FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 8000200

Facility Name: Graham Hospital

Address: 210 West Walnut St (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 944-6431 **Fax #** (309)-649-5411

HFS ID Number:

Date of Initial License for Current Owners: 7/02/1987

Type of Ownership:

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

IRS Exemption Code 501c

In the event there are further questions about this report, please contact:
Name: Melissa Wilson **Telephone Number:** (309) 649-8445
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 07/01/13 to 06/30/14 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)
(Firm Name & Address) McGladrey LLP, 201 N. Harrison Street, Suite 300, Davenport, IA 52801
(Telephone) (563) 888-4404 Fax # (563) 324-6939

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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	18	Intermediate/DD	18	6,570	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	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	345	1,177	3,064	4,586	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	4,227	1,486		5,713	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,572	2,663	3,064	10,299	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.43%

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)
0

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 5/01/1987

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 32 and days of care provided 3,064

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: 6/30/14 Fiscal Year: 6/30/14

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	147,927		202,503	350,430		350,430		350,430			1
2	Food Purchase		467,077		467,077		467,077		467,077			2
3	Housekeeping	160,785		35,254	196,039		196,039		196,039			3
4	Laundry	9,648		90,345	99,993		99,993		99,993			4
5	Heat and Other Utilities											5
6	Maintenance	112,926		284,688	397,614		397,614		397,614			6
7	Other (specify):*											7
8	**TOTAL General Services**	431,286	467,077	612,790	1,511,153		1,511,153		1,511,153			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,457,259		61,073	1,518,332		1,518,332		1,518,332			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Nursing School	44,181		9,400	53,581		53,581		53,581			15
16	**TOTAL Health Care and Programs**	1,501,440		70,473	1,571,913		1,571,913		1,571,913			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	475,707		101,208	576,915		576,915		576,915			21
22	Employee Benefits & Payroll Taxes			414,519	414,519		414,519		414,519			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			180,577	180,577		180,577		180,577			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	475,707		696,304	1,172,011		1,172,011		1,172,011			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,408,433	467,077	1,379,567	4,255,077		4,255,077		4,255,077			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 Graham Hospital #8000200 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

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			210,013	210,013		210,013	545,435	755,448			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):*											36
37	**TOTAL Ownership**			210,013	210,013		210,013	545,435	755,448			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,375	27,375		27,375		27,375			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			27,375	27,375		27,375		27,375			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,408,433	467,077	1,616,955	4,492,465		4,492,465	545,435	5,037,900			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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 Reference	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 See Pg 5A	545,435			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 545,435		$	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))**	$ 545,435		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Graham Hospital

ID# 8000200

Report Period Beginning: 07/01/13

Ending: 06/30/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment of Allocated Depreciation to actual	$ 545,435		1
2	straight line depreciation per page 12&13			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	545,435		49

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 ☐ 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		N/A	$			$	$	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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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 N/A
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		See attached Medicare worksheet B part 1 for allocations from hospital.								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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	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 #** N/A

*** 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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,688 B. General Construction Type: Exterior Brick 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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	ECF/SNF	16,688		$	1
2					2
3	TOTALS	16,688		$	3

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	37			1971	$ 1,047,221	$		$	$ 1,047,221	$ 1,047,221	4
5				1972	866				866	866	5
6				1978	187,881				187,881	187,881	6
7				1982	3,684				3,684	3,684	7
8				1977	1,331,168	27,895	various	27,895	1,203,375	1,231,270	8
	Improvement Type**										
9	1975 VARIOUS BUILDING IMPROVEMENTS			1975	30,771		various			30,771	9
10	1976 VARIOUS BUILDING IMPROVEMENTS			1976	1,880		various			1,880	10
11	1980 VARIOUS BUILDING IMPROVEMENTS			1980	2,093		various			2,093	11
12	1982 VARIOUS BUILDING IMPROVEMENTS			1982	1,543		various			1,543	12
13	1984 VARIOUS BUILDING IMPROVEMENTS			1984	1,169,963	16,169	various	16,169		1,026,706	13
14	1985 VARIOUS BUILDING IMPROVEMENTS			1985	34,258		various			34,258	14
15	1987 VARIOUS BUILDING IMPROVEMENTS			1987	89,317	109	various	109		88,824	15
16	1988 VARIOUS BUILDING IMPROVEMENTS			1988	52,287	4	various	4		52,139	16
17	1990 VARIOUS BUILDING IMPROVEMENTS			1990	28,254	3	various	3		28,197	17
18	1991 VARIOUS BUILDING IMPROVEMENTS			1991	125,804		various			125,804	18
19	1992 VARIOUS BUILDING IMPROVEMENTS			1992	16,693		various			16,693	19
20	1993 VARIOUS BUILDING IMPROVEMENTS			1993	19,686		various			19,686	20
21	1994 VARIOUS BUILDING IMPROVEMENTS			1994	76,132	6	various	6		76,132	21
22	1995 VARIOUS BUILDING IMPROVEMENTS			1995	32,594	51	various	51		32,594	22
23	1996 VARIOUS BUILDING IMPROVEMENTS			1996	47,691	117	various	117		47,486	23
24	1994 VARIOUS BUILDING IMPROVEMENTS			1997	24,479	101	various	101		24,166	24
25	1998 VARIOUS BUILDING IMPROVEMENTS			1998	26,173		various			26,173	25
26	1999 VARIOUS BUILDING IMPROVEMENTS			1999	11,097	555	various	555		9,107	26
27	2000 VARIOUS BUILDING IMPROVEMENTS			2000	800,069	53,720	various	53,720		780,686	27
28	2001 VARIOUS BUILDING IMPROVEMENTS			2001	112,532	7,755	various	7,755		111,416	28
29	2002 VARIOUS BUILDING IMPROVEMENTS			2002	578,790	37,043	various	37,043		482,324	29
30	2003 VARIOUS BUILDING IMPROVEMENTS			2003	356,376	24,613	various	24,613		291,315	30
31	2004 VARIOUS BUILDING IMPROVEMENTS			2004	466,553	35,708	various	35,708		382,286	31
32	2005 VARIOUS BUILDING IMPROVEMENTS			2005	953,088	63,278	various	63,278		574,794	32
33	2006 VARIOUS BUILDING IMPROVEMENTS			2006	2,994,111	156,500	various	156,500		1,465,460	33
34	2007 VARIOUS BUILDING IMPROVEMENTS			2007	2,221,427	93,042	various	93,042		760,063	34
35	2008 VARIOUS BUILDING IMPROVEMENTS			2008	1,406,411	79,001	various	79,001		521,335	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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE DOORS-1ST FLOOR	2009	$ 1,887	$ 126	15	$ 126	$	$ 692	37
38	PCU AUTOMATIC DOORS	2009	1,927	193	10	193		1,060	38
39	ROOF L	2009	13,668	1,367	10	1,367		7,517	39
40	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONST	2009	7,055	470	15	470		2,587	40
41	08.23-GMG BOND EYE AR EA REMODEL-DRYWALL/SNAP	2009	836	56	15	56		307	41
42	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767	77	10	77		422	42
43	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S C	2009	2,106	140	15	140		772	43
44	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONST	2009	1,823	122	15	122		669	44
45	PROJ 09.02-RISK ASSESSMENT REMODEL-PAINT/CARPET	2009	3,002	300	5	300		3,002	45
46	PROJ 09.03-GMG EXAM ROOM FLOOR-TILE/ADHESIVES	2009	449	45	10	45		247	46
47	PROJ 09.03-GMG EXAM ROOM FLOOR-BLADES/KNOVES/D	2009	606	91	4	91		667	47
48	PROJ 09.06-RUSHFORD BUILDING-WIND DAMAGE/CONSTR	2009	2,540	169	15	169		932	48
49	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONS	2009	5,357	357	15	357		1,965	49
50	PROJ 09.08-ACCOUNTING RENOVATION-PAINT/CARPET/	2009	1,892	315	6	315		1,766	50
51	PROJ 08.22-REMODEL PATIENT REGISTRATION-MISC	2009	325	32	5	32		325	51
52	PROJ 08.22-REMODEL PATIENT REGISTRATION-CEILING	2009	351	35	10	35		194	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD	2009	8,730	582	15	582		3,201	53
54	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102	73	15	73		404	54
55	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCT	2009	2,663	178	15	178		977	55
56	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171	78	15	78		429	56
57	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424	228	15	228		1,255	57
58	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	264	27	5	27		264	58
59	PROJ 09.11-GROUND FLOOR CLINIC-BUILDING SUPPLIES	2009	539	54	5	54		539	59
60	PROJ 09.11-GROUND FLOOR CLINIC-RICKARD'S LABOR	2009	2,841	189	15	189		1,042	60
61	PROJ 08.06-SPRINKLER WORK-VARIOUS SUPPLIES FOR P	2009	513	52	5	52		513	61
62	PROJ 08.06-SPRINKLER WORK-REPLACEMENT CEILING	2009	6,420	803	8	803		4,414	62
63	PROJ 09.09-DR. LOUNGE REMODEL-CARPETING AND VAR	2009	1,636	163	5	163		1,636	63
64	PROJ 09.09-DR. LOUNGE REMODEL-HOLTHAUS CO. ROO	2009	1,518	152	10	152		835	64
65	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRUC	2009	4,802	320	15	320		1,761	65
66	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584	306	15	306		1,681	66
67	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769	251	15	251		1,382	67
68	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363	91	15	91		499	68
69		1972	5,755	VARIOUS	VARIOUS	VARIOUS		5,755	69
70	TOTAL (lines 4 thru 69)		$ 14,346,577	$ 603,112		$ 603,112	$ 2,443,027	$ 9,534,564	70

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XI. OWNERSHIP COSTS (continued)

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

1	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		$ 14,346,577	$ 603,112		$ 603,112	$	$ 9,534,564	1
2	1973 FIXED EQUIPMENT	1972	4,926	VARIOUS	VARIOUS	VARIOUS		4,926	2
3	1975 FIXED EQUIPMENT	1975	989	VARIOUS	VARIOUS	VARIOUS		989	3
4	1980 FIXED EQUIPMENT	1980	599	VARIOUS	VARIOUS	VARIOUS		599	4
5	1981 FISED EQUIPMENT	1981	1,188	VARIOUS	VARIOUS	VARIOUS		1,188	5
6	1987 FIXED EQUIPMENT	1987	37,780		VARIOUS			37,780	6
7	1988 FIXED EQUIPMENT	1988	1,439		VARIOUS			1,439	7
8	1992 FIXED EQUIPMENT	1992	3,936		VARIOUS			3,936	8
9	1994 FIXED EQUIPMENT	1994	4,732		VARIOUS			4,732	9
10	1995 FIXED EQUIPMENT	1995	7,700	384	VARIOUS	384		7,489	10
11	1996 FIXED EQUIPMENT	1996	1,422		VARIOUS			1,422	11
12	1998 FIXED EQUIPMENT	1998	2,006	52	VARIOUS	52		2,046	12
13	1999 FIXED EQUIPMENT	1999	2,891		VARIOUS			2,891	13
14	2001 FIXED EQUIPMENT	2001	20,918	1,541	VARIOUS	1,541		20,918	14
15	2002 FIXED EQUIPMENT	2002	920		VARIOUS			920	15
16	2003 FIXED EQUIPMENT	2003	30,047	1,631	VARIOUS	1,631		26,571	16
17	2005 FIXED EQUIPMENT	2005	10,856		VARIOUS			10,856	17
18	PROJ 04.11 NEW ER - CABLING & DUCTWORK	2006	22,004	2,200	10	2,200		18,701	18
19	PROJ 04.11 NEW ER - FIRE & SECURITY SYSTEM	2006	12,357	1,236	10	1,236		10,505	19
20	PROJ 04.11 NEW ER - WALLSLIDE & SUCTION UNITS	2006	5,999	600	10	600		5,100	20
21	PROJ 04.11 NEW ER - SHELVES, DOORS, DIVIDERS	2006	11,707	1,171	10	1,171		9,953	21
22	PROJ 05.04 LAB RENOVATION - DATA CABLING	2006	2,251	225	10	225		1,913	22
23	PROJ 05.10 - 1ST PHASE MED/SURG-PERSONAL PROTECTIC	2007	1,364		5			1,500	23
24	PROJ 06.03 - ADMINISTRATION BOARDROOM - COUNTER	2007	4,359	436	10	436		3,270	24
25	PROJ 06.03 - ADMIN. BOARD RM-LAMINATED CASEWORK	2007	15,097	1,006	15	1,006		7,546	25
26	PROJ 04.16 - PYXIS - CABINETS	2007	442	29	15	29		219	26
27	PROJ 07.08 - THIRD FLOOR ONCOLOGY ROOM - CABINET	2007	2,406	241	10	241		1,807	27
28	PROJ 06.03 - ADMINISTRATION BOARDROOM - DROP-IN S	2007	1,539	154	10	154		1,155	28
29	07.10-HEARTCARE MIDWEST-CABINETS & COUNTERTOP	2008	5,545	370	15	370		2,404	29
30	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387	26	15	26		169	30
31	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTOP	2008	367	24	15	24		157	31
32	08.04-HR RELOCATION-SINK	2008	304	15	20	15		98	32
33	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERTO	2008	1,317	88	15	88		572	33
34	TOTAL (lines 1 thru 33)		$ 14,566,371	$ 614,541		$ 614,541	$	$ 9,728,335	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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		$ 14,566,371	$ 614,541		$ 614,541	$	$ 9,728,335	1
2	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINETS	2008	1,126	75	15	75		488	2
3	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTOI	2008	366	24	15	24		157	3
4	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&CO	2008	401	27	15	27		175	4
5	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424	95	15	95		515	5
6	PROJ 09.11-GROUND FLOOR CLINIC-SINK	2009	215	21	5	21		215	6
7	PROJ 09.11-GROUND FLOOR CLINIC-ROOM DARKENING	2009	3,134	157	20	157		890	7
8	1971 LAND IMPROVEMENTS	1971	32,916		VARIOUS			32,916	8
9	1976 LAND IMPROVEMENT	1976	82,444		VARIOUS			82,444	9
10	1979 LAND IMPROVEMENTS	1979	30,208		VARIOUS			30,208	10
11	1981 LAND IMPROVEMENTS	1981	65,066		VARIOUS			65,066	11
12	1984 LAND IMPROVEMENTS	1984	61,686		VARIOUS			61,686	12
13	1991 LAND IMPROVEMENTS	1991	13,023		VARIOUS			13,023	13
14	1992 LAND IMPROVEMENTS	1992	656		VARIOUS			656	14
15	1993 LAND IMPROVEMENTS	1993	3,134		VARIOUS			3,134	15
16	1994 LAND IMPROVEMENTS	1994	3,983		VARIOUS			3,983	16
17	1995 LAND IMPROVEMENTS	1995	1,178		VARIOUS			1,178	17
18	1996 LAND IMPROVEMENTS	1996	3,963		VARIOUS			3,963	18
19	1998 LAND IMPROVEMENTS	1998	442	17	VARIOUS	17		442	19
20	2001 LAND IMPROVEMENTS	2001	6,453		VARIOUS			6,453	20
21	2002 LAND IMPROVEMENTS	2002	11,727	775	VARIOUS	775		10,851	21
22	2003 LAND IMPROVEMENTS	2003	36,978		VARIOUS			36,978	22
23	2004 LAND IMPROVEMENTS	2004	83,693	5,580	VARIOUS	5,580		58,583	23
24	2005 LAND IMPROVEMENTS	2005	84,686	5,687	VARIOUS	5,687		51,185	24
25	PROJ 07.03 - SOUTH PARKING LOT	2007	9,186	1,148	8	1,148		8,611	25
26	PROJ 07.07 - SOUTH PARKING LOT STAIRS-RICKARD'S/CC	2007	9,465	631	15	631		4,733	26
27	PROJ 07.07 - SOUTH PARKING LOT STAIRS - GRAVEL	2007	141		5			141	27
28	PROJ 06.09-HOME HEALTH MOVE-DEMO OF HOUSE IN SC	2007	3,528	235	15	235		1,763	28
29	SOUTH PATIO IMPROVEMENTS	2008	1,603	107	15	107		695	29
30	PAVING OF CLINIC PARKING LOT	2008	4,353	544	8	544		3,536	30
31	2010 Land Impr - Paving, Rock, Resurface, etc..	2010	15,449	515	30	515		3,083	31
32	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082	54	20	54		324	32
33	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939	118	25	118		531	33
34	TOTAL (lines 1 thru 33)		$ 15,143,019	$ 630,351		$ 630,351	$	$ 10,216,941	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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		$ 15,143,019	$ 630,351		$ 630,351	$	$ 10,216,941	1
2	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INTE	2010	385	10	40	10		45	2
3	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723	29	25	29		130	3
4	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257	731	40	731		3,290	4
5	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889	322	40	322		1,449	5
6	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTERI	2010	2,576	64	40	64		290	6
7	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLO	2010	6,806	681	10	681		3,063	7
8	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENG	2010	1,510	38	40	38		170	8
9	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUPI	2010	7,453	186	40	186		838	9
10	AMBULANCE BUILDING - WALNUT ST.	2010	1,089	27	40	27		122	10
11	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602	460	10	460		2,071	11
12	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963	131	15	131		589	12
13	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301	153	15	153		690	13
14	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061	1,706	10	1,706		7,677	14
15	ROOF M REPLACEMENT - MRI ROOF	2010	6,935	694	10	694		3,121	15
16	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & C	2010	4,786	319	15	319		1,436	16
17	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943	196	15	196		883	17
18	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPL	2010	2,485	166	15	166		746	18
19	PROJ. 10-04-EXT. CARE RENOVATIONS-RICKARD'S LABOR	2010	15,761	394	40	394		1,773	19
20	PROJ. 10-04 EXT. CARE RENOVATIONS-FLAD & ASSOCIATI	2010	2,340	58	40	58		263	20
21	PROJ. 10-04-EXT. CARE RENOVATIONS-KIRWAN ENVIRON	2010	183	5	40	5		21	21
22	PROJ. 10.04-EXT. CARE RENOVATIONS-FLOOR TILING	2010	2,730	137	20	137		614	22
23	PROJ. 10.04-EXT. CARE RENOVATIONS-PAINT/TRIM/WALL	2010	1,576	315	5	315		1,419	23
24	PROJ. 10.04 - EXT. CARE RENOVATIONS-HANDRAILS/COUN	2010	1,663	111	15	111		499	24
25	PROJ. 10.04 - EXT. CARE RENOVATIONS- WASTE	2010	368	9	40	9		41	25
26	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751	15,969	40	15,969		71,860	26
27	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCIA	2010	21,283	532	40	532		2,394	27
28	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739	1,343	40	1,343		6,046	28
29	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIRC	2010	1,006	25	40	25		113	29
30	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973	595	5	595		2,676	30
31	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927	193	10	193		867	31
32	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LABC	2010	770	19	40	19		87	32
33	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617	62	10	62		278	33
34	TOTAL (lines 1 thru 33)		$ 15,994,470	$ 656,031		$ 656,031	$	$ 10,332,502	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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		$ 15,994,470	$ 656,031		$ 656,031	$	$ 10,332,502	1
2	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPLI	2010	16,751	838	20	838		3,769	2
3	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083	1,054	20	1,054		4,744	3
4	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVI	2010	38,130	2,542	15	2,542		11,439	4
5	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVICI	2010	34,111	1,364	25	1,364		6,140	5
6	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR A	2010	2,487	124	20	124		560	6
7	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR ANI	2010	4,482	179	25	179		807	7
8	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINEE	2010	2,571	103	25	103		463	8
9	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SEI	2010	2,274	91	25	91		409	9
10	PROJ. 10.04-EXT. CARE RENOVATIONS-ELECTRICAL SUPP	2010	1,085	108	10	108		488	10
11	PROJ. 10.04-EXT. CARE RENOVATIONS-MED GAS OUTLETS	2010	653	44	15	44		196	11
12	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL	2010	27,126	1,085	25	1,085		4,883	12
13	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530	101	25	101		455	13
14	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637	25	25	25		115	14
15	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010	101	20	101		452	15
16	TABLES - (5)	2011	4,431	295	15	295		1,034	16
17	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494	2,499	5	2,499		8,746	17
18	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BU	2011	6,920	1,384	5	1,384		4,844	18
19	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONT	2011	1,053,994	26,350	40	26,350		92,225	19
20	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269	657	40	657		2,298	20
21	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063	27	40	27		93	21
22	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897	1,022	40	1,022		3,578	22
23	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750	219	40	219		765	23
24	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310	33	40	33		114	24
25	PROJ. 09-07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTIO	2011	635,931	15,898	40	15,898		55,644	25
26	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472	37	40	37		128	26
27	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750	1,469	8	1,469		5,140	27
28	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364	168	20	168		589	28
29	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUM	2011	8,120	406	20	406		1,421	29
30	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S ANI	2011	1,609	80	20	80		281	30
31	PROJ. 10-16-SIX SIGMA ELECTRICITY PROJECT-ELECTRIC	2011	33,624	3,362	10	3,362		11,768	31
32	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732	143	20	143		430	32
33	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295	1,518	8	1,518		4,555	33
34	TOTAL (lines 1 thru 33)		$ 18,032,425	$ 719,357		$ 719,357	$	$ 10,561,075	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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		$ 18,032,425	$ 719,357		$ 719,357	$	$ 10,561,075	1
2	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426	107	2	107		320	2
3	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000	938	8	938		2,813	3
4	LANDSCAPING EP COLEMAN BUILDING	2012	9,287	464	10	464		1,393	4
5	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330	83	2	83		248	5
6	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600	288	8	288		863	6
7	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740	546	8	546		1,639	7
8	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900	1,244	8	1,244		3,732	8
9	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500	219	8	219		657	9
10	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208	810	10	810		2,431	10
11	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTRU	2012	2,498	125	10	125		375	11
12	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543	4,954	5	4,954		14,863	12
13	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE ST	2012	490	49	5	49		147	13
14	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL	2012	2,385	239	5	239		716	14
15	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393	380	15	380		1,139	15
16	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284	76	15	76		228	16
17	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433	114	15	114		343	17
18	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LABO	2012	3,308	110	15	110		331	18
19	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142	105	15	105		314	19
20	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145	14,477	40	14,477		43,430	20
21	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872	96	15	96		287	21
22	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052	205	10	205		410	22
23	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL (	2013	5,691	285	20	285		569	23
24	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411	176	25	176		353	24
25	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - W	2013	671	67	10	67		134	25
26	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592	239	15	239		479	26
27	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940	63	15	63		125	27
28	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055	70	15	70		141	28
29	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787	20	20	20		20	29
30	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122	4	15	4		4	30
31	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPING	2014	215	4	25	4		4	31
32	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79	4	10	4		4	32
33	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRADI	2014	36,383	910	20	910		910	33
34	TOTAL (lines 1 thru 33)		$ 19,405,907	$ 746,828		$ 746,828	$	$ 10,640,497	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 19,405,907	$ 746,828		$ 746,828	$	$ 10,640,497	1
2	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014	5,284	132	20	132		132	2
3	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014	14,291	357	20	357		357	3
4	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014	6,563	164	20	164		164	4
5	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHOP/	2014	2,107	53	20	53		53	5
6	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014	5,772	24	20	24		24	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
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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)		$ 19,439,924	$ 747,558		$ 747,558	$	$ 10,641,227	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$ 429,181	$ 7,890	$ 7,890	$	5-15	$ 373,414	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 429,181	$ 7,890	$ 7,890	$		$ 373,414	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)	$ 19,869,105	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 755,448	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 755,448	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)	$ 11,014,641	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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ N/A Description: N/A
    (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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	N/A	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.

STATE OF ILLINOIS

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/14 (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	$ 2,894,635	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	9,311,856		3
4	Supply Inventory (priced at)	1,308,769		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,027,704		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current	2,900,791		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,443,755	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,642,457		13
14	Buildings, at Historical Cost	64,719,685		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	44,581,976		16
17	Accumulated Depreciation (book methods)	(58,722,974)		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 (sp Assets Limited as to U	61,532,278		22
23	Other(specify): Trust Fund	8,790,944		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 125,544,366	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 142,988,121	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,752,459	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	815,000		29
30	Accrued Salaries Payable	4,471,632		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	3rd Party Settlement	792,439		36
37	Self Insurance Costs	3,178,803		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,010,333	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,755,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap agreements	5,013,515		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 31,768,515	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 43,778,848	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 99,209,273	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 142,988,121	$	48

*(See instructions.)

Facility Name & ID Number Graham Hospital **#** 8000200 **Report Period Beginning:** 07/01/13 **Ending:** 06/30/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 91,196,993	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 91,196,993	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,240,100)	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 Non-Op Rev**	8,516,923	15
16	Other (describe) **Increase in Temp. Resticted Assets Net**	735,457	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 8,012,280	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)**	$ 99,209,273	24 *

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	$ 2,849,417	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,849,417	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	Hospital Misc Rev	3,687,074	28
28a	Hospital Rev	63,991,761	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 67,678,835	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 70,528,252	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,511,153	31
32	Health Care	1,571,913	32
33	General Administration	1,172,011	33
	B. Capital Expense		
34	Ownership	755,448	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	27,375	36
	D. Other Expenses (specify):		
37	Hospital Expenses	66,730,452	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 71,768,352	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,240,100)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,240,100)	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? 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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					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					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)			$ *	$	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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
N/A			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Allocated Benefits	414,519
TOTAL (agree to Schedule V, line 22, col.8)	$ 414,519

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

Description	Line #	Amount
N/A		$
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 Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/13 Ending: 06/30/14

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. **No**

(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? **5-15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **27,375**
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? **N/A**

(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? **N/A** 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. $ **None** Has any meal income been offset against related costs? **N/A** 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 for residents? **N/A** 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?
g. Does the facility transport residents to and from day training? N/A
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: **McGladrey LLP**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.