FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 8000200

Facility Name: Graham Hospital

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

County: Fulton

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kyle Cook 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 7/1/2019 to 6/30/2020 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) (Date)
(Type or Print Name) Julie Reeder
(Title) Vice President of Finance/CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Paul Traczek, CPA, Partner
(Firm Name & Address) Wipfli LLP, 4890 Owen Ayres Court, Suite 200, Eau Claire, WI 54701
(Telephone) (715) 858-6619 Fax # (715) 832-2345

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 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	13,908	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	13,908	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	3,301	2,960	1,904	8,165	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,301	2,960	1,904	8,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.71%

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]

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 20 and days of care provided _____

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [ ] 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 Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	290,174		25,748	315,922		315,922		315,922			1
2	Food Purchase		205,551		205,551		205,551		205,551			2
3	Housekeeping	130,778		26,066	156,844		156,844		156,844			3
4	Laundry	28,098		215,574	243,672		243,672		243,672			4
5	Heat and Other Utilities			97,583	97,583		97,583		97,583			5
6	Maintenance	73,369		91,683	165,052		165,052		165,052			6
7	Other (specify):*											7
8	TOTAL General Services	522,419	205,551	456,654	1,184,624		1,184,624		1,184,624			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,741,489		266,794	2,008,283		2,008,283		2,008,283			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Nursing School	920,046		193,670	1,113,716		1,113,716		1,113,716			15
16	TOTAL Health Care and Programs	2,661,535		460,464	3,121,999		3,121,999		3,121,999			16
	C. General Administration											
17	Administrative	148,732		174,340	323,072		323,072	(752)	322,320			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	100,384		124,032	224,416		224,416		224,416			21
22	Employee Benefits & Payroll Taxes			444,914	444,914		444,914		444,914			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,292	26,292		26,292		26,292			26
27	Other (specify):*											27
28	TOTAL General Administration	249,116		769,578	1,018,694		1,018,694	(752)	1,017,942			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,433,070	205,551	1,686,696	5,325,317		5,325,317	(752)	5,324,565			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Graham Hospital #8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			297,955	297,955		297,955	308,396	606,351			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**			297,955	297,955		297,955	308,396	606,351			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			30,866	30,866		30,866		30,866			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			30,866	30,866		30,866		30,866			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,433,070	205,551	2,015,517	5,654,138		5,654,138	307,644	5,961,782			45

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	(752)	17		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 Depreciation adjustment	308,396			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 307,644		$	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))**	$ 307,644		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

Graham Hospital

ID# 8000200

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment of Allocated Depreciation to actual	$		1
2	straight line depreciation per page 12 & 13	308,396	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**	308,396		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(752)	0	0	0	0	0	0	0	0	0	0	(752)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	(752)	0	0	0	0	0	0	0	0	0	0	(752)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(752)	0	0	0	0	0	0	0	0	0	0	(752)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Graham Hospital # 8000200 **Report Period Beginning:** 7/1/2019 **Ending:** 6/30/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	308,396	0	0	0	0	0	0	0	0	0	0	308,396	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**	308,396	0	0	0	0	0	0	0	0	0	0	308,396	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	307,644	0	0	0	0	0	0	0	0	0	0	307,644	45

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	
	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 # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 ☐

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
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 Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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 Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,688 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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

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

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

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

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

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

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

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ECF/SNF	16,688		$	1
2					2
3	TOTALS	16,688		$	3

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	38			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					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	1,123,720	13
14	1985 VARIOUS BUILDING IMPROVEMENTS			1985	34,258		VARIOUS			34,258	14
15	1987 VARIOUS BUILDING IMPROVEMENTS			1987	89,317		VARIOUS			89,317	15
16	1988 VARIOUS BUILDING IMPROVEMENTS			1988	52,287		VARIOUS	4	4	52,163	16
17	1990 VARIOUS BUILDING IMPROVEMENTS			1990	28,254		VARIOUS	3	3	28,215	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			24,479	24
25	1998 VARIOUS BUILDING IMPROVEMENTS			1998	26,173		VARIOUS			26,173	25
26	1999 VARIOUS BUILDING IMPROVEMENTS			1999	11,097		VARIOUS			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	61,904	61,904	953,088	32
33	2006 VARIOUS BUILDING IMPROVEMENTS			2006	2,994,111		VARIOUS	156,500	156,500	2,404,460	33
34	2007 VARIOUS BUILDING IMPROVEMENTS			2007	2,221,427		VARIOUS	93,042	93,042	1,318,315	34
35	2008 VARIOUS BUILDING IMPROVEMENTS			2008	1,406,411		VARIOUS	79,001	79,001	995,341	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	FIRE DOORS-1ST FLOOR	2009	$ 1,887	$	15	$ 126	$ 126	$ 1,448	37
38	PCU AUTOMATIC DOORS	2009	1,927		10			1,927	38
39	ROOF L	2009	13,668		10			13,668	39
40	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONST	2009	7,055		15	470	470	5,407	40
41	08.23-GMG BOND EYE AR EA REMODEL-DRYWALL/SNAP	2009	836		15	56	56	643	41
42	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767		10			767	42
43	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S C	2009	2,106		15	140	140	1,612	43
44	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONST	2009	1,823		15	122	122	1,401	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			449	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/CONST	2009	2,540		15	169	169	1,946	48
49	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONS	2009	5,357		15	357	357	4,107	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			351	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD	2009	8,730		15	582	582	6,693	53
54	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102		15	73	73	842	54
55	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCT	2009	2,663		15	178	178	2,045	55
56	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171		15	78	78	897	56
57	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424		15	228	228	2,623	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	2,176	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			1,518	64
65	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRU	2009	4,802		15	320	320	3,681	65
66	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584		15	306	306	3,517	66
67	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769		15	251	251	2,888	67
68	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363		15	91	91	1,045	68
69		1972	5,755		VARIOUS			5,755	69
70	TOTAL (lines 4 thru 69)		$ 14,346,577	$		$ 410,359	$ 410,359	$ 12,383,256	70

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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		$ 14,346,577	$		$ 410,359	$ 410,359	$ 12,383,256	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 PROTECTI	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	13,582	25
26	PROJ 04.16 - PYXIS - CABINETS	2007	442		15	29	29	393	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	4,624	29
30	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387		15	26	26	325	30
31	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTOI	2008	367		15	24	24	301	31
32	08.04-HR RELOCATION-SINK	2008	304		20	15	15	188	32
33	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERT	2008	1,317		15	88	88	1,100	33
34	TOTAL (lines 1 thru 33)		$ 14,566,371	$		$ 411,917	$ 411,917	$ 12,600,104	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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		$ 14,566,371	$		$ 411,917	$ 411,917	$ 12,600,104	1
2	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINETS	2008	1,126		15	75	75	938	2
3	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTO	2008	366		15	24	24	301	3
4	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&CC	2008	401		15	27	27	337	4
5	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424		15	95	95	1,085	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	1,832	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			83,693	23
24	2005 LAND IMPROVEMENTS	2005	84,686		VARIOUS	5,066	5,066	84,686	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	8,519	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	3,173	28
29	SOUTH PATIO IMPROVEMENTS	2008	1,603		15	107	107	1,337	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	6,173	31
32	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082		20	54	54	648	32
33	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939		25	118	118	1,239	33
34	TOTAL (lines 1 thru 33)		$ 15,143,019	$		$ 419,021	$ 419,021	$ 13,161,817	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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		$ 15,143,019	$		$ 419,021	$ 419,021	$ 13,161,817	1
2	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INT	2010	385		40	10	10	105	2
3	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723		25	29	29	304	3
4	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257		40	731	731	7,676	4
5	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889		40	322	322	3,381	5
6	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTER	2010	2,576		40	64	64	674	6
7	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLO	2010	6,806		10	338	338	6,806	7
8	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENG	2010	1,510		40	38	38	398	8
9	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUP	2010	7,453		40	186	186	1,954	9
10	AMBULANCE BUILDING - WALNUT ST.	2010	1,089		40	27	27	284	10
11	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602		10	231	231	4,602	11
12	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963		15	131	131	1,375	12
13	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301		15	153	153	1,608	13
14	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061		10	854	854	17,061	14
15	ROOF M REPLACEMENT - MRI ROOF	2010	6,935		10	344	344	6,935	15
16	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & C	2010	4,786		15	319	319	3,350	16
17	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943		15	196	196	2,059	17
18	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPI	2010	2,485		15	166	166	1,742	18
19	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751		40	15,969	15,969	167,674	19
20	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCI	2010	21,283		40	532	532	5,586	20
21	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739		40	1,343	1,343	14,104	21
22	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIRO	2010	1,006		40	25	25	263	22
23	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973		5			2,973	23
24	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927		10	95	95	1,927	24
25	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LAB	2010	770		40	19	19	201	25
26	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617		10	29	29	617	26
27	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPLI	2010	16,751		20	838	838	8,797	27
28	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083		20	1,054	1,054	11,068	28
29	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVI	2010	38,130		15	2,542	2,542	26,691	29
30	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVIC	2010	34,111		25	1,364	1,364	14,324	30
31	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR A	2010	2,487		20	124	124	1,304	31
32	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR AN	2010	4,482		25	179	179	1,881	32
33	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINE	2010	2,571		25	103	103	1,081	33
34	TOTAL (lines 1 thru 33)		$ 16,089,464	$		$ 447,376	$ 447,376	$ 13,480,622	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 12D, Carried Forward		$ 16,089,464	$		$ 447,376	$ 447,376	$ 13,480,622	1
2	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SE	2010	2,274		25	91	91	955	2
3	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL	2010	27,126		25	1,085	1,085	11,393	3
4	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530		25	101	101	1,061	4
5	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637		25	25	25	265	5
6	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010		20	101	101	1,058	6
7	TABLES - (5)	2011	4,431		15	295	295	2,804	7
8	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494		5			12,494	8
9	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BU	2011	6,920		5			6,920	9
10	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONT	2011	1,053,994		40	26,350	26,350	250,325	10
11	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269		40	657	657	6,240	11
12	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063		40	27	27	255	12
13	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897		40	1,022	1,022	9,710	13
14	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750		40	219	219	2,079	14
15	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310		40	33	33	312	15
16	PROJ. 09-07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTIO	2011	635,931		40	15,898	15,898	151,032	16
17	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472		40	37	37	350	17
18	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750		8			11,750	18
19	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364		20	168	168	1,597	19
20	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUM	2011	8,120		20	406	406	3,857	20
21	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S AN	2011	1,609		20	80	80	761	21
22	PROJ. 10-16-SIX SIGMA ELECTRICITY PROJECT-ELECTRI	2011	33,624		10	3,362	3,362	31,940	22
23	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732		20	143	143	1,288	23
24	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295		8	1,518	1,518	13,663	24
25	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426		2			426	25
26	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000		8	938	938	8,441	26
27	LANDSCAPING EP COLEMAN BUILDING	2012	9,287		10	464	464	4,177	27
28	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330		2			330	28
29	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600		8	288	288	2,591	29
30	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740		8	546	546	4,915	30
31	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900		8	1,244	1,244	11,196	31
32	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500		8	219	219	1,971	32
33	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208		10	810	810	7,291	33
34	TOTAL (lines 1 thru 33)		$ 18,084,057	$		$ 503,503	$ 503,503	$ 14,044,069	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 12E, Carried Forward		$ 18,084,057	$		$ 503,503	$ 503,503	$ 14,044,069	1
2	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTR	2012	2,498		10	125	125	1,125	2
3	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543		5	4,954	4,954	44,587	3
4	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE ST	2012	490		5	49	49	441	4
5	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL	2012	2,385		5	239	239	2,150	5
6	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393		15	380	380	3,419	6
7	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284		15	76	76	684	7
8	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433		15	114	114	1,027	8
9	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LAB	2012	3,308		15	110	110	991	9
10	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142		15	105	105	944	10
11	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145		40	14,477	14,477	130,292	11
12	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872		15	96	96	863	12
13	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052		10	205	205	1,640	13
14	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL	2013	5,691		20	285	285	2,279	14
15	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411		25	176	176	1,409	15
16	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - W	2013	671		10	67	67	536	16
17	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592		15	239	239	1,913	17
18	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940		15	63	63	503	18
19	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055		15	70	70	561	19
20	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787		20	40	40	260	20
21	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122		15	8	8	52	21
22	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPIN	2014	215		25	8	8	52	22
23	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79		10	8	8	52	23
24	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRAD	2014	36,383		20	1,820	1,820	11,830	24
25	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014	5,284		20	264	264	1,716	25
26	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014	14,291		20	714	714	4,642	26
27	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014	6,563		20	328	328	2,132	27
28	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHO	2014	2,107		20	106	106	688	28
29	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014	5,772		20	289	289	1,758	29
30	GHA/HH PARKING LOT SEALCOAT/REPAIR	2015	6,829		2			6,829	30
31	GMG/EP COLEMAN/WELLNESS PARKING LOT SEAL COA	2015	5,023		2			5,023	31
32	RISEATLAS 625QM CEILING LIFT	2015	19,373		10	1,937	1,937	10,654	32
33	Telemetry Electrical Cable Pull and Receptacle Install	2015	3,457		20	173	173	951	33
34	TOTAL (lines 1 thru 33)		$ 19,448,247	$		$ 531,028	$ 531,028	$ 14,286,072	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 12F, Carried Forward		$ 19,448,247	$		$ 531,028	$ 531,028	$ 14,286,072	1
2	14.13 - TRANSFORMER REPLACEMENT	2015	43,590		20	2,179	2,179	11,985	2
3	14.15 - JOINT COMMISSION ELECTRICAL/PLUMBING REP	2015	6,278		20	314	314	1,727	3
4	14.15 - JOINT COMMISSION AIR HANDLER REPAIR	2015	378		10	38	38	209	4
5	14.15 - JOINT COMMISSION DOOR CLOSER REPLACEMEN	2015	995		15	66	66	363	5
6	15.03 - WATER SOFTENER REPLACEMENT	2015	4,674		10	467	467	2,569	6
7	15-01 - Patient Registration - ELECTRICAL/DATA CABLE PUL	2015	2,685		20	134	134	737	7
8	15-07 - Chiller Rebuild - TRANE CONTRACTED WORK	2015	54,304		20	2,715	2,715	14,933	8
9	14.10 - 2nd Floor Hallway Remodel	2015	7,446		5	745	745	7,446	9
10	14.15 - JOINT COMMISSION BUILDING REPAIRS	2015	463		5	45	45	463	10
11	HOSPITAL TUCKPOINT AND SKYLIGHT GLASS REPAIR	2015	27,029		40	676	676	3,718	11
12	PROJECT 14.04 - PHARMACY RENOVATIONS - PJ HOERR C	2015	26,155		40	654	654	3,597	12
13	15-01 - Patient Registration - MISC BUILDING SUPPLIES	2015	6,561		5	657	657	6,561	13
14	15-01 - Patient Registration - PJ HOERR CONTRACT WORK	2015	334,913		40	8,373	8,373	46,051	14
15	Project 16-07, 16-08, 16-10, 16-16 - Parking lost asphalt recoat, rep	2016	17,438		15	1,163	1,163	5,233	15
16	Project 16-18 - SNF Remodel Paint & Misc Bldng Supplies	2017	29,433		5	5,887	5,887	20,603	16
17	Project 16-18 - SNF Remodel Contracted Construction	2017	2,048,414		40	51,210	51,210	179,235	17
18	Allocated Depreciation	2019		297,955			(297,955)		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)		$ 22,059,003	$ 297,955		$ 606,351	$ 308,396	$ 14,591,502	34

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$ 406,955	$	$ 28,853	$ 28,853	5 - 20	$ 185,889	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	108,331					108,331	73
74								74
75	TOTALS	$ 515,286	$	$ 28,853	$ 28,853		$ 294,220	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)	$ 22,574,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 297,955	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 635,204	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 337,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,885,722	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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.)

	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 # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2020 (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	$ 20,763,725	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	9,702,725		3
4	Supply Inventory (priced at)	2,056,836		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,217,144		7
8	Accounts Receivable (owners or related parties)	5,459,281		8
9	Other(specify): Other Current			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 39,199,711	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,873,410		13
14	Buildings, at Historical Cost	87,870,328		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,941,326		16
17	Accumulated Depreciation (book methods)	(69,353,014)		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	101,499,670		22
23	Other(specify): Trust Fund	8,560,121		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 186,391,841	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 225,591,552	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,338,001	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,766,632		29
30	Accrued Salaries Payable	3,938,561		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/ Unearned CARES Ac	11,301,077		36
37	Self Insurance	2,789,228		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 26,133,499	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	59,359,052		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Rate Swap Agreements	4,895,255		43
44	Other	1,553,355		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 65,807,662	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 91,941,161	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 133,650,391	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 225,591,552	$	48

***(See instructions.)**

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 133,050,088	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 133,050,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,355,450	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) Non operating losses - Net	(1,958,813)	15
16	Other (describe) Other changes in net assets	203,666	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 600,303	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)**	$ 133,650,391	24 *

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$ 2,392,862	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,392,862	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	10,642,211	28
28a	Hospital Revenue	77,826,718	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 88,468,929	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 90,861,791	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,184,624	31
32	Health Care	3,119,999	32
33	General Administration	1,018,694	33
	B. Capital Expense		
34	Ownership	297,955	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	30,866	36
	D. Other Expenses (specify):		
37	Hospital Expense	82,854,203	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 88,506,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,355,450	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,355,450	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)			$ *	$	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	444,914
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,914

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

Description	Line #	Amount
N/A		$
TOTAL		$

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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. $ **20,089**
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: **Wipfli 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.