

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 8008518

Facility Name: Gottlieb Memorial Hospital

Address: 701 West North Avenue Melrose Park 60160
 Number City Zip Code

County: Cook

Telephone Number: 708-450-4949 **Fax #** 708-681-1688

HFS ID Number: _____

Date of Initial License for Current Owners: 06/10/85

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Elyn Chin **Telephone Number:** 708-450-4534

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(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: 01/01/2006 Ending: 12/31/2006

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	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	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	<u>34</u>	TOTALS	<u>34</u>	<u>12,410</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>228</u>		<u>9,588</u>	<u>9,816</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>228</u>		<u>9,588</u>	<u>9,816</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.10%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/20/85

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 34 and days of care provided 8,398

Medicare Intermediary Admiral Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	147,301	30,605	159,699	337,605		337,605		337,605			1
2	Food Purchase		28,856		28,856		28,856		28,856			2
3	Housekeeping	86,757	16,826	51,932	155,515		155,515		155,515			3
4	Laundry	10,853	12,735	33,080	56,668		56,668		56,668			4
5	Heat and Other Utilities			181,147	181,147		181,147		181,147			5
6	Maintenance	58,872	1,871	35,573	96,316		96,316		96,316			6
7	Other (specify):* Cafeteria	4,079		5,231	9,310	(9,310)						7
8	TOTAL General Services	307,862	90,893	466,662	865,417	(9,310)	856,107		856,107			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,950,786	81,896	112,515	2,145,197		2,145,197		2,145,197			10
10a	Therapy											10a
11	Activities											11
12	Social Services	59,744	165	360	60,269		60,269		60,269			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,010,530	82,061	112,875	2,205,466		2,205,466		2,205,466			16
	C. General Administration											
17	Administrative	80,430	1,505	177,619	259,554		259,554		259,554			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			441,477	441,477	9,310	450,787		450,787			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,427	46,427		46,427		46,427			26
27	Other (specify):*											27
28	TOTAL General Administration	80,430	1,505	665,523	747,458	9,310	756,768		756,768			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,398,822	174,459	1,245,060	3,818,341		3,818,341		3,818,341			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Gottlieb Memorial Hospital

#8008518

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			261,782	261,782		261,782		261,782			30
31	Amortization of Pre-Op. & Org.			31,633	31,633		31,633		31,633			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			293,415	293,415		293,415		293,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,023,271	2,023,271		2,023,271		2,023,271			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			2,023,271	2,023,271		2,023,271		2,023,271			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,398,822	174,459	3,561,746	6,135,027		6,135,027		6,135,027			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:

01/01/2006

Ending:

12/31/2006

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		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			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	0	49

Facility Name & ID Number Gottlieb Memorial Hospital

8008518

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital

8008518

Report Period Beginning:

01/01/2006

Ending:

2/31/2006

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	145,920	\$ 1,571,040	\$ 749,526	28,677	\$ 308,749	1
2	2	Food Purchase	Meals Served	145,920	146,833	0	28,677	28,856	2
3	3	Housekeeping	Time Spent	26,693	1,853,189	1,033,837	2,240	155,514	3
4	4	Laundry	Pounds of Laundry	524,961	516,714	98,963	57,573	56,669	4
5	5	Heat/Utilities	Square Feet	201,683	2,989,715	0	12,220	181,147	5
6	6	Plant	Square Feet	201,683	697,907	397,631	12,220	42,286	6
7	7	Cafeteria	FTEs Served	936	261,642	114,624	33	9,310	7
8	10	Nursing	Direct RN Hours	42,379	1,436,126	1,316,225	3,835	129,959	8
9	10	Medical Records	Time Spent	5,762	1,364,701	1,282,663	296	70,106	9
10	12	Social Services	Time Spent	8,708	293,198	290,644	1,790	60,269	10
11	17	Administration	Revenue	563,026,223	23,869,147	7,396,543	6,122,383	259,555	11
12	22	Employee Benefits	Gross Salaries	51,009,375	12,506,038	0	1,800,689	441,477	12
13	26	Property Insurance	Square Feet	201,683	77,986	0	12,220	4,725	13
14	6	Maintenance	Time Spent	56,430	1,108,698	713,660	2,750	54,030	14
15	26	Malpractice Insurance	Revenue	563,026,223	3,834,948	0	6,122,383	41,701	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 52,527,882	\$ 13,394,316		\$ 1,844,353	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	IHFA		X	Refinance & Equipment	Interest	1990	\$ 27,209,221	\$ 22,617,601	11/15/25	Floating	\$ 9,381	1								
2	IHFA		X	Refinance & Equipment	Interest	1994	12,477,021	11,200,000	11/15/24	Floating	4,361	2								
3	IHFA		X	Refinance & Equipment	Interest	1999	28,900,000	22,613,770		Floating	8,880	3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 68,586,242	\$ 56,431,371			\$ 22,622	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 68,586,242	\$ 56,431,371			\$ 22,622	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

1. Real Estate Tax accrual used on 2005 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 2006 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:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,220 B. General Construction Type: Exterior Concrete Frame Reinforced Concrete Number of Stories 6

C. Does the Operating Entity? (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? (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 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	<u>Hospital & Parking</u>	<u>1,458,000</u>	<u>1961</u>	<u>\$ 61,937</u>	1
2					2
3	TOTALS	1,458,000		\$ 61,937	3

Facility Name & ID Number **Gottlieb Memorial Hospital**

8008518

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 1,789,885	\$ 35,798	50	\$ 35,798		\$ 1,628,799	4
5				1982	1,135,357	39,150	29	39,150		959,179	5
6											6
7											7
8											8
Improvement Type**											
9		Building Improvements		1961	927,147	-	25			927,147	9
10		Building Improvements		1962	5,314	108	49	108		4,759	10
11		Building Improvements		1963	57,578	1,152	47-50	1,152		50,108	11
12		Building Improvements		1964	154	3	46	3		134	12
13		Building Improvements		1965	839,469	9,188	25-50	9,188		761,371	13
14		Building Improvements		1966	18,069	181	20-45	181		17,156	14
15		Building Improvements		1967	99,677	1,123	25-44	1,123		94,629	15
16		Building Improvements		1969	243,126	3,854	10-42	3,854		226,132	16
17		Building Improvements		1970	10,866	-	15-25			10,866	17
18		Building Improvements		1971	410,569	4,156	20-40	4,156		392,144	18
19		Building Improvements		1972	63,023	286	10-39	286		61,855	19
20		Building Improvements		1973	36,443	-	15-20			36,443	20
21		Building Improvements		1974	70,028	1,796	15-37	1,796		61,890	21
22		Building Improvements		1975	2,422	-	10			2,422	22
23		Building Improvements		1976	3,446,023	48,651	5-36	48,651		3,228,384	23
24		Building Improvements		1977	7,474,834	97,201	5-35	97,201		6,940,251	24
25		Building Improvements		1978	172,682	1,285	5-35	1,285		166,418	25
26		Building Improvements		1979	159,159	774	5-34	774		152,222	26
27		Building Improvements		1980	729,897	14,979	8-31	14,979		662,495	27
28		Building Improvements		1981	1,633,608	24,155	10-11	24,155		1,566,324	28
29		Building Improvements		1982	3,024,034	18,356	6-20	18,356		2,941,436	29
30		Building Improvements		1983	3,028,019	87,292	5-28	87,292		2,635,628	30
31		Building Improvements		1984	245,719	-	5-20			245,719	31
32		Building Improvements		1985	7,212,994	69,906	5-40	69,906		5,990,087	32
33		Building Improvements		1986	2,251,370	43,281	5-20	43,281		2,251,370	33
34		Building Improvements		1987	1,228,658	43,864	5-40	43,864		1,157,092	34
35		Building Improvements		1988	1,055,957	44,586	10-20	44,586		978,005	35
36		Building Improvements		1989	5,888,073	273,214	5-25	273,214		5,136,220	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Building Improvements	1990	\$ 5,443,853	\$ 269,266	5-20	\$ 269,266	\$	\$ 4,385,633		37
38 Building Improvements	1991	2,702,153	134,790	10-20	134,790		2,052,528		38
39 Building Improvements	1992	2,395,628	119,127	2-20	119,127		1,735,120		39
40 Building Improvements	1993	1,601,815	79,040	2-20	79,040		1,074,763		40
41 Building Improvements	1994	2,933,038	146,652	20	146,652		1,836,199		41
42 Building Improvements	1995	4,858,946	242,947	20	242,947		2,600,834		42
43 Architecture Fees	1996	591,268	29,563	20	29,563		309,858		43
44 Home Health Remodeling	1996	39,853	1,993	20	1,993		21,335		44
45 Miscellaneous Improvements	1996	111,207	5,560	20	5,560		59,718		45
46 Surgery Remodeling	1996	25,040	1,252	20	1,252		12,983		46
47 South Wing Remodeling	1996	186,939	9,347	20	9,347		102,051		47
48 Same Day Surgery Remodeling	1996	30,902	1,545	20	1,545		15,862		48
49 West Wing Remodeling	1996	29,020	1,451	20	1,451		14,944		49
50 Emergency Water Main	1996	25,593	1,280	20	1,280		13,091		50
51 POB Improvements	1996	470,298	23,515	20	23,515		250,353		51
52 Ultrasound Remodeling	1996	2,052	103	20	103		1,103		52
53 Medical Staff Office Remodeling	1996	2,822	141	20	141		1,524		53
54 Elevator Repairs	1996	7,800	390	20	390		4,160		54
55 Cath Lab Remodeling	1996	595,784	29,789	20	29,789		304,869		55
56 HVAC Improvements	1996	1,220	61	20	61		615		56
57 Absorbtion Machine	1996	551,151	27,558	20	27,558		294,594		57
58 Co-Generation System	1996	1,524,624	76,231	20	76,231		822,718		58
59 Signage	1996	9,074	454	20	454		4,858		59
60 Hospital Entrance	1996	118,241	5,912	20	5,912		59,866		60
61 Architecture Fees	1997	249,954	12,498	20	12,498		118,821		61
62 Labor Room Remodeling	1997	17,902	895	20	895		8,217		62
63 Miscellaneous Improvements	1997	59,102	2,955	20	2,955		27,279		63
64 Physical I herapy Remodeling	1997	2,090	105	20	105		975		64
65 Audiology Remodeling	1997	637	32	20	32		305		65
66 Same Day Surgery Remodeling	1997	2,761	138	20	138		1,363		66
67 Roof Repairs	1997	698	35	20	35		338		67
68 Eye Center Relocation	1997	770	39	20	39		359		68
69 Surgery Remodeling	1997	54,139	2,707	20	2,707		26,477		69
70 TOTAL (lines 4 thru 69)		\$ 67,906,528	\$ 2,091,704		\$ 2,091,704	\$	\$ 55,450,397		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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 67,906,528	\$ 2,091,704		\$ 2,091,704	\$	\$ 55,450,397	1
2	Radiology Remodeling	1997	47,042	2,352	20	2,352		21,369	2
3	Emergency Room Remodeling	1997	12,863	643	20	643		5,848	3
4	South Wing Remodeling	1997	14,778	739	20	739		7,023	4
5	Data Processing Remodeling	1997	11,809	590	20	590		5,807	5
6	West Wing Remodeling	1997	8,210	411	20	411		3,901	6
7	Emergency Water Main	1997	2,900	145	20	145		1,402	7
8	POB Improvements	1997	39,906	1,995	20	1,995		19,301	8
9	Radiology Remodeling	1997	3,642	182	20	182		1,715	9
10	Retention Pond	1997	51,168	2,558	20	2,558		23,648	10
11	GI Lab Remodeling	1997	715	36	20	36		337	11
12	Cath Lab Remodeling	1997	29,968	1,498	20	1,498		14,793	12
13	CI Suite Remodeling	1997	1,230	62	20	62		584	13
14	Co-Generation System	1997	26,349	1,317	20	1,317		12,594	14
15	Signage	1997	2,703	135	20	135		1,248	15
16	Daycare Construction	1997	862,706	43,135	20	43,135		405,622	16
17	Hospital Entrance	1997	2,102,327	105,116	20	105,116		1,014,527	17
18	POB Addition	1997	245,437	12,272	20	12,272		116,369	18
19	Architecture Fees	1998	1,224,933	61,247	20	61,247		519,891	19
20	Labor Room Remodeling	1998	218,500	10,925	20	10,925		96,106	20
21	Miscellaneous Improvements	1998	45,301	2,265	20	2,265		19,555	21
22	Physical Therapy Remodeling	1998	205,829	10,291	20	10,291		84,084	22
23	Roof Repairs	1998	5,189	259	20	259		2,184	23
24	Eye Center Relocation	1998	741	37	20	37		302	24
25	Surgery Remodeling	1998	1,275	64	20	64		563	25
26	Emergency Room Remodeling	1998	2,680	134	20	134		1,206	26
27	Data Processing Remodeling	1998	6,781	339	20	339		2,882	27
28	West Wing Remodeling	1998	344,119	17,206	20	17,206		150,585	28
29	ICU Remodeling	1998	27,500	1,375	20	1,375		11,172	29
30	POB Improvements	1998	703,516	35,176	20	35,176		297,040	30
31	Radiology Remodeling	1998	161,977	8,099	20	8,099		72,536	31
32	Retention Pond	1998	8,952	448	20	448		3,988	32
33	Cath Lab Remodeling	1998	660	33	20	33		289	33
34	TOTAL (lines 1 thru 33)		\$ 74,328,232	\$ 2,412,789		\$ 2,412,789	\$	\$ 58,368,869	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 74,328,232	\$ 2,412,789		\$ 2,412,789	\$	\$ 58,368,869	1
2	CT Suite Remodeling	1998	104,817	5,241	20	5,241		44,544	2
3	HVAC Improvements	1998	370,425	18,521	20	18,521		158,850	3
4	Co-Generation System	1998	5,910	296	20	296		2,660	4
5	Signage	1998	52,972	2,649	20	2,649		21,682	5
6	Daycare Construction	1998	920,137	46,007	20	46,007		405,271	6
7	Hospital Entrance	1998	39,015	1,951	20	1,951		16,999	7
8	POB Addition	1998	3,375,598	168,780	20	168,780		1,458,215	8
9	Architecture Fees	1999	230,457	11,523	20	11,523		90,952	9
10	Miscellaneous Improvements	1999	2,397	120	20	120		897	10
11	Fire Alarm Improvements	1999	97,371	4,869	20	4,869		36,434	11
12	Radiology Remodeling	1999	2,703	135	20	135		1,001	12
13	Emergency Room Remodeling	1999	195,419	9,771	20	9,771		71,078	13
14	South Wing Remodeling	1999	93,107	4,655	20	4,655		34,801	14
15	Physical Therapy Remodeling	1999	446,529	22,326	20	22,326		174,459	15
16	West Wing Remodeling	1999	563,059	28,153	20	28,153		198,125	16
17	Warehouse Improvements	1999	7,126	356	20	356		2,713	17
18	POB Improvements	1999	825,022	41,251	20	41,251		315,218	18
19	POB Addition	1999	1,209,362	60,468	20	60,468		458,448	19
20	Integrated Medicine	1999	34,842	1,742	20	1,742		12,972	20
21	Back to Work Remodeling	1999	802	40	20	40		321	21
22	Cashier Area Remodeling	1999	3,902	195	20	195		1,496	22
23	Home Health Remodeling	1999	25,475	1,274	20	1,274		9,126	23
24	Lab Remodeling	1999	2,129	106	20	106		843	24
25	CT Suite Remodeling	1999	2,242	112	20	112		869	25
26	Pharmacy Remodeling	1999	1,152	58	20	58		426	26
27	HVAC Improvements	1999	4,460	223	20	223		1,735	27
28	Co-Generation System	1999	640	32	20	32		229	28
29	Signage	1999	8,479	424	20	424		3,237	29
30	Daycare Construction	1999	24,254	1,213	20	1,213		9,142	30
31	Hospital Entrance	1999	1,923	96	20	96		730	31
32	Architecture Fees	2000	5,461,410	273,071	20	273,071		1,661,700	32
33	Miscellaneous Improvements	2000	25,044	1,252	20	1,252		7,782	33
34	TOTAL (lines 1 thru 33)		\$ 88,466,412	\$ 3,119,698		\$ 3,119,698	\$	\$ 63,571,824	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 88,466,412	\$ 3,119,698		\$ 3,119,698	\$	\$ 63,571,824	1
2	Fire Alarm Improvements	2000	12,000	600	20	600		4,117	2
3	Labor Room Remodel	2000	900	45	20	45		289	3
4	Surgery Remodeling	2000	8,595	430	20	430		2,779	4
5	Radiology Remodeling	2000	6,504	325	20	325		2,165	5
6	Emergency Room Remodeling	2000	444,702	22,235	20	22,235		147,400	6
7	South Wing Remodeling	2000	172,378	8,619	20	8,619		53,512	7
8	Physical Therapy Remodeling	2000	10	0	20	0		3	8
9	West Wing Remodeling	2000	2,427	121	20	121		832	9
10	Warehouse Improvements	2000	9,357	468	20	468		3,197	10
11	POB Improvements	2000	415,372	20,769	20	20,769		139,470	11
12	Medical Staff Office Remodeling	2000	3,118	156	20	156		961	12
13	MRI Remodeling	2000	840	42	20	42		280	13
14	Architecture Fees	2001	3,333,020	166,651	20	166,651		851,215	14
15	Miscellaneous Improvements	2001	77,530	3,877	20	3,877		20,327	15
16	Fire Alarm Improvements	2001	7,871	394	20	394		2,329	16
17	Surgery Remodeling	2001	51,757	2,588	20	2,588		13,375	17
18	Radiology Remodeling	2001	25,457	1,273	20	1,273		6,579	18
19	Emergency Room Remodeling	2001	88,159	4,408	20	4,408		25,175	19
20	Physical Therapy Remodeling	2001	3,130	157	20	157		861	20
21	Adult Day Care Remodeling	2001	41,648	2,082	20	2,082		11,901	21
22	Coffee Shop	2001	78,411	3,921	20	3,921		20,172	22
23	PHO Project	2001	24,282	1,214	20	1,214		6,283	23
24	3 West Remodeling	2001	9,493	475	20	475		2,413	24
25	Home Health Remodeling	2001	35,700	1,785	20	1,785		9,371	25
26	POB Improvements	2001	297,944	14,897	20	14,897		78,339	26
27	West Wing Remodeling	2001	29,024	1,451	20	1,451		7,605	27
28	Pharmacy Remodeling	2001	23,294	1,165	20	1,165		5,989	28
29	Absorption Machine	2001	23,221	1,161	20	1,161		6,094	29
30	Medical Staff Office Remodeling	2001	360	18	20	18		96	30
31	South Wing Remodeling	2001	257,386	12,869	20	12,869		72,937	31
32	HVAC Improvements	2001	18,771	939	20	939		4,927	32
33	Hospital Entrance	2001	1,226	61	20	61		322	33
34	TOTAL (lines 1 thru 33)		\$ 93,970,295	\$ 3,394,893		\$ 3,394,893	\$	\$ 65,073,138	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 93,970,295	\$ 3,394,893		\$ 3,394,893	\$	\$ 65,073,138	1
2	Roof Repairs	2001	15,190	760	20	760		3,881	2
3	Cafeteria Remodeling	2001	29,986	1,499	20	1,499		7,812	3
4	Miscellaneous Improvements	2002	35,713	1,786	20	1,786		8,361	4
5	Main Lobby Remodeling	2002	11,636	582	20	582		2,861	5
6	Surgery Remodeling	2002	231,396	11,570	20	11,570		49,749	6
7	Coffe Shop Construction	2002	40,990	2,050	20	2,050		9,907	7
8	PHO Project	2002	50,071	2,504	20	2,504		11,931	8
9	3 West Remodeling	2002	3,223	161	20	161		669	9
10	Pharmacy Remodeling	2002	124,144	6,207	20	6,207		29,307	10
11	POB Improvements	2002	776,904	38,845	20	38,845		176,902	11
12	Emergency Generator Project	2002	455,695	22,805	20	22,805		93,546	12
13	West Wing Remodeling	2002	750,146	38,444	20	38,444		163,866	13
14	Lab Remodeling	2002	589	29	20	29		137	14
15	CI Suite Construction	2002	98,770	4,938	20	4,938		22,843	15
16	Medical Staff Office Remodeling	2002	188,519	9,558	20	9,558		40,701	16
17	South Wing Remodeling	2002	63,834	3,192	20	3,192		14,486	17
18	HVAC Improvements	2002	57,325	2,866	20	2,866		13,809	18
19	Hospital Entrance Construction	2002	562	28	20	28		119	19
20	Cath Lab Remodeling	2002	157,692	7,937	20	7,937		33,704	20
21	Cafeteria Remodeling	2002	24,618	1,231	20	1,231		6,155	21
22	Miscellaneous Improvements	2003	2,622	406	20	406		1,414	22
23	Surgery Remodeling	2003	261,619	13,112	20	13,112		23,428	23
24	POB Improvements	2003	194,747	12,162	20	12,162		43,274	24
25	Emergency Generator Project	2003	116,721	7,619	20	7,619		28,958	25
26	E/R Decon Room	2003	12,328	616	20	616		2,316	26
27	Stand By Generator	2003	65,400	3,270	20	3,270		10,678	27
28	MRI Remodeling	2003	112,180	5,609	20	5,609		18,938	28
29	Medical Staff Office Remodeling	2003	16,083	847	20	847		3,203	29
30	HVAC Improvements	2003	20,500	1,025	20	1,025		4,100	30
31	2 West Remodeling	2003	12,362	628	20	628		2,499	31
32	Cath Lab Remodeling	2003	801,506	40,456	20	40,456		149,979	32
33	Cysto Project	2004	2,224	111	20	111		222	33
34	TOTAL (lines 1 thru 33)		\$ 98,705,588	\$ 3,637,744		\$ 3,637,744	\$	\$ 66,052,890	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 98,705,588	\$ 3,637,744		\$ 3,637,744	\$	\$ 66,052,890	1
2	Surgery Remodeling	2004	2,096,819	104,841	20	104,841		149,618	2
3	Physical Therapy Remodeling	2004	2,894	233	20	233		661	3
4	Install Fire Connectors/Warehouse	2004	6,284	314	20	314		707	4
5	PHO Project	2004	800	40	20	40		83	5
6	Stand By Generator	2004	39,435	1,972	20	1,972		4,426	6
7	POB Improvements	2004	142,638	14,690	20	14,690		34,775	7
8	6 South Remodeling	2004	85,392	4,270	20	4,270		12,809	8
9	Pharmacy Remodeling	2004	9,561	478	20	478		1,112	9
10	Lobby Floor Improvements	2004	21,475	2,295	20	2,295		5,904	10
11	Radiology Remodeling	2004	80,041	4,002	20	4,002		9,089	11
12	Eye Center Remodeling	2004	880	44	20	44		110	12
13	Medical Records Remodeling	2004	5,502	275	20	275		665	13
14	Dietary Remodeling	2004	2,432	122	20	122		294	14
15	Energy Management Project	2004	67,666	3,924	20	3,924		8,554	15
16	Chem Pack Project Planning	2004	3,580	179	20	179		403	16
17	POB Improvements	2005	529,583	34,320	20	34,320		55,333	17
18	Cysto Project	2005	167,478	8,374	20	8,374		12,186	18
19	Hyperbaric Suite	2005	378,333	18,922	20	18,922		29,917	19
20	Surgery Bank Farm Project	2005	1,534	77	20	77		147	20
21	Geriatric Psych Unit Construction	2005	5,473	274	20	274		441	21
22	ICU Renovation	2005	1,800	90	20	90		148	22
23	Roofing Repairs	2005	10,065	970	20	970		1,937	23
24	Surgery Remodeling	2005	2,531,719	128,285	20	128,285		75,621	24
25	Eye Center Cabinet Replacement	2005	2,585	172	20	172		259	25
26	PHO Project	2005	190,477	9,535	20	9,535		16,307	26
27	Stand By Generator Repairs	2005	32,494	1,625	20	1,625		2,843	27
28	Pharmacy Remodeling	2005	83,840	4,192	20	4,192		7,253	28
29	Radiology Remodeling	2005	7,179	359	20	359		688	29
30	Dietary Remodeling	2005	600	30	20	30		50	30
31	Energy Management Project	2005	127,648	8,324	20	8,324		15,098	31
32	Plumbing Repairs	2005	19,930	915	20	915		1,636	32
33	Signs	2005	618	62	20	62		82	33
34	TOTAL (lines 1 thru 33)		\$ 105,362,343	\$ 3,991,947		\$ 3,991,947	\$	\$ 66,502,045	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 105,362,343	\$ 3,991,947		\$ 3,991,947	\$	\$ 66,502,045	1
2	Wallpapering	2005	7,313	1,463	20	1,463		1,706	2
3	Geriatric Psych Construction	2006	361,414	2,798	20	2,798		2,798	3
4	ICU Renovation	2006	1,552	52	20	52		52	4
5	POB Improvements	2006	206,949	11,532	20	11,532		11,532	5
6	Surgery Improvements	2006	955,217	26,424	20	26,424		26,424	6
7	Radiology Remodeling	2006	4,630	309	20	309		309	7
8	Warehouse Improvements	2006	31,076	1,554	20	1,554		1,554	8
9	Energy Management	2006	43,035	473	20	473		473	9
10	Co-Generation System	2006	3,137	118	20	118		118	10
11	HVAC Improvements	2006	7,095	266	20	266		266	11
12	Cath Lab Remodeling	2006	35,291	169	20	169		169	12
13	Window Replacement	2006	3,120	286	20	286		286	13
14	Cateteria Remodeling	2006	40	1	20	1		1	14
15	Daycare Carpeting	2006	4,361	401	20	401		401	15
16	Land Improvements	1976	4,301	-	15-20			4,301	16
17	Land Improvements	1977	198,253		10-15			198,253	17
18	Land Improvements	1978	27,586		10-15			27,586	18
19	Land Improvements	1979	55,686		12-15			55,686	19
20	Land Improvements	1980	12,600		5			12,600	20
21	Land Improvements	1982	42,796		10-12			42,796	21
22	Land Improvements	1983	17,983		10-12			17,983	22
23	Land Improvements	1984	57,682		10-12			57,682	23
24	Land Improvements	1985	1,669,559		10-15			1,669,559	24
25	Land Improvements	1986	668,352	273	5-25	273		667,068	25
26	Land Improvements	1987	421,090	1,877	5-25	1,877		410,454	26
27	Land Improvements	1988	55,285	1,966	10-25	1,966		47,942	27
28	Land Improvements	1989	85,543		2-15			85,543	28
29	Land Improvements	1990	76,987		10			76,987	29
30	Land Improvements	1991	21,910		10			21,910	30
31	Land Improvements	1992	99,765	2,696	10-25	2,696		84,277	31
32	Land Improvements	1993	155,563	2,439	10-20	2,439		149,006	32
33	Land Improvements	1994	18,654	523	10-12	523		18,654	33
34	TOTAL (lines 1 thru 33)		\$ 110,716,168	\$ 4,047,564		\$ 4,047,564	\$	\$ 70,196,417	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:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 110,716,168	\$ 4,047,564		\$ 4,047,564	\$	\$ 70,196,417	1
2	Land Improvements	1995	125,207	7,464	2-20	7,464		99,203	2
3	Land Improvements	1996	60,293	2,457	5-20	2,457		39,019	3
4	Land Improvements	1997	26,467	2,450	10-20	2,450		22,745	4
5	Land Improvements	1998	281,717	24,145	10-20	24,145		202,366	5
6	Land Improvements	1999	113,685	10,106	10-20	10,106		76,687	6
7	Land Improvements	2000	108,414	10,592	10-20	10,592		67,948	7
8	Land Improvements	2001	64,570	3,229	10-20	3,229		17,488	8
9	Land Improvements	2002	9,170	459	10-20	459		1,987	9
10	Land Improvements	2004	221,698	27,696	10-21	27,696		66,848	10
11	Land Improvements	2005	150,540	18,414	15	18,414		27,638	11
12	Land Improvements	2006	3,797	169	15	169		169	12
13									13
14									14
15									15
16									16
17	Amount Not Allocated to Extended Care Unit		(104,844,365)	(3,893,411)		(3,893,411)		(66,364,029)	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,037,360	\$ 261,333		\$ 261,333	\$	\$ 4,454,485	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: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 42,714	\$ 299	\$ 299	\$ (0)	3-15	\$ 28,634	71
72	Current Year Purchases	899	150	150	0	3	150	72
73	Fully Depreciated Assets	40,014					40,014	73
74								74
75	TOTALS	\$ 83,627	\$ 449	\$ 449	\$ 0		\$ 68,798	75

D. Vehicle Depreciation (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)	\$ 7,182,923	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,782	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 261,782	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,523,283	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital

8008518

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (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	\$ 7,534,650	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,714,164</u>)	13,783,332		3
4	Supply Inventory (priced at <u>cost</u>)	2,384,468		4
5	Short-Term Investments	23,597,474		5
6	Prepaid Insurance	4,242,464		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Affiliates</u>	5,136,216		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 56,678,604	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	101,980,591		12
13	Land	4,293,071		13
14	Buildings, at Historical Cost	111,881,725		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	43,386,227		16
17	Accumulated Depreciation (book methods)	(102,732,658)		17
18	Deferred Charges	8,211,382		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 <u>Inv in PHO/Other</u>)	401,445		22
23	Other(specify): <u>Self Insurance</u>	1,299,286		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 168,721,069	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 225,399,673	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,212,940	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,079,358		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	<u>Accr Exp/Bond Payable</u>	3,290,231		36
37	<u>Third Party Settlements</u>	14,003,316		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 29,585,845	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	101,191		39
40	Mortgage Payable			40
41	Bonds Payable	56,431,371		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Reserve for Self Insurance</u>	5,785,200		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 62,317,762	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 91,903,607	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 133,496,066	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 225,399,673	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 128,818,687	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 128,818,687	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,276,910	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) Increase in Market Value	400,469	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,677,379	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)	\$ 133,496,066	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: 01/01/2006Ending: 12/31/2006**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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 563,026,223	1
2	Discounts and Allowances for all Levels	(440,359,547)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 122,666,676	3
B. Ancillary Revenue			
4	Day Care	523,619	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 523,619	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	49,888	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	335,492	14
15	Telephone, Television and Radio	11,075	15
16	Rental of Facility Space	329,533	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,777,991	19
20	Radiology and X-Ray	4,517	20
21	Other Medical Services	32,339	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,540,835	23
D. Non-Operating Revenue			
24	Contributions	376,339	24
25	Interest and Other Investment Income***	7,241,772	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,618,111	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Operating Revenue	(88,540)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (88,540)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 134,260,700	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	129,983,790	31
32	Health Care		32
33	General Administration		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			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 129,983,790	40
41	Income before Income Taxes (line 30 minus line 40)**	4,276,910	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,276,910	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Gottlieb Memorial Hospital

8008518

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$ 96,399	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,950	33,209	1,070,362	32.23	3
4	Licensed Practical Nurses	5,660	6,516	138,504	21.26	4
5	CNAs & Orderlies	25,753	28,514	337,085	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,785	2,061	34,904	16.94	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	2,035	2,248	53,955	24.00	22
23	Office Manager					23
24	Clerical	4,578	4,994	64,657	12.95	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)	68,761	77,542	\$ 1,795,866 *	\$ 23.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	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	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	69	\$ 4,823		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	69	\$ 4,823		53

Facility Name & ID Number Gottlieb Memorial Hospital**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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. _____
- (9) Are you presently operating under a sublease agreement? No YES _____ 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. \$ 0
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? 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. \$ 9,310 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst and Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this time
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.