520	36,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							18,615	18,615			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**							55,135	55,135			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,002,496	130,285	70,192	2,202,973		2,202,973	2,827,883	5,030,856			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: July 1, 2012 Ending: June 30, 2013

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 Sch. 5A	2,827,883			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,827,883		$	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))**	$ 2,827,883		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: July 1, 2012

Ending: June 30, 2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Hospital WS B Overhead Cost Alloc.-Dietary	$ 347,077	1	1
2	Hospital WS B Overhead Cost Alloc.-Food Purch	119,927	2	2
3	Hospital WS B Overhead Cost Alloc.-Housekping	278,123	3	3
4	Hospital WS B Overhead Cost Alloc.-Laundry	103,990	4	4
5	Hospital WS B OH Cost Alloc.-Utilities (Plant)	365,152	5	5
6	Hospital WS B OH Cost Alloc.-Maintenance	2,347	6	6
7	Hospital WS B OH Cost Alloc.-Cafeteria	66,048	22	7
8	Hospital WS B OH Cost Alloc.-Nursing Admin	280,715	10	8
9	Hospital WS B OH Cost Alloc.-Central Supply	21,049	10	9
10	Hospital WS B OH Cost Alloc.-Pharmacy	1,171	10	10
11	Hospital WS B OH Cost Alloc.-Administration	546,094	17	11
12	Hospital WS B OH Cost Alloc.-Employee Bene.	564,898	22	12
13	Hospital WS B OH Cost Alloc.-Depreciation	126,589	30	13
14	LTC Cost in Hosp Adm for Provider Partici. Fees	18,615	42	14
15	Hospital WS A-6 Reclass of Pt Transport Cost	13,782	7	15
16	Hospital WS A-6 Reclass of Floor Stock Supplies	(64,214)	10	16
17	TCU Calculated Ancillary Services Cost	36,520	39	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	2,827,883		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** July 1, 2012 **Ending:** June 30, 2013

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	347,077	0	0	0	0	0	0	0	0	0	0	347,077	1
2	Food Purchase	119,927	0	0	0	0	0	0	0	0	0	0	119,927	2
3	Housekeeping	278,123	0	0	0	0	0	0	0	0	0	0	278,123	3
4	Laundry	103,990	0	0	0	0	0	0	0	0	0	0	103,990	4
5	Heat and Other Utilities	365,152	0	0	0	0	0	0	0	0	0	0	365,152	5
6	Maintenance	2,347	0	0	0	0	0	0	0	0	0	0	2,347	6
7	Other (specify):*	13,782	0	0	0	0	0	0	0	0	0	0	13,782	7
8	**TOTAL General Services**	1,230,398	0	0	0	0	0	0	0	0	0	0	1,230,398	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	238,721	0	0	0	0	0	0	0	0	0	0	238,721	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**	238,721	0	0	0	0	0	0	0	0	0	0	238,721	16
	C. General Administration													
17	Administrative	546,094	0	0	0	0	0	0	0	0	0	0	546,094	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	630,946	0	0	0	0	0	0	0	0	0	0	630,946	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**	1,177,040	0	0	0	0	0	0	0	0	0	0	1,177,040	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	2,646,159	0	0	0	0	0	0	0	0	0	0	2,646,159	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** July 1, 2012 **Ending:** June 30, 2013

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	126,589	0	0	0	0	0	0	0	0	0	0	126,589	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**	126,589	0	0	0	0	0	0	0	0	0	0	126,589	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	36,520	0	0	0	0	0	0	0	0	0	0	36,520	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	18,615	0	0	0	0	0	0	0	0	0	0	18,615	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	55,135	0	0	0	0	0	0	0	0	0	0	55,135	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,827,883	0	0	0	0	0	0	0	0	0	0	2,827,883	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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: July 1, 2012 Ending: June 30, 2013

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	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: July 1, 2012 Ending: ne 30, 2013

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	N/A									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: July 1, 2012 Ending: June 30, 2013

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	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											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: July 1, 2012 Ending: June 30, 2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT Patrick Fitzgibbons, Manager - Reimbursement

TELEPHONE (708) 216-0746 FAX #: (708) 216-6034

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: July 1, 2012 Ending: June 30, 2013

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: July 1, 2012 Ending: June 30, 2013

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		839,469	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	(0)	158,797	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	0	6,584,288	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: July 1, 2012 Ending: June 30, 2013

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		3,082,741	42
43	Various	1995	4,858,946	364,421		364,421		4,665,887	43
44	Various	1996	4,322,888	324,217		324,217		4,131,731	44
45	Various	1997	3,851,805	283,697		283,697		3,272,623	45
46	Various	1998	7,826,827	586,151		586,151		6,479,636	46
47	Various	1999	3,782,851	283,714		283,714		3,032,966	47
48	Various	2000	6,562,656	492,199		492,199		4,781,472	48
49	Various	2001	4,472,858	335,464		335,464		3,240,963	49
50	Various	2002	3,071,826	232,098		232,098		1,994,272	50
51	Various	2003	1,616,067	128,016		128,016		1,015,417	51
52	Various	2004	2,567,622	203,241		203,241		1,393,752	52
53	Various	2005	4,098,669	324,788		324,788		2,067,722	53
54	Various	2006	1,656,917	66,572		66,572		421,622	54
55	Various	2007	1,091,422	40,123		40,123		247,758	55
56	Various	2008	392,789	21,427		21,427		116,566	56
57	Various	2009	3,415,801	121,618		121,618		650,520	57
58									58
59	MISC PROJECT - CORRIDOR WALL P	2011	23,660	4,732	5	4,732		11,830	59
60	WAITING ROOM ADDITION - CONSTR	2011	2,357	59	40	59		142	60
61	WAITING ROOM ADDITION - MOVERS	2011	1,309	33	40	33		79	61
62	WAREHOUSE - DOORS 8/11	2011	6,370	319	20	319		770	62
63	LOBBY PROJECT - CONSTRUCTION 8	2011	1,653	83	20	83		200	63
64	EYE CENTER - WALLPAPER 8/11	2011	510	102	5	102		247	64
65	SURGERY WAITING ADDITION - ENG	2011	1,080	27	40	27		63	65
66	SURGERY WAITING ADDITION - PLU	2011	877	22	40	22		51	66
67	SURGERY WAITING ADDITION - PLA	2011	176	4	40	4		10	67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 111,964,576**	**$ 4,152,906**		**$ 4,152,905**	**$ (0)**	**$ 95,285,930**	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: July 1, 2012 Ending: June 30, 2013

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		$ 111,964,576	$ 4,152,906		$ 4,152,905	$ (0)	$ 95,285,930	1
2	MISC PROJECTS - ENERGY CONSUMP	2011	9,075	454	20	454		1,059	2
3	MISC POB PROJECTS - LIGHTING P	2011	4,012	201	20	201		468	3
4	MISC PROJECTS - OLD LOBBY - WA	2011	1,560	312	5	312		728	4
5	MAMMOGRAPHY PROJECT - PLUMBING	2011	475	24	20	24		55	5
6	ENERGY CONSUMPTION PROJECT - 1	2011	38,076	1,904	20	1,904		4,284	6
7	OLD DIALYSIS PROJECT - ELECTRI	2011	2,943	147	20	147		331	7
8	MISC POB PROJECTS - SUITE 507	2011	1,240	248	5	248		558	8
9	ENERGY CONSUMPTION PROJECT - 1 (ADJ)	2011	(37,722)	(1,886)	20	(1,886)		(4,244)	9
10	SURGERY PROJECT - CONSTRUCTION	2011	17,515	438	40	438		949	10
11	RHINO SHIELD PROJECT	2011	66,112	3,306	20	3,306		7,162	11
12	LAB PROJECT - CONSTRUCTION 11/	2011	24,615	1,231	20	1,231		2,667	12
13	DR'S LOUNGE PROJECT-WALLPAPER	2011	4,233	847	5	847		1,834	13
14	MISC POB PROJ - STE 507 - FLOO	2011	2,680	536	5	536		1,161	14
15	ENERGY CONSUMPTION PROJECT - E	2011	1,291	86	15	86		186	15
16	MASTER PLAN PROJECT - ARCHITEC	2011	696	35	20	35		75	16
17	ENERGY CONSUMPTION PROJECT - E (ADJ)	2011	(891)	(59)	15	(59)		(129)	17
18	DR'S LOUNGE PROJECT - 12/11 CO	2011	74,339	3,717	20	3,717		7,744	18
19	POB HALLWAYS - WALLPAPER 12/11	2011	26,200	5,240	5	5,240		10,917	19
20	ENERGY CONSUMPTION PROJECT - E	2011	266	18	15	18		37	20
21									21
22	RIVER FOREST CONSTRUCTION 12/1	2012	431,303	21,565	20	21,565		43,130	22
23	DOCTOR'S LOUNGE PROJECT - CONS	2012	67,009	3,350	20	3,350		6,701	23
24	POB HALLWAYS - FLOORING 1/12	2012	65,642	6,564	10	6,564		13,128	24
25	RIVER FOREST - ELECTRIC 11/11-	2012	34,819	1,741	20	1,741		3,482	25
26	SUITE 416 PROJECT - CONSTRUCTI	2012	33,076	1,654	20	1,654		3,308	26
27	POB HALLWAYS - CONSTRUCTION 1/	2012	24,429	1,221	20	1,221		2,443	27
28	POB HALLWAYS - WALLPAPER 1/12	2012	12,420	2,484	5	2,484		4,968	28
29	POB HALLWAYS - ELECTRIC 1/12	2012	11,790	589	20	589		1,179	29
30	POB HALLWAYS - WALLPAPER 1/12	2012	11,417	2,283	5	2,283		4,567	30
31	POB MISC PROJECTS - STE 414 -	2012	8,823	1,765	5	1,765		3,529	31
32	POB HALLWAYS - CARPET 1/12	2012	7,965	1,593	5	1,593		3,186	32
33	MISC PROJECTS - O/P REHAB - CA	2012	7,301	1,460	5	1,460		2,920	33
34	**TOTAL (lines 1 thru 33)**		$ 112,917,283	$ 4,215,972		$ 4,215,972	$ (0)	$ 95,414,314	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: July 1, 2012 Ending: June 30, 2013

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		$ 112,917,283	$ 4,215,972		$ 4,215,972	$ (0)	$ 95,414,314	1
2	LAB PROJECT - CONSTRUCTION 1/1	2012	2,735	137	20	137		274	2
3	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,072	104	20	104		207	3
4	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,070	104	20	104		207	4
5	DOCTOR'S LOUNGE PROJECT - HEAT	2012	695	46	15	46		93	5
6	RIVER FOREST - ELECTRIC 11/11- (ADJ)	2012	(1,537)	(77)	20	(77)		(154)	6
7	ASPHALT PROJECT	2012	146,845	18,356	8	18,356		36,711	7
8	BARIATRIC PROJECT - LANDSCAPIN	2012	4,825	483	10	483		965	8
9	RIVER FOREST - CONSTRUCTION 2/	2012	593,385	29,669	20	29,669		56,866	9
10	POB HALLWAYS PROJECT - WALLPAP	2012	2,055	411	5	411		788	10
11	ELECTRONIC LEAD SIGN 2/12	2012	42,941	4,294	10	4,294		8,230	11
12	BARIATRIC OFFICE PROJECT - CON	2012	77,320	3,866	20	3,866		7,088	12
13	AIR HANDLER PROJECT - ENGINEER	2012	35,230	2,349	15	2,349		4,306	13
14	RIVER FOREST - CONSTRUCTION 3/	2012	5,470	274	20	274		501	14
15	RIVER FOREST - ELECTRIC 3/12	2012	4,177	209	20	209		383	15
16	BARIATRIC PROJECT - ARCHITECTU	2012	4,098	205	20	205		376	16
17	BARIATRIC OFFICE PROJECT - ARC	2012	2,958	148	20	148		271	17
18	BARIATRIC PROJECT - ARCHITECTU	2012	27	1	20	1		2	18
19	RIVER FOREST MEDICAL PROJECT-E	2012	7,920	396	20	396		693	19
20	FLOORING	2012	3,850	385	10	385		674	20
21	BARIATRIC OFFICE PROJECT - CON	2012	102,212	5,111	20	5,111		8,518	21
22	MISC PROJECTS - HOME HEALTH -	2012	11,410	2,282	5	2,282		3,803	22
23	PLUMBING	2012	1,810	91	20	91		151	23
24	BARIATRIC OFFICE PROJECT - ARC	2012	870	44	20	44		73	24
25	TURF	2012	3,996	799	5	799		1,332	25
26	CHILLER PLANT UPGRADE - CONSTR	2012	417,631	20,882	20	20,882		33,062	26
27	ELECTRICAL FEED UPGRADE - CONS	2012	284,386	14,219	20	14,219		22,514	27
28	CHILLER PLANT UPGRADE - CONSTR	2012	274,632	13,732	20	13,732		21,742	28
29	AIR HANDLER PROJECT - CONSTRUC	2012	249,380	12,469	20	12,469		19,743	29
30	CHILLER PLANT UPGRADE - CONSTR	2012	214,979	10,749	20	10,749		17,019	30
31	CHILLER	2012	191,970	12,798	15	12,798		20,264	31
32	AIR HANDLER PROJECT - CONSTRUC	2012	127,960	6,398	20	6,398		10,130	32
33	CHILLER PLANT UPGRADE - CONSTR	2012	99,932	4,997	20	4,997		7,911	33
34	**TOTAL (lines 1 thru 33)**		$ 115,835,586	$ 4,381,899		$ 4,381,898	$ (0)	$ 95,699,056	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: July 1, 2012 Ending: June 30, 2013

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		$ 115,835,586	$ 4,381,899		$ 4,381,898	$ (0)	$ 95,699,056	1
2	CHILLER PLANT UPGRADE - ENGINE	2012	96,156	4,808	20	4,808		7,612	2
3	AIR HANDLER PROJECT - INSULATI	2012	80,000	4,000	20	4,000		6,333	3
4	CHILLER PLANT UPGRADE - ENGINE	2012	53,034	2,652	20	2,652		4,199	4
5	AIR HANDLER PROJECT - CONSTRUC	2012	47,235	2,362	20	2,362		3,739	5
6	AIR HANDLER PROJECT - ENGINEER	2012	29,017	1,451	20	1,451		2,297	6
7	CHILLER PLANT UPGRADE - ENGINE	2012	22,413	1,121	20	1,121		1,774	7
8	AIR HANDLER PROJECT - ENGINEER	2012	22,355	1,118	20	1,118		1,770	8
9	ELECTRICAL FEED UPGRADE - ENGI	2012	12,380	619	20	619		980	9
10	CHILLER PLANT PROJECT - ENGINE	2012	12,173	609	20	609		964	10
11	AIR HANDLER PROJECT - PLAN REV	2012	9,600	640	15	640		1,013	11
12	CHILLER PLANT UPGRADE - ENGINE	2012	9,500	475	20	475		752	12
13	CHILLER PLANT UPGRADE - DEMOLI	2012	7,500	500	15	500		792	13
14	CHILLER PLANT UPGRADE - ENGINE	2012	6,180	309	20	309		489	14
15	CHILLER PLANT UPGRADE - DOCK P	2012	4,890	245	20	245		387	15
16	CHILLER PLANT UPGRADE - ELECTR	2012	4,850	243	20	243		384	16
17	AIR HANDLER PROJECT - DUCTS 6/	2012	3,640	182	20	182		288	17
18	NEW LAB FOR E.R. - PLUMBING 5/	2012	3,500	175	20	175		277	18
19	ELECTRICAL FEED UPGRADE - PAIN	2012	2,220	444	5	444		703	19
20	ELECTRICAL FEED UPGRADE - ELEC	2012	2,200	110	20	110		174	20
21	NEW LAB FOR E.R.-ELECTRIC	2012	2,197	110	20	110		174	21
22	ELECTRICAL FEED UPGRADE - ELEC	2012	1,670	84	20	84		132	22
23	AIR HANDLER PROJECT - BLINDS 3	2012	1,436	287	5	287		455	23
24	ON SITE WITNESS TO COMED SHUTD	2012	1,385	277	5	277		439	24
25	NEW LAB FOR E.R. - WALLLPAPER/	2012	720	144	5	144		228	25
26	EXTERNAL SIGNAGE	2012	81,052	8,105	10	8,105		12,833	26
27	PARKING LOT REJUVENATOR	2012	45,674	5,709	8	5,709		8,564	27
28	AIR HANDLER PROJECT - CONSTRUC	2012	1,359,117	67,956	20	67,956		101,934	28
29	RADIOLOGY RENOVATION - CONSTRU	2012	239,900	11,995	20	11,995		17,993	29
30	GI LAB WAITING ROOM PROJECT -	2012	199,651	9,983	20	9,983		14,974	30
31	CHILLER PLANT UPGRADE-CONSTRUC	2012	163,437	8,172	20	8,172		12,258	31
32	SUITE 201/202 REHAB - CONSTRUC	2012	135,242	6,762	20	6,762		10,143	32
33	STE 201/202 REHAB - CONSTRUCTI	2012	107,999	5,400	20	5,400		8,100	33
34	**TOTAL (lines 1 thru 33)**		**$ 118,603,909**	**$ 4,528,942**		**$ 4,528,942**	**$ (0)**	**$ 95,922,210**	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: July 1, 2012 Ending: June 30, 2013

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		$ 118,603,909	$ 4,528,942		$ 4,528,942	$ (0)	$ 95,922,210	1
2	ELECTRIC FEED UPGRADE - CONSTR	2012	54,580	2,729	20	2,729		4,094	2
3	AIR HANDLER PROJECT - ENGINEER	2012	42,945	2,147	20	2,147		3,221	3
4	AIR HANDLER PROJECT-GLOSSTEK F	2012	12,100	2,420	5	2,420		3,630	4
5	CHILLER PLANT UPGRADE-ENGINEER	2012	8,459	423	20	423		634	5
6	AIR HANDLER PROJECT - CARPET 7	2012	4,140	828	5	828		1,242	6
7	GI LAB WAITING ROOM - ARCHITEC	2012	1,500	75	20	75		113	7
8	ELECTRIC FEED UPGRADE - ELECTR	2012	1,110	56	20	56		83	8
9	ELECTRIC FEED UPGRADE - ENGINE	2012	580	29	20	29		43	9
10	XRAY ROOM #2 - CONSTRUCTION 7/	2012	231,000	11,550	20	11,550		16,363	10
11	SLEEP STUDY RENOVATION - CONST	2012	43,046	2,152	20	2,152		2,690	11
12	MCC PROJECT - ELECTRIC	2012	37,839	1,892	20	1,892		2,365	12
13									13
14	HW TANK SOUTH WING	2013	86,900.00	7,966	10	7,966		7,966	14
15	NEW CHILLER	2013	53,149.00	3,248	15	3,248		3,248	15
16	HW TANK SOUTH WING	2013	16,900.00	1,549	10	1,549		1,549	16
17	ENGINEERING FEES FOR NEW CHILL	2013	14,400.00	880	15	880		880	17
18	BTU BOILER	2013	8,850.00	406	20	406		406	18
19	ENGINEERING FEES FOR NEW CHILL	2013	133.90	8	15	8		8	19
20	LIFE SAFETY UPGRADES	2013	14,591.95	2,432	5	2,432		2,432	20
21	HOT WATER TANK SOUTH WING	2013	6,782.02	565	10	565		565	21
22	LIFE SAFETY UPGRADES	2013	4,973.27	829	5	829		829	22
23	NEW CHILLER - CONSTRUCTION	2013	413,944.00	20,697	15	20,697		20,697	23
24	NEW CHILLER - CONSTRUCTION	2013	139,452.00	6,973	15	6,973		6,973	24
25	LIFE SAFETY UPGRADES	2013	9,665.00	1,450	5	1,450		1,450	25
26	LIFE SAFETY UPGRADES	2013	6,143.19	921	5	921		921	26
27	NEW CHILLER - ENGINEERING	2013	3,600.00	180	15	180		180	27
28	NEW CHILLER - ENGINEERING	2013	2,350.00	118	15	118		118	28
29	NEW CHILLER - ASBESTOS INSPECT	2013	1,900.00	95	15	95		95	29
30	NEW CHILLER	2013	205,750.00	9,144	15	9,144		9,144	30
31	SUITE 312 RENOVATION - CONSTRU	2013	137,075.00	4,569	20	4,569		4,569	31
32	NEW CHILLER	2013	6,169.53	274	15	274		274	32
33	CHILLER	2013	4,700.00	209	15	209		209	33
34	**TOTAL (lines 1 thru 33)**		**$ 120,178,638**	**$ 4,615,756**		**$ 4,615,756**	**$ (0)**	**$ 96,019,201**	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: July 1, 2012 Ending: June 30, 2013

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		$ 120,178,638	$ 4,615,756		$ 4,615,756	$ (0)	$ 96,019,201	1
2	LIFE SAFETY UPGRADES - LOEBL -	2013	543.99	73	5	73		73	2
3	STORAGE GARAGE	2013	43,800.00	1,022	25	1,022		1,022	3
4									4
5									5
6	Recocile to TCU current year depr exp as allocated			-4490262		(4,490,262)			6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 120,222,982	$ 126,589		$ 126,589	$ (0)	$ 96,020,295	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: July 1, 2012 Ending: June 30, 2013

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	N/A			$	$	$	$		$	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)	$	120,284,919	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	126,589	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	126,589	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(0)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	96,020,295	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: July 1, 2012 Ending: June 30, 2013

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			$ N/A			3
4	Additions	N/A			N/A			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.	/2014	$
13.	/2015	$
14.	/2016	$

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	N/A		$	$	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: July 1, 2012 Ending: June 30, 2013

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 only 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.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	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: July 1, 2012 Ending: June 30, 2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2013 (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	$ 5,137,557	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,492,361)	31,007,718		3
4	Supply Inventory (priced at)	2,939,000		4
5	Short-Term Investments	100,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	154,452		7
8	Accounts Receivable (owners or related parties)	33,332,189		8
9	Other(specify): self ins. Fund	63,113		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 72,734,029	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	78,315,605		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			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 Self Ins & Other	5,201,732		22
23	Other(specify): Investmnt in Uncons Affil	101,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 83,618,837	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 156,352,866	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 20,937,207	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,613,020		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	11,874,943		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 38,425,170	$	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	Self Ins Reserve	8,516,178		43
44	Accrued Pension and Other	25,428,554		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,944,732	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 72,369,902	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 83,982,964	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 156,352,866	$	48

***(See instructions.)**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 74,502,422	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,502,422	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,696,796	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) **Other Interco Transfers**	3,783,746	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 9,480,542	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)**	$ 83,982,964	24 *

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	$ 638,349,235	1
2	Discounts and Allowances for all Levels	(516,973,596)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 121,375,639	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 Hospital Revenues	9,875,366	28
28a	Hospital Investment Earnings	720,316	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,595,682	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 131,971,321	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	10,269	31
32	Health Care	1,839,103	32
33	General Administration	335,073	33
	B. Capital Expense		
34	Ownership	18,528	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Other Hospital Expenses not Allocated to TCU / LTC	124,071,552	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 126,274,525	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,696,796	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,696,796	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ N/A	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? Yes If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

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	1,885	2,145	$ 111,009	$ 51.75	1
2	Assistant Director of Nursing	1,787	2,026	84,407	41.66	2
3	Registered Nurses	26,979	30,406	1,040,393	34.22	3
4	Licensed Practical Nurses	5,051	5,561	129,999	23.38	4
5	CNAs & Orderlies	20,385	24,498	312,098	12.74	5
6	CNA Trainees					6
7	Licensed Therapist	1,761	2,048	39,395	19.24	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,256	1,423	19,921	14.00	10
11	Social Service Workers	1,920	2,196	59,069	26.90	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	7,650	8,620	206,205	23.92	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)	68,674	78,923	$ 2,002,496 *	$ 25.37	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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2012 Ending: June 30, 2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrative Manager	Admin	0	$ 109,207
Supervisors	Assistant Adm	0	85,090
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 194,297

B. Administrative - Other

Description	Amount
Misc Other Expenses	$ 1,475
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,475

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	$ 49,281
Unemployment Compensation Insurance	3,546
FICA Taxes	149,359
Employee Health Insurance	243,751
Employee Meals	66,048
Illinois Municipal Retirement Fund (IMRF)*	
Pension	103,260
Tuition Reimbursement	1,326
Lif Ins Prem.	1,112
Disability Ins	6,391
Dental Ins	6,872
TB Life Ins pymts	10,992
TOTAL (agree to Schedule V, line 22, col.8)	$ 641,938

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: July 1, 2012 Ending: June 30, 2013

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: July 1, 2012 Ending: June 30, 201

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 political 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 for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **18,615**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **66,048** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **324,703**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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 other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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 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.