FOR BHF USE

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: David Paluck   Telephone Number: (708) 216-6719
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2019 to June 30, 2020 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) ____ 10/31/2020 (Date)
(Type or Print Name) David Paluck
(Title) Regional Director of Reimbursement

Paid Preparer
(Signed) ____ 10/31/2020 (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: July 1, 2019 Ending: June 30, 2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	34	TOTALS	34	12,410	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	238		6,855	7,093	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	238		6,855	7,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.16%

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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/20/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ____________ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 5,599

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** July 1, 2019 **Ending:** June 30, 2020

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		9,162		9,162		9,162	247,201	256,363			1
2	Food Purchase											2
3	Housekeeping							327,752	327,752			3
4	Laundry											4
5	Heat and Other Utilities							261,189	261,189			5
6	Maintenance											6
7	Other (specify):*											7
8	**TOTAL General Services**		9,162		9,162		9,162	836,142	845,304			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,689,928	131,483	703,674	2,525,085		2,525,085	(69,494)	2,455,591			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**	1,689,928	131,483	703,674	2,525,085		2,525,085	(69,494)	2,455,591			16
	C. General Administration											
17	Administrative	624,475	951		625,426		625,426	449,856	1,075,282			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses		8,419		8,419		8,419	94,227	102,646			21
22	Employee Benefits & Payroll Taxes							480,589	480,589			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	624,475	9,370		633,845		633,845	1,024,673	1,658,518			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,314,403	150,015	703,674	3,168,092		3,168,092	1,791,321	4,959,413			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.

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							167,651	167,651			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**							167,651	167,651			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							21,623	21,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**							21,623	21,623			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,314,403	150,015	703,674	3,168,092		3,168,092	1,980,594	5,148,686			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** July 1, 2019 **Ending:** June 30, 2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	1,980,594			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,980,594		$	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))**	$ 1,980,594		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

STATE OF ILLINOIS

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: July 1, 2019

Ending: June 30, 2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Hospital W/S A-6 Reclass for Drugs Charged	$ (586)	10	1
2	Hospital W/S A-6 Reclass for Med Supplies	(71,027)	10	2
3	Hospital W/S B Overhead Alloc - Bldg & Fixt	162,503	30	3
4	Hospital W/S B Overhead Alloc - Movbl Equip	5,147	30	4
5	Hospital W/S B Overhead Alloc - Emp Benefits	480,589	22	5
6	Hospital W/S B Overhead Alloc - Admin & Gen	218,866	17	6
7	Hospital W/S B Overhead Alloc - Plant Oper	261,189	5	7
8	Hospital W/S B Overhead Alloc - Housekeeping	327,752	3	8
9	Hospital W/S B Overhead Alloc - Dietary	247,201	1	9
10	Hospital W/S B Overhead Alloc - Cafeteria	94,227	21	10
11	LTC Cost in Hosp Adm for Provider Partici. Fees	21,623	42	11
12	Hospital W/S B Overhead Alloc - Nursing Admin	230,990	17	12
13	Hospital W/S B Overhead Alloc - Central Supply	2,119	10	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**	1,980,594		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	247,201	0	0	0	0	0	0	0	0	0	0	247,201	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	327,752	0	0	0	0	0	0	0	0	0	0	327,752	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	261,189	0	0	0	0	0	0	0	0	0	0	261,189	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**	836,142	0	0	0	0	0	0	0	0	0	0	836,142	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	(69,494)	0	0	0	0	0	0	0	0	0	0	(69,494)	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**	(69,494)	0	0	0	0	0	0	0	0	0	0	(69,494)	16
	C. General Administration													
17	Administrative	449,856	0	0	0	0	0	0	0	0	0	0	449,856	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	94,227	0	0	0	0	0	0	0	0	0	0	94,227	21
22	Employee Benefits & Payroll Taxes	480,589	0	0	0	0	0	0	0	0	0	0	480,589	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**	1,024,673	0	0	0	0	0	0	0	0	0	0	1,024,673	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,791,321	0	0	0	0	0	0	0	0	0	0	1,791,321	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	167,651	0	0	0	0	0	0	0	0	0	0	167,651	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**	167,651	0	0	0	0	0	0	0	0	0	0	167,651	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	21,623	0	0	0	0	0	0	0	0	0	0	21,623	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	21,623	0	0	0	0	0	0	0	0	0	0	21,623	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,980,594	0	0	0	0	0	0	0	0	0	0	1,980,594	45

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 ☐ NO

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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: July 1, 2019 Ending: June 30, 2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: July 1, 2019 Ending: ne 30, 2020

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

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.)**

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item	Amount	Line
1. Real Estate Tax accrual used on 2019 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 2020 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:			Line
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY

Line	Item	Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT David Paluck

TELEPHONE (708) 216-6719 FAX #: (708) 216-8340

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation***. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Hospital and Parking	1,458,000	1961	$ 61,937	1
2					2
3	TOTALS	1,458,000		$ 61,937	3

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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				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					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: July 1, 2019 Ending: June 30, 2020

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					2,395,628	40
41	Various	1993	1,601,815					1,601,815	41
42	Various	1994	2,933,038					2,933,038	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					3,851,805	45
46	Various	1998	7,826,827					7,826,827	46
47	Various	1999	3,782,851					3,782,851	47
48	Various	2000	6,562,656					6,562,656	48
49	Various	2001	4,472,858					4,472,858	49
50	Various	2002	3,071,826					3,071,826	50
51	Various	2003	1,616,067					1,616,067	51
52	Various	2004	2,567,622	157,665		157,665		2,567,622	52
53	Various	2005	4,098,669	324,788		324,788		4,016,450	53
54	Various	2006	1,656,917	66,572		66,572		821,054	54
55	Various	2007	1,091,422	40,123		40,123		488,495	55
56	Various	2008	392,789	21,427		21,427		245,128	56
57	Various	2009	3,415,801	121,618		121,618		1,380,228	57
58	Various	2011	274,704	22,176		22,176		204,467	58
59	Various	2012	6,839,918	383,542		383,542		3,319,708	59
60	Various	2013	1,181,773	63,608		63,608		502,720	60
61	Various	2014	1,833,044	246,499		246,499		1,478,998	61
62	Various	2015	2,485,362	144,859		144,859		761,961	62
63	Various	2016	15,339,088	1,725,424		1,725,424		7,712,346	63
64	Various	2017	8,660,187	1,143,481		1,143,481		4,002,228	64
65	Various	2018	1,901,793	142,358		142,358		427,074	65
66									66
67	ALS Defibrillator with battery	2019	72,043	11,207	15	11,207		22,414	67
68	APEX 4.6 Upgrade with SQL DB	2019	7,500	1,146	3	1,146		2,292	68
69	Barrier Gate Paylot	2019	4,783	1,528	3	1,528		3,056	69
70	TOTAL (lines 4 thru 69)		$ 147,871,686	$ 4,618,021		$ 4,618,021	$	$ 123,523,586	70

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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		$ 147,871,686	$ 4,618,021		$ 4,618,021	$	$ 123,523,586	1
2	Bench Type Mixer w/Bowl Beater	2019	5,539	346	10	346		692	2
3	Computer Cart w/shelf&basket	2019	18,835	2,982	5	2,982		5,964	3
4	EEG Sleep Acq Desktop w Camera	2019	26,459	3,307	7	3,307		6,615	4
5	Eye Center Custom Cabinetry	2019	50,210	3,208	15	3,208		6,416	5
6	Eye Center Labor only	2019	70,985	4,535	15	4,535		9,070	6
7	Eye Center Labor only Plumbing	2019	6,030	385	15	385		771	7
8	Eye Surgery Stretcher-White	2019	32,828	4,494	42	4,494		8,989	8
9	Fire Proof PACU-doors&frames	2019	9,395	450	20	450		900	9
10	Fire Proof PACU-labor only	2019	19,866	1,269	15	1,269		2,538	10
11	Fire Proof PACU-plumbing	2019	569	27	20	27		55	11
12	Freezer-Lab 30 cu ft upright	2019	6,991	379	10	379		757	12
13	Hand Held Computer MC55X-HC	2019	25,758	3,220	42	3,220		6,439	13
14	Heat Exchgr Build Auto Control	2019	6,250	226	15	226		451	14
15	Heat Exchgr Butterfly Valve	2019	5,889	213	15	213		425	15
16	Heat Exchgr Difftl Transmitter	2019	1,400	51	15	51		101	16
17	Heat Exchgr PDC Labor only	2019	1,316	69	15	69		139	17
18	Heat Exchgr PDC Labor only	2019	1,514	71	15	71		143	18
19	Heat Exchgr PDC Labor only	2019	1,456	61	15	61		121	19
20	Heat Exchgr Plate&Frame Instal	2019	95,000	5,014	15	5,014		10,028	20
21	Heat Exchgr Radiant Ceil Heat	2019	4,454	161	15	161		322	21
22	Honeywell BarCode Scanner 1900	2019	4,189	663	70	663		1,326	22
23	Honeywell BarCode Scanner 1902	2019	10,758	1,703	75	1,703		3,407	23
24	HP Dual Vesa Sleeve G1K22AA	2019	112	18	5	18		35	24
25	HP Elite E242 24inch Monitor	2019	3,116	493	70	493		987	25
26	HP G2 Mini Windows10 with tag	2019	10,642	1,685	100	1,685		3,370	26
27	Keyboard Med Grade SSWKSV207	2019	262	41	5	41		83	27
28	M&M Mighty Mouse White	2019	353	56	5	56		112	28
29	OEC C-Arm Ergo 31cm dicom kit	2019	149,525	13,706	5	13,706		27,413	29
30	Painting 6 rooms&corridor	2019	17,800	3,412	5	3,412		6,823	30
31	Painting Suite 505	2019	4,460	855	5	855		1,710	31
32	Philips Tee Probe X7-2T	2019	22,150	3,138	5	3,138		6,276	32
33	Planar LED Monitor PLL2210MW	2019	1,455	230	30	230		461	33
34	TOTAL (lines 1 thru 33)		$ 148,487,250	$ 4,674,491		$ 4,674,491	$	$ 123,636,526	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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		$ 148,487,250	$ 4,674,491		$ 4,674,491	$	$ 123,636,526	1
2	Pool Heat Exchanger&Repiping	2019	20,000	625	20	625		1,250	2
3	Pyxis ES Platform Upgrade	2019	24,927	1,316	15	1,316		2,631	3
4	Refurbish Desmo EVO Treadmill	2019	24,942	2,858	24	2,858		5,716	4
5	Relocate File System 216to101	2019	4,445	284	15	284		568	5
6	Software OEC Elite upgrade ESP	2019	51,000	4,958	3	4,958		9,917	6
7	Suite 101 Ceiling Acoustical T	2019	3,700	443	8	443		886	7
8	Suite 101 Conduit and Wiring	2019	30,926	1,482	20	1,482		2,964	8
9	Suite 101 Drywall materials	2019	3,916	250	15	250		500	9
10	Suite 101 HVAC	2019	5,775	369	15	369		738	10
11	Suite 101 Labor only	2019	293,850	18,774	15	18,774		37,548	11
12	Suite 101 Light Fixtures	2019	7,776	745	10	745		1,490	12
13	Suite 101 Metal Frames&Hardwar	2019	14,070	674	20	674		1,348	13
14	Suite 101 Painting&Wallpaperin	2019	8,580	1,645	5	1,645		3,289	14
15	Suite 101 Pipe Insulation	2019	950	61	15	61		121	15
16	Suite 101 Plumbing Fixtures	2019	3,262	156	20	156		313	16
17	Suite 101 Sprinkler System	2019	7,118	273	25	273		546	17
18	Suite 101 Temperature Controls	2019	1,095	105	10	105		210	18
19	Suite 101 Vinyl Tile Flooring	2019	6,782	650	10	650		1,300	19
20	Suite 101 Window Roller Shades	2019	5,982	1,147	5	1,147		2,293	20
21	Suite 303 Ceiling Acoustical T	2019	3,220	386	8	386		771	21
22	Suite 303 Conduit and Wiring	2019	42,060	2,015	20	2,015		4,031	22
23	Suite 303 Custom Cabinetry	2019	17,030	1,088	15	1,088		2,176	23
24	Suite 303 Drywall materials	2019	4,169	266	15	266		533	24
25	Suite 303 HVAC	2019	39,180	2,503	15	2,503		5,006	25
26	Suite 303 Labor only	2019	343,836	21,967	15	21,967		43,935	26
27	Suite 303 Light Fixtures	2019	11,855	1,136	10	1,136		2,272	27
28	Suite 303 Metal Frames&Hardwar	2019	6,090	292	20	292		584	28
29	Suite 303 Painting&Wallpaperin	2019	7,890	1,512	5	1,512		3,025	29
30	Suite 303 Plumbing Fixtures	2019	5,500	264	20	264		527	30
31	Suite 303 Sprinkler System	2019	3,000	115	25	115		230	31
32	Suite 303 Temperature Controls	2019	7,797	747	10	747		1,494	32
33	Suite 303 Waste Vent Storm Pip	2019	8,500	407	20	407		815	33
34	TOTAL (lines 1 thru 33)		$ 149,506,473	$ 4,744,004		$ 4,744,004	$	$ 123,775,552	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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		$ 149,506,473	$ 4,744,004		$ 4,744,004	$	$ 123,775,552	1
2	Suite 303 Window Roller Shades	2019	5,066	971	5	971		1,942	2
3	Suite 303 Wood Door Reception	2019	1,920	123	15	123		245	3
4	Suite 505 Architectural Servic	2019	34,933	2,232	15	2,232		4,464	4
5	Suite 505 Asbestos Abate Remov	2019	4,100	196	20	196		393	5
6	Suite 505 Custom Cabinetry	2019	12,050	770	15	770		1,540	6
7	Suite 505 Decorating	2019	3,660	702	5	702		1,403	7
8	Suite 505 Electrical Materials	2019	9,310	446	20	446		892	8
9	Suite 505 Flooring Materials	2019	2,322	223	10	223		445	9
10	Suite 505 Labor only	2019	23,167	1,480	15	1,480		2,960	10
11	Suite 505 Labor only Decoratin	2019	14,640	935	15	935		1,871	11
12	Suite 505 Labor only Electrica	2019	14,000	894	15	894		1,789	12
13	Suite 505 Labor only Flooring	2019	9,378	599	15	599		1,198	13
14	Suite 505 Labor only Plumbimg	2019	3,450	220	15	220		441	14
15	Suite 505 Labor only-PDC	2019	11,058	707	15	707		1,413	15
16	Suite 505 Metal Frames&Hardwar	2019	2,500	120	20	120		240	16
17	Suite303 Architectural Service	2019	2,667	170	15	170		341	17
18	Thermal Portable PrinterQLn220	2019	16,282	2,035	42	2,035		4,071	18
19	TV 32in LED MPEG2	2019	299	57	5	57		114	19
20	Landscaping Soil testing	2020	58,795	735	10	735		735	20
21	Asbestos inspection	2020	4,135	34	15	34		34	21
22	Construction Architect fees	2020	10,486,890	87,391	15	87,391		87,391	22
23	Signage	2020	91,219	1,140	10	1,140		1,140	23
24	Architect fees Pro services	2020	905,722	7,548	15	7,548		7,548	24
25	Fan replacement S1 upgrade	2020	361,596	21,093	15	21,093		21,093	25
26	Copier Printer Scanner	2020	5,547	1,063	5	1,063		1,063	26
27	TV RCA 49" LED	2020	15,312	2,935	5	2,935		2,935	27
28	Worksurface Locking pedestals	2020	94,376	786	15	786		786	28
29	Fridge Shelving TV	2020	90,231	752	15	752		752	29
30	Nortel telephone adapter	2020	5,244	66	10	66		66	30
31	Ceiling lifts Vacuum sys	2020	246,159	2,051	15	2,051		2,051	31
32	Reconciliation adjustment for non-TCU assets					(4,714,828)	(4,714,828)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 162,042,500	$ 4,882,479		$ 167,651	$ (4,714,828)	$ 123,926,907	34

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

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)	$ 162,104,437	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,882,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,651	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,714,828)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 123,926,907	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.

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: *

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.

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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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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.

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2020 (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	$ 12,335,989	$	1
2	Cash-Patient Deposits	92,380,990		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 88,442,411)	13,830,529		3
4	Supply Inventory (priced at)	3,019,002		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	33,852		7
8	Accounts Receivable (owners or related parties)	2,437,244		8
9	Other(specify):	81,195,054		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 205,232,660	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	71,148		12
13	Land	12,097,000		13
14	Buildings, at Historical Cost	74,483,348		14
15	Leasehold Improvements, at Historical Cost	19,664,045		15
16	Equipment, at Historical Cost	50,626,727		16
17	Accumulated Depreciation (book methods)	(81,604,882)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,978,121		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,106,408		21
22	Other Long-Term Assets (specify):	210,328		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 81,632,243	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 286,864,903	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,911,275	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	537,812		29
30	Accrued Salaries Payable	3,809,742		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	Other Accrued Expenses	10,866,117		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 182,124,947	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,529,850		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other LT Liab	4,580,821		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,110,672	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 202,235,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 84,629,284	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 286,864,903	$	48

*(See instructions.)

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2019 Ending: June 30, 2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 100,287,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 100,287,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,007,422	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)**	$ 5,007,422	17
	B. Transfers (Itemize):		
18	**Other Adjustments and Transfers**	(20,665,661)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (20,665,661)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 84,629,284	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	$ 559,821,330	1
2	Discounts and Allowances for all Levels	(444,610,780)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 115,210,550	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***	1,052,099	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,052,099	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Other Revenue	10,711,879	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,711,879	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 126,974,528	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	9,162	31
32	Health Care	2,525,085	32
33	General Administration	633,845	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 the TCU/LTC	118,799,014	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 121,967,106	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,007,422	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,007,422	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 20,467,107	44
45	Private Pay - Net Inpatient Revenue	870,262	45
46	Medicare - Net Inpatient Revenue	53,713,602	46
47	Other-(specify) Commercial Payors	40,159,579	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 115,210,550	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	1,600	1,936	$ 140,500	$ 72.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,236	25,095	1,220,138	48.62	3
4	Licensed Practical Nurses	3,880	4,383	139,536	31.84	4
5	CNAs & Orderlies	21,182	24,409	506,951	20.77	5
6	CNA Trainees					6
7	Licensed Therapist	1,639	1,911	62,311	32.61	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	867	943	16,439	17.44	10
11	Social Service Workers	10	10	430	41.95	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	24	24	524	21.48	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,832	6,608	227,574	34.44	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)	57,270	65,319	$ 2,314,403 *	$ 35.43	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
Management			$ 231,480
Other Administrative			251,080
Clerical			141,915
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 624,475

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	$ 20,512
Unemployment Compensation Insurance	7,536
FICA Taxes	90,124
Employee Health Insurance	198,486
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension	1,364
401K	25,098
Life Insurance	2,182
Disability Insurance	8,397
Tuition Reimbursement	814
Employee Recognition	0
Severance and Other	389
TOTAL (agree to Schedule V, line 22, col.8)	$ 354,902

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

XX. GENERAL INFORMATION:

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

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

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(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? **12 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. $ **21,623**
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 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.