		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 800200

Facility Name: Graham Hospital Association

Address: 210 West Walnut (Number) Canton (City) 61520-2497 (Zip Code)

County: Fulton

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

HFS ID Number:

Date of Initial License for Current Owners: 7/2/1987

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Julie Reeder **Telephone Number:** (309) 647-5240
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 7/1/17 to 6/30/18 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) See Accountants Report
(Firm Name & Address) RSM US 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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	38	Skilled (SNF)	38	13,870	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	38	TOTALS	38	13,870	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	3,405	3,405	2,450	9,260	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,405	3,405	2,450	9,260	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.49%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 5/1/1987

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 2,450

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: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	20,254	-	17,378	37,632		37,632	-	37,632			1
2	Food Purchase		371,830		371,830		371,830	-	371,830			2
3	Housekeeping	167,635	-	36,482	204,116		204,116	-	204,116			3
4	Laundry	12,467	-	100,137	112,604		112,604	-	112,604			4
5	Heat and Other Utilities			-				-				5
6	Maintenance	94,428	-	230,524	324,952		324,952	-	324,952			6
7	Other (specify):*	-	-	-				-				7
8	TOTAL General Services	294,783	371,830	384,522	1,051,135		1,051,135		1,051,135			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				-				9
10	Nursing and Medical Records	1,829,556	-	120,181	1,949,737		1,949,737	-	1,949,737			10
10a	Therapy	-	-	-				-				10a
11	Activities	-	-	-				-				11
12	Social Services	-	-	-				-				12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):* Nursing School	136,845	-	23,258	160,102		160,102	-	160,102			15
16	TOTAL Health Care and Programs	1,966,400		143,439	2,109,839		2,109,839		2,109,839			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	534,572	-	90,855	625,427		625,427	-	625,427			21
22	Employee Benefits & Payroll Taxes			461,882	461,882		461,882	-	461,882			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			-				-				24
25	Other Admin. Staff Transportation		-	-				-				25
26	Insurance-Prop.Liab.Malpractice			110,461	110,461		110,461	-	110,461			26
27	Other (specify):*	-	-	-				-				27
28	TOTAL General Administration	534,572		663,198	1,197,770		1,197,770	-	1,197,770			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,795,755	371,830	1,191,158	4,358,744		4,358,744		4,358,744			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 Association #800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			238,485	238,485		238,485	440,216	678,701			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**			238,485	238,485		238,485	440,216	678,701			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			20,805	20,805		20,805	-	20,805			42
43	Other (specify):*	-	-	-				-				43
44	**TOTAL Special Cost Centers**			20,805	20,805		20,805		20,805			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,795,755	371,830	1,450,448	4,618,034		4,618,034	440,216	5,058,250			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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	440,216			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 440,216		$	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))**	$ 440,216		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

Graham Hospital Association

ID# 800200

Report Period Beginning: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment of Allocated Depreciation to actual	$		1
2	straight line depreciation per page 12&13	440,216	30	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**	440,216		49

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

* 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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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.)**	Alloc Fr. Mgmt Co.	$	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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Graham Hospital Association COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 800200

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16688 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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	4
5				1972	866					866	5
6				1978	187,881					187,881	6
7				1982	3,684					3,684	7
8				1977	1,331,168		various	16,213	16,213	1,331,168	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		various	16,169	16,169	1,091,382	13
14	1985 VARIOUS BUILDING IMPROVEMENTS			1985	34,258		various			34,258	14
15	1987 VARIOUS BUILDING IMPROVEMENTS			1987	89,317		various	109	109	89,260	15
16	1988 VARIOUS BUILDING IMPROVEMENTS			1988	52,287		various	4	4	52,155	16
17	1990 VARIOUS BUILDING IMPROVEMENTS			1990	28,254		various	3	3	28,209	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		various			76,132	21
22	1995 VARIOUS BUILDING IMPROVEMENTS			1995	32,594		various			32,594	22
23	1996 VARIOUS BUILDING IMPROVEMENTS			1996	47,691		various			47,691	23
24	1994 VARIOUS BUILDING IMPROVEMENTS			1997	24,479		various	10	10	24,479	24
25	1998 VARIOUS BUILDING IMPROVEMENTS			1998	26,173		various			26,173	25
26	1999 VARIOUS BUILDING IMPROVEMENTS			1999	11,097		various	325	325	11,097	26
27	2000 VARIOUS BUILDING IMPROVEMENTS			2000	800,069		various			800,069	27
28	2001 VARIOUS BUILDING IMPROVEMENTS			2001	112,532		various			112,532	28
29	2002 VARIOUS BUILDING IMPROVEMENTS			2002	578,790		various			578,790	29
30	2003 VARIOUS BUILDING IMPROVEMENTS			2003	356,376		various			356,376	30
31	2004 VARIOUS BUILDING IMPROVEMENTS			2004	466,553		various			466,553	31
32	2005 VARIOUS BUILDING IMPROVEMENTS			2005	953,088		various	63,278	63,278	827,906	32
33	2006 VARIOUS BUILDING IMPROVEMENTS			2006	2,994,111		various	156,500	156,500	2,091,460	33
34	2007 VARIOUS BUILDING IMPROVEMENTS			2007	2,221,427		various	93,042	93,042	1,132,231	34
35	2008 VARIOUS BUILDING IMPROVEMENTS			2008	1,406,411		various	79,001	79,001	837,339	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$	15	$ 126	$ 126	$ 1,196	37
38	PCU AUTOMATIC DOORS	2009	1,927		10	193	193	1,832	38
39	ROOF L	2009	13,668		10	1,367	1,367	12,985	39
40	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONSTI	2009	7,055		15	470	470	4,467	40
41	08.23-GMG BOND EYE AR EA REMODEL-DRYWALL/SNAP	2009	836		15	56	56	531	41
42	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767		10	77	77	730	42
43	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S CC	2009	2,106		15	140	140	1,332	43
44	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONSTR	2009	1,823		15	122	122	1,157	44
45	PROJ 09.02-RISK ASSESSMENT REMODEL-PAINT/CARPET	2009	3,002		5			3,002	45
46	PROJ 09.03-GMG EXAM ROOM FLOOR-TILE/ADHESIVES	2009	449		10	45	45	427	46
47	PROJ 09.03-GMG EXAM ROOM FLOOR-BLADES/KNOVES/D	2009	606		4			606	47
48	PROJ 09.06-RUSHFORD BUILDING-WIND DAMAGE/CONSTR	2009	2,540		15	169	169	1,608	48
49	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONST	2009	5,357		15	357	357	3,393	49
50	PROJ 09.08-ACCOUNTING RENOVATION-PAINT/CARPET/	2009	1,892		6			1,892	50
51	PROJ 08.22-REMODEL PATIENT REGISTRATION-MISC	2009	325		5			325	51
52	PROJ 08.22-REMODEL PATIENT REGISTRATION-CEILING	2009	351		10	35	35	334	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD'S	2009	8,730		15	582	582	5,529	53
54	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102		15	73	73	696	54
55	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCTI	2009	2,663		15	178	178	1,689	55
56	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171		15	78	78	741	56
57	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424		15	228	228	2,167	57
58	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	264		5			264	58
59	PROJ 09.11-GROUND FLOOR CLINIC-BUILDING SUPPLIES	2009	539		5			539	59
60	PROJ 09.11-GROUND FLOOR CLINIC-RICKARD'S LABOR	2009	2,841		15	189	189	1,798	60
61	PROJ 08.06-SPRINKLER WORK-VARIOUS SUPPLIES FOR P	2009	513		5			513	61
62	PROJ 08.06-SPRINKLER WORK-REPLACEMENT CEILING	2009	6,420		8			6,420	62
63	PROJ 09.09-DR. LOUNGE REMODEL-CARPETING AND VAR	2009	1,636		5			1,636	63
64	PROJ 09.09-DR. LOUNGE REMODEL-HOLTHAUS CO. ROO	2009	1,518		10	152	152	1,443	64
65	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRUC	2009	4,802		15	320	320	3,041	65
66	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584		15	306	306	2,905	66
67	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769		15	251	251	2,386	67
68	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363		15	91	91	863	68
69		1972	5,755		VARIOUS			5,755	69
70	TOTAL (lines 4 thru 69)		$ 14,346,577	$		$ 430,259	$ 430,259	$ 11,560,178	70

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 14,346,577	$		$ 430,259	$ 430,259	$ 11,560,178	1
2	1973 FIXED EQUIPMENT	1972	4,926		VARIOUS			4,926	2
3	1975 FIXED EQUIPMENT	1975	989		VARIOUS			989	3
4	1980 FIXED EQUIPMENT	1980	599		VARIOUS			599	4
5	1981 FISED EQUIPMENT	1981	1,188		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		VARIOUS			7,700	10
11	1996 FIXED EQUIPMENT	1996	1,422		VARIOUS			1,422	11
12	1998 FIXED EQUIPMENT	1998	2,006		VARIOUS			2,006	12
13	1999 FIXED EQUIPMENT	1999	2,891		VARIOUS			2,891	13
14	2001 FIXED EQUIPMENT	2001	20,918		VARIOUS			20,918	14
15	2002 FIXED EQUIPMENT	2002	920		VARIOUS			920	15
16	2003 FIXED EQUIPMENT	2003	30,047		VARIOUS			30,047	16
17	2005 FIXED EQUIPMENT	2005	10,856		VARIOUS			10,856	17
18	PROJ 04.11 NEW ER - CABLING & DUCTWORK	2006	22,004		10			22,004	18
19	PROJ 04.11 NEW ER - FIRE & SECURITY SYSTEM	2006	12,357		10			12,357	19
20	PROJ 04.11 NEW ER - WALLSLIDE & SUCTION UNITS	2006	5,999		10			5,999	20
21	PROJ 04.11 NEW ER - SHELVES, DOORS, DIVIDERS	2006	11,707		10			11,707	21
22	PROJ 05.04 LAB RENOVATION - DATA CABLING	2006	2,251		10			2,251	22
23	PROJ 05.10 - 1ST PHASE MED/SURG-PERSONAL PROTECTIO	2007	1,364		5			1,364	23
24	PROJ 06.03 - ADMINISTRATION BOARDROOM - COUNTER	2007	4,359		10			4,359	24
25	PROJ 06.03 - ADMIN. BOARD RM-LAMINATED CASEWORK	2007	15,097		15	1,006	1,006	11,570	25
26	PROJ 04.16 - PYXIS - CABINETS	2007	442		15	29	29	335	26
27	PROJ 07.08 - THIRD FLOOR ONCOLOGY ROOM - CABINET	2007	2,406		10			2,406	27
28	PROJ 06.03 - ADMINISTRATION BOARDROOM - DROP-IN S	2007	1,539		10			1,539	28
29	07.10-HEARTCARE MIDWEST-CABINETS & COUNTERTOP	2008	5,545		15	370	370	3,884	29
30	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387		15	26	26	273	30
31	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTOPS	2008	367		15	24	24	253	31
32	08.04-HR RELOCATION-SINK	2008	304		20	15	15	158	32
33	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERTO	2008	1,317		15	88	88	924	33
34	TOTAL (lines 1 thru 33)		$ 14,566,371	$		$ 431,817	$ 431,817	$ 11,773,910	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 431,817	$ 431,817	$ 11,773,910	1
2	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINETS	2008	1,126		15	75	75	788	2
3	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTOP	2008	366		15	24	24	253	3
4	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&COU	2008	401		15	27	27	283	4
5	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424		15	95	95	895	5
6	PROJ 09.11-GROUND FLOOR CLINIC-SINK	2009	215		5			215	6
7	PROJ 09.11-GROUND FLOOR CLINIC-ROOM DARKENING	2009	3,134		20	157	157	1,518	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		VARIOUS			442	19
20	2001 LAND IMPROVEMENTS	2001	6,453		VARIOUS			6,453	20
21	2002 LAND IMPROVEMENTS	2002	11,727		VARIOUS			11,727	21
22	2003 LAND IMPROVEMENTS	2003	36,978		VARIOUS			36,978	22
23	2004 LAND IMPROVEMENTS	2004	83,693		VARIOUS	5,580	5,580	80,903	23
24	2005 LAND IMPROVEMENTS	2005	84,686		VARIOUS	5,687	5,687	73,933	24
25	PROJ 07.03 - SOUTH PARKING LOT	2007	9,186		8			9,186	25
26	PROJ 07.07 - SOUTH PARKING LOT STAIRS-RICKARD'S/CC	2007	9,465		15	631	631	7,257	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		15	235	235	2,703	28
29	SOUTH PATIO IMPROVEMENTS	2008	1,603		15	107	107	1,123	29
30	PAVING OF CLINIC PARKING LOT	2008	4,353		8			4,353	30
31	2010 Land Impr - Paving, Rock, Resurface, etc..	2010	15,449		30	515	515	5,143	31
32	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082		20	54	54	540	32
33	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939		25	118	118	1,003	33
34	TOTAL (lines 1 thru 33)		$ 15,143,019	$		$ 445,122	$ 445,122	$ 12,318,004	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 445,122	$ 445,122	$ 12,318,004	1
2	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INTE	2010	385		40	10	10	85	2
3	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723		25	29	29	246	3
4	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257		40	731	731	6,214	4
5	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889		40	322	322	2,737	5
6	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTERE	2010	2,576		40	64	64	546	6
7	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLOS	2010	6,806		10	681	681	5,787	7
8	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENGI	2010	1,510		40	38	38	322	8
9	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUPP	2010	7,453		40	186	186	1,582	9
10	AMBULANCE BUILDING - WALNUT ST.	2010	1,089		40	27	27	230	10
11	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602		10	460	460	3,911	11
12	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963		15	131	131	1,113	12
13	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301		15	153	153	1,302	13
14	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061		10	1,706	1,706	14,501	14
15	ROOF M REPLACEMENT - MRI ROOF	2010	6,935		10	694	694	5,897	15
16	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & CO	2010	4,786		15	319	319	2,712	16
17	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943		15	196	196	1,667	17
18	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPL	2010	2,485		15	166	166	1,410	18
19	PROJ. 10-04-EXT. CARE RENOVATIONS-RICKARD'S LABOR	2010	15,761		40	394	394	3,349	19
20	PROJ. 10-04 EXT. CARE RENOVATIONS-FLAD & ASSOCIATE	2010	2,340		40	58	58	495	20
21	PROJ. 10-04-EXT. CARE RENOVATIONS-KIRWAN ENVIRONM	2010	183		40	5	5	41	21
22	PROJ. 10.04-EXT. CARE RENOVATIONS-FLOOR TILING	2010	2,730		20	137	137	1,162	22
23	PROJ. 10.04-EXT. CARE RENOVATIONS-PAINT/TRIM/WALLC	2010	1,576		5			1,576	23
24	PROJ. 10.04 - EXT. CARE RENOVATIONS-HANDRAILS/COUN	2010	1,663		15	111	111	943	24
25	PROJ. 10.04 - EXT. CARE RENOVATIONS- WASTE	2010	368		40	9	9	77	25
26	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751		40	15,969	15,969	135,736	26
27	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCIA	2010	21,283		40	532	532	4,522	27
28	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739		40	1,343	1,343	11,418	28
29	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIRO	2010	1,006		40	25	25	213	29
30	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973		5			2,973	30
31	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927		10	193	193	1,639	31
32	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LABO	2010	770		40	19	19	163	32
33	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617		10	62	62	526	33
34	TOTAL (lines 1 thru 33)		$ 15,994,470	$		$ 469,892	$ 469,892	$ 12,533,099	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 469,892	$ 469,892	$ 12,533,099	1
2	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPLIE	2010	16,751		20	838	838	7,121	2
3	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083		20	1,054	1,054	8,960	3
4	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVIC	2010	38,130		15	2,542	2,542	21,607	4
5	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVICE	2010	34,111		25	1,364	1,364	11,596	5
6	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR AN	2010	2,487		20	124	124	1,056	6
7	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR AND	2010	4,482		25	179	179	1,523	7
8	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINEE	2010	2,571		25	103	103	875	8
9	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SER	2010	2,274		25	91	91	773	9
10	PROJ. 10.04-EXT. CARE RENOVATIONS-ELECTRICAL SUPPL	2010	1,085		10	108	108	920	10
11	PROJ. 10.04-EXT. CARE RENOVATIONS-MED GAS OUTLETS	2010	653		15	44	44	372	11
12	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL S	2010	27,126		25	1,085	1,085	9,223	12
13	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530		25	101	101	859	13
14	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637		25	25	25	215	14
15	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010		20	101	101	856	15
16	TABLES - (5)	2011	4,431		15	295	295	2,214	16
17	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494		5			12,494	17
18	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BUI	2011	6,920		5			6,920	18
19	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONTR	2011	1,053,994		40	26,350	26,350	197,625	19
20	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269		40	657	657	4,926	20
21	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063		40	27	27	201	21
22	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897		40	1,022	1,022	7,666	22
23	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750		40	219	219	1,641	23
24	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310		40	33	33	246	24
25	PROJ. 09-07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTION	2011	635,931		40	15,898	15,898	119,236	25
26	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472		40	37	37	276	26
27	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750		8	1,469	1,469	11,016	27
28	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364		20	168	168	1,261	28
29	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUME	2011	8,120		20	406	406	3,045	29
30	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S AND	2011	1,609		20	80	80	601	30
31	PROJ. 10-16-SIX SIGMA ELECTRICITY PROJECT-ELECTRIC	2011	33,624		10	3,362	3,362	25,216	31
32	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732		20	143	143	1,002	32
33	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295		8	1,518	1,518	10,627	33
34	TOTAL (lines 1 thru 33)		$ 18,032,425	$		$ 529,335	$ 529,335	$ 13,005,268	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 529,335	$ 529,335	$ 13,005,268	1
2	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426		2			426	2
3	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000		8	938	938	6,565	3
4	LANDSCAPING EP COLEMAN BUILDING	2012	9,287		10	464	464	3,249	4
5	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330		2			330	5
6	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600		8	288	288	2,015	6
7	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740		8	546	546	3,823	7
8	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900		8	1,244	1,244	8,708	8
9	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500		8	219	219	1,533	9
10	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208		10	810	810	5,671	10
11	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTRU	2012	2,498		10	125	125	875	11
12	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543		5	4,954	4,954	34,679	12
13	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE STA	2012	490		5	49	49	343	13
14	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL A	2012	2,385		5	239	239	1,672	14
15	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393		15	380	380	2,659	15
16	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284		15	76	76	532	16
17	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433		15	114	114	799	17
18	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LABO	2012	3,308		15	110	110	771	18
19	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142		15	105	105	734	19
20	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145		40	14,477	14,477	101,338	20
21	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872		15	96	96	671	21
22	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052		10	205	205	1,230	22
23	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL C	2013	5,691		20	285	285	1,709	23
24	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411		25	176	176	1,057	24
25	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - WI	2013	671		10	67	67	402	25
26	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592		15	239	239	1,435	26
27	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940		15	63	63	377	27
28	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055		15	70	70	421	28
29	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787		20	40	40	180	29
30	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122		15	8	8	36	30
31	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPING	2014	215		25	8	8	36	31
32	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79		10	8	8	36	32
33	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRADE	2014	36,383		20	1,820	1,820	8,190	33
34	TOTAL (lines 1 thru 33)		$ 19,405,907	$		$ 557,558	$ 557,558	$ 13,197,770	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$		$ 557,558	$ 557,558	$ 13,197,770	1
2	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014	5,284		20	264	264	1,188	2
3	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014	14,291		20	714	714	3,214	3
4	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014	6,563		20	328	328	1,476	4
5	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHOP/	2014	2,107		20	106	106	476	5
6	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014	5,772		20	289	289	1,180	6
7	GHA/HH PARKING LOT SEALCOAT/REPAIR	2015	6,829		2			6,829	7
8	GMG/EP COLEMAN/WELLNESS PARKING LOT SEAL COAT/REI	2015	5,023		2			5,023	8
9	RISEATLAS 625QM CEILING LIFT	2015	19,373		10	1,937	1,937	6,780	9
10								-	10
11								-	11
12	Telemetry Electrical Cable Pull and Receptacle Install	2015	3,457		20	173	173	605	12
13	14.13 - TRANSFORMER REPLACEMENT	2015	43,590		20	2,179	2,179	7,627	13
14	14.15 - JOINT COMMISSION ELECTRICAL/PLUMBING REPAIRS	2015	6,278		20	314	314	1,099	14
15	14.15 - JOINT COMMISSION AIR HANDLER REPAIR	2015	378		10	38	38	133	15
16	14.15 - JOINT COMMISSION DOOR CLOSER REPLACEMENT	2015	995		15	66	66	231	16
17	15.03 - WATER SOFTENER REPLACEMENT	2015	4,674		10	467	467	1,635	17
18								-	18
19	15-01 - Patient Registration - ELECTRICAL/DATA CABLE PULL/INS	2015	2,685		20	134	134	469	19
20	15-07 - Chiller Rebuild - TRANE CONTRACTED WORK	2015	54,304		20	2,715	2,715	9,503	20
21	14.10 - 2nd Floor Hallway Remodel	2015	7,446		5	1,489	1,489	5,212	21
22	14.15 - JOINT COMMISSION BUILDING REPAIRS	2015	463		5	93	93	325	22
23	HOSPITAL TUCKPOINT AND SKYLIGHT GLASS REPAIR	2015	27,029		40	676	676	2,366	23
24	PROJECT 14.04 - PHARMACY RENOVATIONS - PJ HOERR CONT	2015	26,155		40	654	654	2,289	24
25								-	25
26								-	26
27	15-01 - Patient Registration - MISC BUILDING SUPPLIES	2015	6,561		5	1,312	1,312	4,592	27
28	15-01 - Patient Registration - PJ HOERR CONTRACT WORK	2015	334,913		40	8,373	8,373	29,305	28
29								-	29
30	Project 16-07, 16-08, 16-10, 16-16 - Parking lost asphalt recoat, repair	2016	17,438		15	1,163	1,163	2,907	30
31	concrete apron repair, sidewalk repair								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 20,007,517	$		$ 581,042	$ 581,042	$ 13,292,235	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 20,007,517	$		$ 581,042	$ 581,042	$ 13,292,235	1
2	Project 16-18 - SNF Remodel Paint & Misc Bldng Supplies	2017	29,433		5	5,887	5,887	8,829	2
3	Project 16-18 - SNF Remodel Contracted Construction	2017	2,048,414		40	51,210	51,210	76,815	3
4									4
5									5
6									6
7									7
8									8
9									9
10	Allocated Depreciation	2018		238,485			(238,485)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 22,085,364	$ 238,485		$ 638,139	$ 399,654	$ 13,377,879	34

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 514,175	$	$ 29,216	$ 29,216	5-15	$ 235,255	71
72	Current Year Purchases	-		-	-		-	72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 514,175	$	$ 29,216	$ 29,216		$ 235,255	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)	$ 22,599,539	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 238,485	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 667,354	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 428,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,613,133	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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

It is the policy of this facility to only hire certified nurses aides.

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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.

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/18 (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	$ 8,462,817	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,509,083		3
4	Supply Inventory (priced at)	1,873,940		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,553,555		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current	6,805,097		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 32,204,492	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,625,990		13
14	Buildings, at Historical Cost	84,140,977		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	49,894,156		16
17	Accumulated Depreciation (book methods)	(65,976,412)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Assets Limited as to U	82,971,214		22
23	Other(specify): Trust Fund	8,482,820		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 165,138,745	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 197,343,237	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,656,852		26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,675,000		29
30	Accrued Salaries Payable	4,068,338		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	Third Party Payors	1,106,538		36
37	Self Insurance	6,609,453		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 17,116,181	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,053,239		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Rate Swap Agreements	4,131,350		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 48,184,589	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 65,300,770	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 132,042,467	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 197,343,237	$	48

*(See instructions.)

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 118,681,207	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 118,681,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,529,791	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**	7,514,013	15
16	Other (describe) **Decrease in Temp. Restricted Assets Net**	317,456	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 13,361,260	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)**	$ 132,042,467	24 *

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

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 2,863,914	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,863,914	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 Revenue	7,837,834	28
28a	Hospital Revenue	80,091,443	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 87,929,277	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 90,793,191	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,051,135	31
32	Health Care	2,109,839	32
33	General Administration	1,197,770	33
	B. Capital Expense		
34	Ownership	238,485	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	20,805	36
	D. Other Expenses (specify):		
37	Hosptital Expense	80,645,366	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 85,263,400	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,529,791	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,529,791	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.**

^ Entity is a cash basis taxpayer

Facility Name & ID Number Graham Hospital Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	461,882
TOTAL (agree to Schedule V, line 22, col.8)	$ 461,882

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 Association # 800200 Report Period Beginning: 7/1/17 Ending: 6/30/18

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? **No**

(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. $ **20,805**
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?

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: **RSM US 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.