FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 8008518

Facility Name: Gottlieb Memorial Hospital

Address: 701 West North 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: Silia Miglio, Corporate Controller **Telephone Number:** (708) 216-4135
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 7/01/15 to 6/30/16 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) Daniel P. Isacksen Jr.
(Title) Senior Vice President of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: 7/01/15 Ending: 6/30/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	34	TOTALS	34	12,444	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	326	0	9,236	9,562	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	326		9,236	9,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.84%

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 8,786

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		7,700		7,700		7,700	164,877	172,577			1
2	Food Purchase											2
3	Housekeeping							284,455	284,455			3
4	Laundry											4
5	Heat and Other Utilities							403,534	403,534			5
6	Maintenance											6
7	Other (specify):*											7
8	TOTAL General Services		7,700		7,700		7,700	852,866	860,566			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,904,930	110,400	1,332,900	3,348,230		3,348,230	(91,484)	3,256,746			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	1,904,930	110,400	1,332,900	3,348,230		3,348,230	(91,484)	3,256,746			16
	C. General Administration											
17	Administrative	51,439			51,439		51,439	858,681	910,120			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			130	130		130		130			20
21	Clerical & General Office Expenses	135,781	10,520		146,301		146,301	114,767	261,068			21
22	Employee Benefits & Payroll Taxes							474,449	474,449			22
23	Inservice Training & Education											23
24	Travel and Seminar			305	305		305		305			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	187,220	10,520	435	198,175		198,175	1,447,897	1,646,072			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,092,150	128,620	1,333,335	3,554,105		3,554,105	2,209,278	5,763,383			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: 7/01/15 Ending: 6/30/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							337,395	337,395			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			3,550	3,550		3,550		3,550			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,550	3,550		3,550	337,395	340,945			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											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,092,150	128,620	1,336,885	3,557,655		3,557,655	2,546,674	6,104,329			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: 7/01/15 Ending: 6/30/16

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 See PG5A	2,546,674			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,546,674		$	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))**	$ 2,546,674		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: 7/01/15

Ending: 6/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Hospital W/S A-6 Reclass for Drugs Charged	$ (804)	10	1
2	Hospital W/S A-6 Reclass for Med Supplies	(97,389)	10	2
3	Hospital W/S B Overhead Alloc - Bldg & Fixt	337,181	30	3
4	Hospital W/S B Overhead Alloc - Movbl Equip	215	30	4
5	Hospital W/S B Overhead Alloc - Emp Benefits	474,449	22	5
6	Hospital W/S B Overhead Alloc - Admin & Gen	657,568	17	6
7	Hospital W/S B Overhead Alloc - Plant Oper	403,534	5	7
8	Hospital W/S B Overhead Alloc - Housekeeping	284,455	3	8
9	Hospital W/S B Overhead Alloc - Dietary	164,877	1	9
10	Hospital W/S B Overhead Alloc - Cafeteria	114,767	21	10
11	Hospital W/S B Overhead Alloc - Nursing Admin	201,113	17	11
12	Hospital W/S B Overhead Alloc - Central Supply	6,709	10	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**	2,546,674		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 7/01/15 **Ending:** 6/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	164,877	0	0	0	0	0	0	0	0	0	0	164,877	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	284,455	0	0	0	0	0	0	0	0	0	0	284,455	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	403,534	0	0	0	0	0	0	0	0	0	0	403,534	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	852,866	0	0	0	0	0	0	0	0	0	0	852,866	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	(91,484)	0	0	0	0	0	0	0	0	0	0	(91,484)	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**	(91,484)	0	0	0	0	0	0	0	0	0	0	(91,484)	16
	C. General Administration													
17	Administrative	858,681	0	0	0	0	0	0	0	0	0	0	858,681	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	114,767	0	0	0	0	0	0	0	0	0	0	114,767	21
22	Employee Benefits & Payroll Taxes	474,449	0	0	0	0	0	0	0	0	0	0	474,449	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**	1,447,897	0	0	0	0	0	0	0	0	0	0	1,447,897	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	2,209,278	0	0	0	0	0	0	0	0	0	0	2,209,278	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 7/01/15 **Ending:** 6/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	337,395	0	0	0	0	0	0	0	0	0	0	337,395	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**	337,395	0	0	0	0	0	0	0	0	0	0	337,395	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,546,674	0	0	0	0	0	0	0	0	0	0	2,546,674	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Gottlieb Memorial Hospital **#** 8008518 **Report Period Beginning:** 7/01/15 **Ending:** 6/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT Silia Miglio

TELEPHONE (708) 216-4135 FAX #: (708) 216-8340

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 7/01/15 Ending: 6/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,018 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

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

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

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

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

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

F. 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: 7/01/15 Ending: 6/30/16

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	$ 61,937	$	50	$	$	$	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					154	11
12	Various			1965	839,469					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					159,159	25
26	Various			1980	729,897					729,897	26
27	Various			1981	1,633,608					1,633,608	27
28	Various			1982	4,159,391					4,159,391	28
29	Various			1983	3,028,019					3,028,019	29
30	Various			1984	245,719					245,719	30
31	Various			1985	7,212,994	104,859		104,859		6,794,006	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: 7/01/15 Ending: 6/30/16

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					3,082,741	42
43	Various	1995	4,858,946					4,858,946	43
44	Various	1996	4,322,888					4,322,888	44
45	Various	1997	3,851,805	283,697		283,697		3,840,018	45
46	Various	1998	7,826,827	586,151		586,151		7,651,938	46
47	Various	1999	3,782,851	283,714		283,714		3,600,394	47
48	Various	2000	6,562,656	492,199		492,199		5,765,871	48
49	Various	2001	4,472,858	335,464		335,464		3,911,891	49
50	Various	2002	3,071,826	232,098		232,098		2,458,468	50
51	Various	2003	1,616,067	128,016		128,016		1,271,448	51
52	Various	2004	2,567,622	203,241		203,241		1,800,234	52
53	Various	2005	4,098,669	324,788		324,788		2,717,298	53
54	Various	2006	1,656,917	66,572		66,572		554,766	54
55	Various	2007	1,091,422	40,123		40,123		328,004	55
56	Various	2008	392,789	21,427		21,427		159,420	56
57	Various	2009	3,415,801	121,618		121,618		893,756	57
58	Various	2011	274,704	22,176		22,176		115,763	58
59									59
60	RIVER FOREST CONSTRUCTION 12/1	2012	431,303	21,565	20	21,565		107,826	60
61	DOCTOR'S LOUNGE PROJECT - CONS	2012	67,009	3,350	20	3,350		16,752	61
62	POB HALLWAYS - FLOORING 1/12	2012	65,642	6,564	10	6,564		32,821	62
63	RIVER FOREST - ELECTRIC 11/11-	2012	34,819	1,741	20	1,741		8,705	63
64	SUITE 416 PROJECT - CONSTRUCTI	2012	33,076	1,654	20	1,654		8,269	64
65	POB HALLWAYS - CONSTRUCTION 1/	2012	24,429	1,221	20	1,221		6,107	65
66	POB HALLWAYS - WALLPAPER 1/12	2012	12,420	2,484	5	2,484		12,420	66
67	POB HALLWAYS - ELECTRIC 1/12	2012	11,790	589	20	589		2,947	67
68	POB HALLWAYS - WALLPAPER 1/12	2012	11,417	2,283	5	2,283		11,417	68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 110,238,099**	**$ 3,287,596**		**$ 3,287,596**	**$**	**$ 99,711,049**	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: 7/01/15 Ending: 6/30/16

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		$ 110,238,099	$ 3,287,596		$ 3,287,596	$	$ 99,711,049	1
2	POB MISC PROJECTS - STE 414 -	2012	8,823	1,765	5	1,765		8,823	2
3	POB HALLWAYS - CARPET 1/12	2012	7,965	1,593	5	1,593		7,965	3
4	MISC PROJECTS - O/P REHAB - CA	2012	7,301	1,460	5	1,460		7,301	4
5	LAB PROJECT - CONSTRUCTION 1/1	2012	2,735	137	20	137		684	5
6	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,072	104	20	104		518	6
7	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,070	104	20	104		518	7
8	DOCTOR'S LOUNGE PROJECT - HEAT	2012	695	46	15	46		232	8
9	RIVER FOREST - ELECTRIC 11/11- (ADJ)	2012	(1,537)	(77)	20	(77)		(384)	9
10	ASPHALT PROJECT	2012	146,845	18,356	8	18,356		91,778	10
11	BARIATRIC PROJECT - LANDSCAPIN	2012	4,825	483	10	483		2,413	11
12	RIVER FOREST - CONSTRUCTION 2/	2012	593,385	29,669	20	29,669		145,874	12
13	POB HALLWAYS PROJECT - WALLPAP	2012	2,055	411	5	411		2,021	13
14	ELECTRONIC LEAD SIGN 2/12	2012	42,941	4,294	10	4,294		21,113	14
15	BARIATRIC OFFICE PROJECT - CON	2012	77,320	3,866	20	3,866		18,686	15
16	AIR HANDLER PROJECT - ENGINEER	2012	35,230	2,349	15	2,349		11,352	16
17	RIVER FOREST - CONSTRUCTION 3/	2012	5,470	274	20	274		1,322	17
18	RIVER FOREST - ELECTRIC 3/12	2012	4,177	209	20	209		1,009	18
19	BARIATRIC PROJECT - ARCHITECTU	2012	4,098	205	20	205		990	19
20	BARIATRIC OFFICE PROJECT - ARC	2012	2,958	148	20	148		715	20
21	BARIATRIC PROJECT - ARCHITECTU	2012	27	1	20	1		7	21
22	RIVER FOREST MEDICAL PROJECT-E	2012	7,920	396	20	396		1,881	22
23	FLOORING	2012	3,850	385	10	385		1,829	23
24	BARIATRIC OFFICE PROJECT - CON	2012	102,212	5,111	20	5,111		23,849	24
25	MISC PROJECTS - HOME HEALTH -	2012	11,410	2,282	5	2,282		10,649	25
26	PLUMBING	2012	1,810	91	20	91		422	26
27	BARIATRIC OFFICE PROJECT - ARC	2012	870	44	20	44		203	27
28	TURF	2012	3,996	799	5	799		3,730	28
29	CHILLER PLANT UPGRADE - CONSTR	2012	417,631	20,882	20	20,882		95,707	29
30	ELECTRICAL FEED UPGRADE - CONS	2012	284,386	14,219	20	14,219		65,172	30
31	CHILLER PLANT UPGRADE - CONSTR	2012	274,632	13,732	20	13,732		62,937	31
32	AIR HANDLER PROJECT - CONSTRUC	2012	249,380	12,469	20	12,469		57,150	32
33									33
34	TOTAL (lines 1 thru 33)		$ 112,545,650	$ 3,423,399		$ 3,423,399	$	$ 100,357,511	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: 7/01/15 Ending: 6/30/16

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		$ 112,545,650	$ 3,423,399		$ 3,423,399	$	$ 100,357,511	1
2	CHILLER PLANT UPGRADE - CONSTR	2012	214,979	10,749	20	10,749		49,266	2
3	CHILLER	2012	191,970	12,798	15	12,798		58,658	3
4	AIR HANDLER PROJECT - CONSTRUC	2012	127,960	6,398	20	6,398		29,324	4
5	CHILLER PLANT UPGRADE - CONSTR	2012	99,932	4,997	20	4,997		22,901	5
6	CHILLER PLANT UPGRADE - ENGINE	2012	96,156	4,808	20	4,808		22,036	6
7	AIR HANDLER PROJECT - INSULATI	2012	80,000	4,000	20	4,000		18,333	7
8	CHILLER PLANT UPGRADE - ENGINE	2012	53,034	2,652	20	2,652		12,154	8
9	AIR HANDLER PROJECT - CONSTRUC	2012	47,235	2,362	20	2,362		10,825	9
10	AIR HANDLER PROJECT - ENGINEER	2012	29,017	1,451	20	1,451		6,650	10
11	CHILLER PLANT UPGRADE - ENGINE	2012	22,413	1,121	20	1,121		5,136	11
12	AIR HANDLER PROJECT - ENGINEER	2012	22,355	1,118	20	1,118		5,123	12
13	ELECTRICAL FEED UPGRADE - ENGI	2012	12,380	619	20	619		2,837	13
14	CHILLER PLANT PROJECT - ENGINE	2012	12,173	609	20	609		2,790	14
15	AIR HANDLER PROJECT - PLAN REV	2012	9,600	640	15	640		2,933	15
16	CHILLER PLANT UPGRADE - ENGINE	2012	9,500	475	20	475		2,177	16
17	CHILLER PLANT UPGRADE - DEMOLI	2012	7,500	500	15	500		2,292	17
18	CHILLER PLANT UPGRADE - ENGINE	2012	6,180	309	20	309		1,416	18
19	CHILLER PLANT UPGRADE - DOCK P	2012	4,890	245	20	245		1,121	19
20	CHILLER PLANT UPGRADE - ELECTR	2012	4,850	243	20	243		1,111	20
21	AIR HANDLER PROJECT - DUCTS 6/	2012	3,640	182	20	182		834	21
22	NEW LAB FOR E.R. - PLUMBING 5/	2012	3,500	175	20	175		802	22
23	ELECTRICAL FEED UPGRADE - PAIN	2012	2,220	444	5	444		2,035	23
24	ELECTRICAL FEED UPGRADE - ELEC	2012	2,200	110	20	110		504	24
25	NEW LAB FOR E.R.-ELECTRIC	2012	2,197	110	20	110		503	25
26	ELECTRICAL FEED UPGRADE - ELEC	2012	1,670	84	20	84		383	26
27	AIR HANDLER PROJECT - BLINDS 3	2012	1,436	287	5	287		1,316	27
28	ON SITE WITNESS TO COMED SHUTD	2012	1,385	277	5	277		1,270	28
29	NEW LAB FOR E.R. - WALLLPAPER/	2012	720	144	5	144		660	29
30	EXTERNAL SIGNAGE	2012	81,052	8,105	10	8,105		37,149	30
31	PARKING LOT REJUVENATOR	2012	45,674	5,709	8	5,709		25,692	31
32	AIR HANDLER PROJECT - CONSTRUC	2012	1,359,117	67,956	20	67,956		305,801	32
33	RADIOLOGY RENOVATION - CONSTRU	2012	239,900	11,995	20	11,995		53,978	33
34	TOTAL (lines 1 thru 33)		$ 115,342,485	$ 3,575,068		$ 3,575,068	$	$ 101,045,520	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: 7/01/15 Ending: 6/30/16

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		$ 115,342,485	$ 3,575,068		$ 3,575,068	$	$ 101,045,520	1
2	GI LAB WAITING ROOM PROJECT -	2012	199,651	9,983	20	9,983		44,921	2
3	CHILLER PLANT UPGRADE-CONSTRUC	2012	163,437	8,172	20	8,172		36,773	3
4	SUITE 201/202 REHAB - CONSTRUC	2012	135,242	6,762	20	6,762		30,429	4
5	STE 201/202 REHAB - CONSTRUCTI	2012	107,999	5,400	20	5,400		24,300	5
6	ELECTRIC FEED UPGRADE - CONSTR	2012	54,580	2,729	20	2,729		12,281	6
7	AIR HANDLER PROJECT - ENGINEER	2012	42,945	2,147	20	2,147		9,663	7
8	AIR HANDLER PROJECT-GLOSSTEK F	2012	12,100	2,420	5	2,420		10,890	8
9	CHILLER PLANT UPGRADE-ENGINEER	2012	8,459	423	20	423		1,903	9
10	AIR HANDLER PROJECT - CARPET 7	2012	4,140	828	5	828		3,726	10
11	GI LAB WAITING ROOM - ARCHITEC	2012	1,500	75	20	75		338	11
12	ELECTRIC FEED UPGRADE - ELECTR	2012	1,110	56	20	56		250	12
13	ELECTRIC FEED UPGRADE - ENGINE	2012	580	29	20	29		130	13
14	XRAY ROOM #2 - CONSTRUCTION 7/	2012	231,000	11,550	20	11,550		51,013	14
15	SLEEP STUDY RENOVATION - CONST	2012	43,046	2,152	20	2,152		9,147	15
16	MCC PROJECT - ELECTRIC	2012	37,839	1,892	20	1,892		8,041	16
17	HW TANK SOUTH WING	2013	86,900	7,966	10	7,966		31,863	17
18	NEW CHILLER	2013	53,149	3,248	15	3,248		12,992	18
19	HW TANK SOUTH WING	2013	16,900	1,549	10	1,549		6,197	19
20	ENGINEERING FEES FOR NEW CHILL	2013	14,400	880	15	880		3,520	20
21	BTU BOILER	2013	8,850	406	20	406		1,623	21
22	ENGINEERING FEES FOR NEW CHILL	2013	134	8	15	8		33	22
23	LIFE SAFETY UPGRADES	2013	14,592	2,432	5	2,432		9,728	23
24	HOT WATER TANK SOUTH WING	2013	6,782	565	10	565		2,261	24
25	LIFE SAFETY UPGRADES	2013	4,973	829	5	829		3,316	25
26	NEW CHILLER - CONSTRUCTION	2013	413,944	20,697	15	20,697		82,789	26
27	NEW CHILLER - CONSTRUCTION	2013	139,452	6,973	15	6,973		27,890	27
28	LIFE SAFETY UPGRADES	2013	9,665	1,450	5	1,450		5,799	28
29	LIFE SAFETY UPGRADES	2013	6,143	921	5	921		3,686	29
30	NEW CHILLER - ENGINEERING	2013	3,600	180	15	180		720	30
31	NEW CHILLER - ENGINEERING	2013	2,350	118	15	118		470	31
32	NEW CHILLER - ASBESTOS INSPECT	2013	1,900	95	15	95		380	32
33	NEW CHILLER	2013	205,750	9,144	15	9,144		36,578	33
34	TOTAL (lines 1 thru 33)		$ 117,375,598	$ 3,687,146		$ 3,687,146	$	$ 101,519,168	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: 7/01/15 Ending: 6/30/16

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		$ 117,375,598	$ 3,687,146		$ 3,687,146	$	$ 101,519,168	1
2	SUITE 312 RENOVATION - CONSTRU	2013	137,075	4,569	20	4,569		13,708	2
3	NEW CHILLER	2013	6,170	274	15	274		823	3
4	CHILLER	2013	4,700	209	15	209		627	4
5	LIFE SAFETY UPGRADES - LOEBL -	2013	544	73	5	73		219	5
6	STORAGE GARAGE	2013	43,800	1,022	25	1,022		3,066	6
7	X-RAY UNIT - TOMOGRAPHY	2014	5,500	786	7	786		1,571	7
8	4 CHANNEL BREAST ARRAY MRI COI	2014	35,754	5,108	7	5,108		10,215	8
9	TIS - LAWSON	2014	82,621	11,803	7	11,803		23,606	9
10	TIS - RIVER FOREST EPIC	2014	1,388	198	7	198		396	10
11	TIS - EPIC	2014	249,434	35,633	7	35,633		71,267	11
12	TIS - EPIC EMPLOYED PHYSICIANS	2014	1,955	279	7	279		559	12
13	TIS - EPIC CLIN/REV IMPLEMENTA	2014	177,473	25,353	7	25,353		50,706	13
14	TIS - PEOPLESOFT FMS IMPLEMENT	2014	13,598	1,943	7	1,943		3,885	14
15	TIS - PEOPLESOFT OPERATING IMP	2014	835	119	7	119		239	15
16	TIS - LAWSON/KRONOS IMPLEM - O	2014	366	52	7	52		105	16
17	MIRA PORTABLE X-RAY UNITS	2014	325,000	46,429	7	46,429		92,857	17
18	IV CART	2014	30,748	3,075	10	3,075		6,150	18
19	X-RAY UNIT TOMOGRAPHY	2014	30,450	4,350	7	4,350		8,700	19
20	RALS ABBOTT ISTAT	2014	9,140	1,828	5	1,828		3,656	20
21	CART WASHER	2014	4,650	465	10	465		930	21
22	NEOWARES - HP	2014	4,830	966	5	966		1,932	22
23	X-RAY UNIT TOMOGRAPHY	2014	248,671	35,524	7	35,524		71,049	23
24	X-RAY UNIT TOMOGRAPHY	2014	320,000	45,714	7	45,714		91,429	24
25	NEW CHILLER	2014	94,986	6,332	15	6,332		12,665	25
26	AUDIOMETER	2014	10,934	1,093	10	1,093		2,187	26
27	PRINTER XEROX 5330	2014	8,720	1,744	5	1,744		3,488	27
28	LAB LABEL PRINTER	2014	750	150	5	150		300	28
29	20% DOWN ON ENTERPRISE LEVEL S	2014	1,825	365	5	365		730	29
30	CART WASHER	2014	129,824	12,982	10	12,982		25,965	30
31	INFANT/PATIENT SECURITY SYSTEM	2014	39,147	3,915	10	3,915		7,829	31
32	INFANT/PATIENT SECURITY SYSTEM	2014	1,416	142	10	142		283	32
33	LIFE SAFETY UPGRADES - ARCHITE	2014	3,029	151	20	151		303	33
34	TOTAL (lines 1 thru 33)		$ 119,400,930	$ 3,939,794		$ 3,939,794	$	$ 102,030,611	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: 7/01/15 Ending: 6/30/16

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		$ 119,400,930	$ 3,939,794		$ 3,939,794	$	$ 102,030,611	1
2	Renovation 5 South	2015	70,225	4,682	15	4,682		6,822	2
3	Marj Weinberg Cancer CtrRen construction	2015	279,055	18,604	15	18,604		25,859	3
4	6 South Renovation	2015	886,131	59,075	15	59,075		84,737	4
5	AIR HANDLER REPLACE S6 & 7	2015	1,249,951	62,498	20	62,498		65,107	5
6	100NX? Sterilizer 10104003	2016	85,000	4,554	84	4,554		4,554	6
7	3D Monitor 32in LMD3251MT/3G	2016	6,061	556	60	556		556	7
8	Accumax Mattresses 35inX86in	2016	19,755	1,482	60	1,482		1,482	8
9	Accumax Mattresses 35inX86in	2016	19,755	823	60	823		823	9
10	Anesthesia Machine AISYS CS2 m	2016	745,048	75,392	84	75,392		75,392	10
11	AtmosAir9000 Mattress Nonpower	2016	11,070	1,015	60	1,015		1,015	11
12	Barbell set & storage rack	2016	2,668	170	180	170		170	12
13	Barco 2221 21in MDRC	2016	1,040	199	60	199		199	13
14	BladderScan BVI9400&mobile car	2016	14,765	2,830	60	2,830		2,830	14
15	Carescape life upgrade monitor	2016	239,791	18,555	84	18,555		18,555	15
16	Carescape life upgrade monitor	2016	265,318	20,531	84	20,531		20,531	16
17	Container Gray Handle Perforat	2016	1,011	76	60	76		76	17
18	Cystoscope Promo Flex 7FR 15FR	2016	9,390	1,174	36	1,174		1,174	18
19	Data cabling installed for PAC	2016	19,650	450	240	450		450	19
20	DaVinci XI dual console IS4000	2016	2,150,000	140,774	84	140,774		140,774	20
21	DaVinci XI Procedure Tray 1644	2016	5,179	194	120	194		194	21
22	Defibrillator US00588011	2016	16,650	2,636	60	2,636		2,636	22
23	Defibrillator US00588012	2016	16,650	2,636	60	2,636		2,636	23
24	Defibrillator US00588013	2016	16,650	2,636	60	2,636		2,636	24
25	Defibrillator US00588014	2016	16,650	2,636	60	2,636		2,636	25
26	Electrical&Data Cabling Pyxis	2016	39,250	1,227	240	1,227		1,227	26
27	Endoscope 8MM Cannula 8MM	2016	58,101	3,804	84	3,804		3,804	27
28	Endowrist stapler instru start	2016	18,270	1,196	84	1,196		1,196	28
29	Exam&Lab room construction	2016	54,352	2,265	180	2,265		2,265	29
30	Eye Surg Stretcher 1602033030&	2016	11,567	225	180	225		225	30
31	Furnish/Install sump alarms	2016	2,375	73	180	73		73	31
32	Glidescope AVL Premium Cart AN	2016	18,264	989	120	989		989	32
33	Glidescope Blade MD096970	2016	500	63	36	63		63	33
34	TOTAL (lines 1 thru 33)		$ 125,751,069	$ 4,373,812		$ 4,373,812	$	$ 102,502,296	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: 7/01/15 Ending: 6/30/16

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		$ 125,751,069	$ 4,373,812		$ 4,373,812	$	$ 102,502,296	1
2	Gower Chairs-23 Tables-10	2016	43,140	2,037	180	2,037		2,037	2
3	HP Z620V2 V3900X1	2016	2,129	680	36	680		680	3
4	ICU Reno-Aluminum Window Syste	2016	33,840	846	180	846		846	4
5	ICU Reno-Auto Door Equipment	2016	140,673	5,275	120	5,275		5,275	5
6	ICU Reno-Cambria Countertops	2016	5,184	130	180	130		130	6
7	ICU Reno-Cart Tray Delivery	2016	3,682	138	120	138		138	7
8	ICU Reno-Ceiling Tile	2016	14,339	538	120	538		538	8
9	ICU Reno-Ceiling Tile	2016	20,678	969	96	969		969	9
10	ICU Reno-Ceramic Flooring	2016	13,199	247	240	247		247	10
11	ICU Reno-Chairs Tables Stools	2016	139,851	3,496	180	3,496		3,496	11
12	ICU Reno-Conduit&Wiring	2016	258,574	4,848	240	4,848		4,848	12
13	ICU Reno-Corner Guards	2016	10,505	394	120	394		394	13
14	ICU Reno-Custom Cabinetry	2016	193,500	4,838	180	4,838		4,838	14
15	ICU Reno-Custom Printed Photos	2016	5,990	449	60	449		449	15
16	ICU Reno-Door Alarm	2016	20,140	755	120	755		755	16
17	ICU Reno-Fire Alarm System	2016	5,000	188	120	188		188	17
18	ICU Reno-Fire Resistant Waste	2016	2,971	223	60	223		223	18
19	ICU Reno-Headwall Sys Patient	2016	124,991	3,125	180	3,125		3,125	19
20	ICU Reno-HVAC	2016	685,305	12,849	240	12,849		12,849	20
21	ICU Reno-Ice&Water Dispenser	2016	10,280	386	120	386		386	21
22	ICU Reno-LED TV with Mounts	2016	8,537	640	60	640		640	22
23	ICU Reno-Light Fixtures&Bulbs	2016	112,667	4,225	120	4,225		4,225	23
24	ICU Reno-Metal Frames&Hardware	2016	31,727	595	240	595		595	24
25	ICU Reno-Metal Storage Cabinet	2016	25,695	642	180	642		642	25
26	ICU Reno-Nurse Call	2016	72,435	2,716	120	2,716		2,716	26
27	ICU Reno-Paging System	2016	27,615	518	240	518		518	27
28	ICU Reno-Painting&Wallpapering	2016	53,100	3,983	60	3,983		3,983	28
29	ICU Reno-Patient Lift System	2016	78,752	2,953	120	2,953		2,953	29
30	ICU Reno-Pipe Insulation	2016	45,148	1,129	180	1,129		1,129	30
31	ICU Reno-Plumbing Fixtures-Pip	2016	204,553	3,835	240	3,835		3,835	31
32	ICU Reno-Pneumatic Tube System	2016	45,000	1,125	180	1,125		1,125	32
33	ICU Reno-Projector Screen	2016	1,300	49	120	49		49	33
34	**TOTAL (lines 1 thru 33)**		$ 128,191,569	$ 4,438,633		$ 4,438,633	$	$ 102,567,118	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: 7/01/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 128,191,569	$ 4,438,633		$ 4,438,633	$	$ 102,567,118	1
2	ICU Reno-Signs Indoor Direct&D	2016	16,910	1,268	60	1,268		1,268	2
3	ICU Reno-Sprinkler System	2016	19,620	294	300	294		294	3
4	ICU Reno-Switchgear Electrical	2016	51,690	1,292	180	1,292		1,292	4
5	ICU Reno-Temp Control Computer	2016	45,015	1,688	120	1,688		1,688	5
6	ICU Reno-Terrazo Floor	2016	32,399	810	180	810		810	6
7	ICU Reno-Trash Cans	2016	1,097	82	60	82		82	7
8	ICU Renovation-Labor A&E Fees	2016	2,676,102	66,903	180	66,903		66,903	8
9	ICU Reno-Vinyl Tile	2016	59,111	2,217	120	2,217		2,217	9
10	ICU Reno-Window Roller Shades	2016	27,000	2,025	60	2,025		2,025	10
11	ICU Reno-Wood Doors	2016	39,571	989	180	989		989	11
12	ICU Reno-Workstation	2016	17,209	645	120	645		645	12
13	ICU-Gypsum-Insulatn-Wood Panel	2016	76,000	1,900	180	1,900		1,900	13
14	Install 60amp fusible&60amp 3p	2016	1,081	20	240	20		20	14
15	Insufflator 0620040654	2016	6,267	470	60	470		470	15
16	Lifecycle Bike&Console GED1350	2016	1,300	249	60	249		249	16
17	Medical 3D Recorder HVO3000MT	2016	13,459	1,009	60	1,009		1,009	17
18	Mobile Surgical Cart ELO1528L	2016	2,585	118	120	118		118	18
19	Nurse Call 3West electrical	2016	16,000	1,133	120	1,133		1,133	19
20	Nurse Call 3West replacement	2016	98,704	6,992	120	6,992		6,992	20
21	Pulse 120H Holmium Laser	2016	195,000	17,875	60	17,875		17,875	21
22	Pump plus wiring POB	2016	41,872	1,745	180	1,745		1,745	22
23	Pyxis Platform Upgrade	2016	319,597	4,439	180	4,439		4,439	23
24	Pyxis Platform Upgrade	2016	565,738	7,857	180	7,857		7,857	24
25	Reno 6 south Interior signs	2016	1,484	235	60	235		235	25
26	Renovation 5 South floor prep	2016	10,000	417	180	417		417	26
27	Renovation 6 South	2016	24,614	1,026	180	1,026		1,026	27
28	Renovation 6 South Interior Si	2016	10,002	1,750	60	1,750		1,750	28
29	Repaired Access Keypads all fl	2016	3,236	310	120	310		310	29
30	Replace 60 Keypad Control Pane	2016	16,500	1,581	120	1,581		1,581	30
31	Security Fencing-8ft woven mes	2016	6,910	979	60	979		979	31
32	Shelving Units Blue Shelf Bins	2016	35,733	1,266	240	1,266		1,266	32
33	Stretcher Prime 5th Wheel	2016	46,535	2,973	180	2,973		2,973	33
34	TOTAL (lines 1 thru 33)		$ 132,669,912	$ 4,571,192		$ 4,571,192	$	$ 102,699,676	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: 7/01/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 132,669,912	$ 4,571,192		$ 4,571,192	$	$ 102,699,676	1
2	Stretcher Prime 5th Wheel with	2016	36,557	2,336	180	2,336		2,336	2
3	Surgeon console chair vinyl co	2016	1,145	22	180	22		22	3
4	Surgical lights aurora 5 light	2016	30,179	922	180	922		922	4
5	Surgical Table Armboard Pad lo	2016	37,785	945	180	945		945	5
6	TIS Proj CDW EBR Deployment	2016	2,975	273	60	273		273	6
7	TIS Proj ConduitCAT6 patchpane	2016	18,456	577	240	577		577	7
8	TIS Proj EPIC sftwre consult f	2016	1,030,001	91,964	84	91,964		91,964	8
9	TIS Proj EPIC/CSI&Jaworski sft	2016	38,953	3,014	84	3,014		3,014	9
10	TIS Proj EPIC/Dearborn&HighPoi	2016	141,659	9,275	84	9,275		9,275	10
11	TIS Proj GCX/CDW Seal Shield	2016	27,923	3,025	60	3,025		3,025	11
12	TIS Proj HP650 G1 no webcam	2016	689	132	60	132		132	12
13	TIS Proj Tangent MedixM24 EBR	2016	470,580	58,823	60	58,823		58,823	13
14	TIS Project C2G 1.5FT USB Ser	2016	576	34	60	34		34	14
15	TIS Project Clarity Fees Barco	2016	12,319	1,687	84	1,687		1,687	15
16	TIS Project EBR Deploy channel	2016	5,179	216	60	216		216	16
17	TIS Project EBR Deploy Honeywe	2016	4,122	103	60	103		103	17
18	TIS Project electrical work fo	2016	60,900	508	180	508		508	18
19	TIS Project HP800 G1 Mini	2016	667	39	60	39		39	19
20	TIS Project labor charges	2016	29,528	1,933	84	1,933		1,933	20
21	TIS Project labor charges	2016	35,807	1,918	84	1,918		1,918	21
22	TIS Project labor charges	2016	35,339	1,052	84	1,052		1,052	22
23	TIS Project labor charges	2016	10,588	189	84	189		189	23
24	TIS Project labor charges	2016	242,912	1,446	84	1,446		1,446	24
25	TIS Project NurseCall report s	2016	59,240	11,354	60	11,354		11,354	25
26	TIS Project Phases of Care	2016	119,007	10,626	84	10,626		10,626	26
27	TIS Project Phases of Care Lab	2016	(1,000)	(77)	84	(77)		(77)	27
28	TIS Project Phases of Care Lab	2016	1,000	77	84	77		77	28
29	TIS Project Phases of Care Lab	2016	(760)	(50)	84	(50)		(50)	29
30	TIS Project Phases of Care Lab	2016	760	50	84	50		50	30
31	TIS Project Phases of Care Lab	2016	21,840	1,430	84	1,430		1,430	31
32	Other Equip Placed into Service in FY2016	2016	940,518	66,747	105	66,747		66,747	32
33	Reconciliation adjustment for non-TCU assets					(4,504,385)	(4,504,385)		33
34	TOTAL (lines 1 thru 33)		$ 136,085,356	$ 4,841,780		$ 337,395	$ (4,504,385)	$ 102,970,265	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: 7/01/15 Ending: 6/30/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	136,147,293	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	4,841,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	337,395	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(4,504,385)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	102,970,265	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ 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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 7/01/15 Ending: 6/30/16

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

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

Facility Name & ID Number Gottlieb Memorial Hospital **#** 8008518 **Report Period Beginning:** 7/01/15 **Ending:** 6/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/16 **(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	$ 2,347,665	$	1
2	Cash-Patient Deposits	16,952,087		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,722,421)	14,985,618		3
4	Supply Inventory (priced at)	2,816,000		4
5	Short-Term Investments	63,185		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	235,862		7
8	Accounts Receivable (owners or related parties)	1,310,790		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 38,711,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	55,652,685		11
12	Long-Term Investments	88,000		12
13	Land	13,487,143		13
14	Buildings, at Historical Cost	66,101,921		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	41,871,311		16
17	Accumulated Depreciation (book methods)	(38,506,619)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,610,854		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 142,305,295	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 181,016,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 52,085,242	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,369,274		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	40,960		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payable to Third Party	8,133,255		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 65,628,731	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,531,334		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Pension	22,561,771		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 42,093,105	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 107,721,836	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 73,294,666	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 181,016,502	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 79,477,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 79,477,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,064,515	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 7,064,515	17
	B. Transfers (Itemize):		
18	**Other Adjustments and Transfers**	(13,247,371)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (13,247,371)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 73,294,666	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 480,230,178	1
2	Discounts and Allowances for all Levels	(371,392,370)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 108,837,808	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	4,982	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,982	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(497,331)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (497,331)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	19,057,474	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,057,474	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 127,402,933	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,700	31
32	Health Care	3,348,230	32
33	General Administration	198,175	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Other Hospital Expenses not Allocated to TCU / LTC	116,784,313	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 120,338,418	40
41	**Income before Income Taxes (line 30 minus line 40)****	7,064,515	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 7,064,515	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 19,334,992	44
45	Private Pay - Net Inpatient Revenue	822,125	45
46	Medicare - Net Inpatient Revenue	50,742,494	46
47	Other-(specify) Commercial Payors	37,938,197	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 108,837,808	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	816	896	$ 51,147	$ 57.08	1
2	Assistant Director of Nursing	1,104	1,496	67,111	44.86	2
3	Registered Nurses	26,635	30,585	1,165,409	38.10	3
4	Licensed Practical Nurses	4,561	5,317	129,330	24.33	4
5	CNAs & Orderlies	19,373	21,559	306,946	14.24	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,800	2,105	48,260	22.93	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	1,722	1,796	23,245	12.95	10
11	Social Service Workers	2,346	2,554	75,737	29.66	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	0	0	0		17
18	Housekeepers	34	34	366	10.76	18
19	Laundry	0	0	0		19
20	Administrator	0	0	0		20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	7,820	8,863	224,598	25.34	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	66,208	75,204	$ 2,092,150 *	$ 27.82	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrative Manager			$ 51,439
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,439

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	$ 16,323
Unemployment Compensation Insurance	1,653
FICA Taxes	113,197
Employee Health Insurance	141,962
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	109,334
401K	84,266
Life Insurance	1,767
Disability Insurance	1,315
Tuition Reimbursement	4,053
Employee Recognition	579
TOTAL (agree to Schedule V, line 22, col.8)	$ 474,449

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	
Journals/Periodicals/Books	130
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 130

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	305
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 305

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(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? **9 Years**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **23,311**
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. $ **N/A** 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? **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**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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