



Facility Name & ID Number Gottlieb Memorial Hospital

# 8008518 Report Period Beginning: July 1, 2014 Ending: June 30, 2015

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 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	101	26	9,599	9,726	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	101	26	9,599	9,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.37%

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 5/20/1985

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 9,114

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary		6,833		6,833		6,833	454,717	461,550		1
2	Food Purchase							159,766	159,766		2
3	Housekeeping							295,075	295,075		3
4	Laundry							51	51		4
5	Heat and Other Utilities							402,951	402,951		5
6	Maintenance		1,005	82	1,087		1,087	1,362	2,449		6
7	Other (specify):*							16,570	16,570		7
8	<b>TOTAL General Services</b>		7,838	82	7,920		7,920	1,330,492	1,338,412		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,848,176	123,900	679,272	2,651,348		2,651,348	255,036	2,906,384		10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,848,176	123,900	679,272	2,651,348		2,651,348	255,036	2,906,384		16
	<b>C. General Administration</b>										
17	Administrative	93,242			93,242		93,242	740,907	834,149		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	135,290	11,175	124	146,589		146,589		146,589		21
22	Employee Benefits & Payroll Taxes							553,829	553,829		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	228,532	11,175	124	239,831		239,831	1,294,736	1,534,567		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,076,708	142,913	679,478	2,899,099		2,899,099	2,880,264	5,779,363		29

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							339,912	339,912			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):*			18,375	18,375		18,375		18,375			36
37	<b>TOTAL Ownership</b>			18,375	18,375		18,375	339,912	358,287			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							36,520	36,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							18,615	18,615			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>							55,135	55,135			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,076,708	142,913	697,853	2,917,474		2,917,474	3,275,311	6,192,785			45

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

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	3,275,311			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 3,275,311		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 3,275,311		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Gottlieb Memorial HospitalID# 8008518Report Period Beginning: July 1, 2014Ending: June 30, 2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Hospital WS B Overhead Cost Alloc.-Dietary	\$ 454,717	1	1
2	Hospital WS B Overhead Cost Alloc.-Food Purch	159,766	2	2
3	Hospital WS B Overhead Cost Alloc.-Housekping	295,075	3	3
4	Hospital WS B Overhead Cost Alloc.-Laundry	51	4	4
5	Hospital WS B OH Cost Alloc.-Utilities (Plant)	402,951	5	5
6	Hospital WS B OH Cost Alloc.-Maintenance	1,362	6	6
7	Hospital WS B OH Cost Alloc.-Cafeteria	67,790	22	7
8	Hospital WS B OH Cost Alloc.-Nursing Admin	203,335	10	8
9	Hospital WS B OH Cost Alloc.-Central Supply	35,542	10	9
10	Hospital WS B OH Cost Alloc.-Pharmacy	16,159	10	10
11	Hospital WS B OH Cost Alloc.-Administration	740,907	17	11
12	Hospital WS B OH Cost Alloc.-Employee Bene.	486,039	22	12
13	Hospital WS B OH Cost Alloc.-Depreciation	339,912	30	13
14	LTC Cost in Hosp Adm for Provider Partici. Fees	18,615	42	14
15	Hospital WS A-6 Reclash of Pt Transport Cost	16,570	7	15
16	TCU Calculated Ancillary Services Cost	36,520	39	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	<b>Total</b>	3,275,311		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2014

Ending:

June 30, 2015

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	454,717	0	0	0	0	0	0	0	0	0	0	454,717	1
2	Food Purchase	159,766	0	0	0	0	0	0	0	0	0	0	159,766	2
3	Housekeeping	295,075	0	0	0	0	0	0	0	0	0	0	295,075	3
4	Laundry	51	0	0	0	0	0	0	0	0	0	0	51	4
5	Heat and Other Utilities	402,951	0	0	0	0	0	0	0	0	0	0	402,951	5
6	Maintenance	1,362	0	0	0	0	0	0	0	0	0	0	1,362	6
7	Other (specify):*	16,570	0	0	0	0	0	0	0	0	0	0	16,570	7
8	<b>TOTAL General Services</b>	<b>1,330,492</b>	<b>0</b>	<b>1,330,492</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	255,036	0	0	0	0	0	0	0	0	0	0	255,036	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	<b>TOTAL Health Care and Programs</b>	<b>255,036</b>	<b>0</b>	<b>255,036</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	740,907	0	0	0	0	0	0	0	0	0	0	740,907	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	553,829	0	0	0	0	0	0	0	0	0	0	553,829	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	<b>TOTAL General Administration</b>	<b>1,294,736</b>	<b>0</b>	<b>1,294,736</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>2,880,264</b>	<b>0</b>	<b>2,880,264</b>	<b>29</b>									

STATE OF ILLINOIS

Facility Name & ID Number Gottlieb Memorial Hospital

# 8008518

Report Period Beginning:

July 1, 2014 Ending:

Summary B

June 30, 2015

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	339,912	0	0	0	0	0	0	0	0	0	0	339,912	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	<b>TOTAL Ownership</b>	<b>339,912</b>	<b>0</b>	<b>339,912</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	36,520	0	0	0	0	0	0	0	0	0	0	36,520	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	18,615	0	0	0	0	0	0	0	0	0	0	18,615	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>55,135</b>	<b>0</b>	<b>55,135</b>	<b>44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>3,275,311</b>	<b>0</b>	<b>3,275,311</b>	<b>45</b>									

**VII. RELATED PARTIES**

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

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

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

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

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

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

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

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: July 1, 2014 Ending: ne 30, 2015

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	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
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Gottlieb Memorial Hospital

# 8008518

Report Period Beginning:

July 1, 2014 Ending:

June 30, 2015

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

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2014 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 2015 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____	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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT Silia Miglio

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		<b>TOTALS</b>	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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	Hospital & Parking	1,458,000	1961	\$ 61,937	1
2					2
3	TOTALS	1,458,000		\$ 61,937	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	34		1961	\$	\$	50	\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Various		1962	5,314					5,314
10	Various		1963	57,578					57,578
11	Various		1964	154					154
12	Various		1965	839,469					839,469
13	Various		1966	18,069					18,069
14	Various		1967	99,677					99,677
15	Various		1969	243,126					243,126
16	Various		1970	10,866					10,866
17	Various		1971	410,569					410,569
18	Various		1972	63,023					63,023
19	Various		1973	36,443					36,443
20	Various		1974	70,028					70,028
21	Various		1975	2,422					2,422
22	Various		1976	3,446,023					3,446,023
23	Various		1977	7,474,834					7,474,834
24	Various		1978	172,682					172,682
25	Various		1979	159,159	362			(362)	159,159
26	Various		1980	729,897					729,897
27	Various		1981	1,633,608					1,633,608
28	Various		1982	4,159,391					4,159,391
29	Various		1983	3,028,019					3,028,019
30	Various		1984	245,719					245,719
31	Various		1985	7,212,994	104,859			(104,859)	6,689,147
32	Various		1986	2,251,370					2,251,370
33	Various		1987	1,228,658					1,228,658
34	Various		1988	1,055,957					1,055,957
35									
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

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	Various	1989	\$ 5,888,073	\$		\$	\$	\$ 5,888,073	37
38	Various	1990	5,443,853					5,443,853	38
39	Various	1991	2,702,153					2,702,153	39
40	Various	1992	2,395,628					2,390,318	40
41	Various	1993	1,601,815					1,509,482	41
42	Various	1994	2,933,038					3,082,741	42
43	Various	1995	4,858,946	193,059		193,059		4,858,946	43
44	Various	1996	4,322,888	191,157		191,157		4,322,888	44
45	Various	1997	3,851,805	283,697		283,697		3,556,321	45
46	Various	1998	7,826,827	586,151		586,151		7,065,787	46
47	Various	1999	3,782,851	283,714		283,714		3,316,680	47
48	Various	2000	6,562,656	492,199		492,199		5,273,672	48
49	Various	2001	4,472,858	335,464		335,464		3,576,427	49
50	Various	2002	3,071,826	232,098		232,098		2,226,370	50
51	Various	2003	1,616,067	128,016		128,016		1,143,432	51
52	Various	2004	2,567,622	203,241		203,241		1,596,993	52
53	Various	2005	4,098,669	324,788		324,788		2,392,510	53
54	Various	2006	1,656,917	66,572		66,572		488,194	54
55	Various	2007	1,091,422	40,123		40,123		287,881	55
56	Various	2008	392,789	21,427		21,427		137,993	56
57	Various	2009	3,415,801	121,618		121,618		772,138	57
58	Various	2011	274,704	22,176		22,176		93,587	58
59									59
60	RIVER FOREST CONSTRUCTION 12/1	2012	431,303	21,565	20	21,565		86,261	60
61	DOCTOR'S LOUNGE PROJECT - CONS	2012	67,009	3,350	20	3,350		13,402	61
62	POB HALLWAYS - FLOORING 1/12	2012	65,642	6,564	10	6,564		26,257	62
63	RIVER FOREST - ELECTRIC 11/11-	2012	34,819	1,741	20	1,741		6,964	63
64	SUITE 416 PROJECT - CONSTRUCTI	2012	33,076	1,654	20	1,654		6,615	64
65	POB HALLWAYS - CONSTRUCTION 1/	2012	24,429	1,221	20	1,221		4,886	65
66	POB HALLWAYS - WALLPAPER 1/12	2012	12,420	2,484	5	2,484		9,936	66
67	POB HALLWAYS - ELECTRIC 1/12	2012	11,790	589	20	589		2,358	67
68	<b>POB HALLWAYS - WALLPAPER 1/12</b>	2012	11,417	2,283	5	2,283		9,134	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 110,176,162	\$ 3,672,174		\$ 3,566,953	\$ (105,221)	\$ 96,423,453	70

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

Facility Name & ID Number Gottlieb Memorial Hospital**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 110,176,162	\$ 3,672,174		\$ 3,566,953	\$ (105,221)	\$ 96,423,453	1
2	POB MISC PROJECTS - STE 414 -	2012	8,823	1,765	5	1,765		7,058	2
3	POB HALLWAYS - CARPET 1/12	2012	7,965	1,593	5	1,593		6,372	3
4	MISC PROJECTS - O/P REHAB - CA	2012	7,301	1,460	5	1,460		5,841	4
5	LAB PROJECT - CONSTRUCTION 1/1	2012	2,735	137	20	137		547	5
6	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,072	104	20	104		414	6
7	DOCTOR'S LOUNGE PROJECT - CONS	2012	2,070	104	20	104		414	7
8	DOCTOR'S LOUNGE PROJECT - HEAT	2012	695	46	15	46		185	8
9	RIVER FOREST - ELECTRIC 11/11- (ADJ)	2012	(1,537)	(77)	20	(77)		(307)	9
10	ASPHALT PROJECT	2012	146,845	18,356	8	18,356		73,423	10
11	BARIATRIC PROJECT - LANDSCAPIN	2012	4,825	483	10	483		1,930	11
12	RIVER FOREST - CONSTRUCTION 2/	2012	593,385	29,669	20	29,669		116,205	12
13	POB HALLWAYS PROJECT - WALLPAP	2012	2,055	411	5	411		1,610	13
14	ELECTRONIC LEAD SIGN 2/12	2012	42,941	4,294	10	4,294		16,819	14
15	BARIATRIC OFFICE PROJECT - CON	2012	77,320	3,866	20	3,866		14,820	15
16	AIR HANDLER PROJECT - ENGINEER	2012	35,230	2,349	15	2,349		9,003	16
17	RIVER FOREST - CONSTRUCTION 3/	2012	5,470	274	20	274		1,048	17
18	RIVER FOREST - ELECTRIC 3/12	2012	4,177	209	20	209		801	18
19	BARIATRIC PROJECT - ARCHITECTU	2012	4,098	205	20	205		785	19
20	BARIATRIC OFFICE PROJECT - ARC	2012	2,958	148	20	148		567	20
21	<b>BARIATRIC PROJECT - ARCHITECTU</b>	2012	27	1	20	1		5	21
22	RIVER FOREST MEDICAL PROJECT-E	2012	7,920	396	20	396		1,485	22
23	FLOORING	2012	3,850	385	10	385		1,444	23
24	BARIATRIC OFFICE PROJECT - CON	2012	102,212	5,111	20	5,111		18,739	24
25	MISC PROJECTS - HOME HEALTH -	2012	11,410	2,282	5	2,282		8,367	25
26	PLUMBING	2012	1,810	91	20	91		332	26
27	BARIATRIC OFFICE PROJECT - ARC	2012	870	44	20	44		160	27
28	TURF	2012	3,996	799	5	799		2,930	28
29	CHILLER PLANT UPGRADE - CONSTR	2012	417,631	20,882	20	20,882		74,826	29
30	ELECTRICAL FEED UPGRADE - CONS	2012	284,386	14,219	20	14,219		50,952	30
31	CHILLER PLANT UPGRADE - CONSTR	2012	274,632	13,732	20	13,732		49,205	31
32	AIR HANDLER PROJECT - CONSTRUC	2012	249,380	12,469	20	12,469		44,681	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 112,483,713	\$ 3,807,977		\$ 3,702,756	\$ (105,221)	\$ 96,934,112	34

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

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12B, Carried Forward</b>		\$ 112,483,713	\$ 3,807,977		\$ 3,702,756	\$ (105,221)	\$ 96,934,112	1
2	CHILLER PLANT UPGRADE - CONSTR	2012	214,979	10,749	20	10,749		38,517	2
3	CHILLER	2012	191,970	12,798	15	12,798		45,860	3
4	AIR HANDLER PROJECT - CONSTRU	2012	127,960	6,398	20	6,398		22,926	4
5	CHILLER PLANT UPGRADE - CONSTR	2012	99,932	4,997	20	4,997		17,904	5
6	CHILLER PLANT UPGRADE - ENGINE	2012	96,156	4,808	20	4,808		17,228	6
7	AIR HANDLER PROJECT - INSULATI	2012	80,000	4,000	20	4,000		14,333	7
8	CHILLER PLANT UPGRADE - ENGINE	2012	53,034	2,652	20	2,652		9,502	8
9	AIR HANDLER PROJECT - CONSTRU	2012	47,235	2,362	20	2,362		8,463	9
10	AIR HANDLER PROJECT - ENGINEER	2012	29,017	1,451	20	1,451		5,199	10
11	CHILLER PLANT UPGRADE - ENGINE	2012	22,413	1,121	20	1,121		4,016	11
12	AIR HANDLER PROJECT - ENGINEER	2012	22,355	1,118	20	1,118		4,005	12
13	ELECTRICAL FEED UPGRADE - ENGI	2012	12,380	619	20	619		2,218	13
14	CHILLER PLANT PROJECT - ENGINE	2012	12,173	609	20	609		2,181	14
15	AIR HANDLER PROJECT - PLAN REV	2012	9,600	640	15	640		2,293	15
16	CHILLER PLANT UPGRADE - ENGINE	2012	9,500	475	20	475		1,702	16
17	CHILLER PLANT UPGRADE - DEMOLI	2012	7,500	500	15	500		1,792	17
18	CHILLER PLANT UPGRADE - ENGINE	2012	6,180	309	20	309		1,107	18
19	CHILLER PLANT UPGRADE - DOCK P	2012	4,890	245	20	245		876	19
20	CHILLER PLANT UPGRADE - ELECTR	2012	4,850	243	20	243		869	20
21	AIR HANDLER PROJECT - DUCTS 6/	2012	3,640	182	20	182		652	21
22	NEW LAB FOR E.R. - PLUMBING 5/	2012	3,500	175	20	175		627	22
23	ELECTRICAL FEED UPGRADE - PAIN	2012	2,220	444	5	444		1,591	23
24	ELECTRICAL FEED UPGRADE - ELEC	2012	2,200	110	20	110		394	24
25	NEW LAB FOR E.R.-ELECTRIC	2012	2,197	110	20	110		394	25
26	ELECTRICAL FEED UPGRADE - ELEC	2012	1,670	84	20	84		299	26
27	AIR HANDLER PROJECT - BLINDS 3	2012	1,436	287	5	287		1,029	27
28	ON SITE WITNESS TO COMED SHUTD	2012	1,385	277	5	277		993	28
29	NEW LAB FOR E.R. - WALLPAPER/	2012	720	144	5	144		516	29
30	EXTERNAL SIGNAGE	2012	81,052	8,105	10	8,105		29,044	30
31	PARKING LOT REJUVENATOR	2012	45,674	5,709	8	5,709		19,982	31
32	AIR HANDLER PROJECT - CONSTRU	2012	1,359,117	67,956	20	67,956		237,845	32
33	RADIOLOGY RENOVATION - CONSTRU	2012	239,900	11,995	20	11,995		41,983	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 115,280,548	\$ 3,959,646		\$ 3,854,425	\$ (105,221)	\$ 97,470,452	34

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

Facility Name & ID Number Gottlieb Memorial Hospital**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12C, Carried Forward</b>		\$ 115,280,548	\$ 3,959,646		\$ 3,854,425	\$ (105,221)	\$ 97,470,452	1
2	GI LAB WAITING ROOM PROJECT -	2012	199,651	9,983	20	9,983		34,939	2
3	CHILLER PLANT UPGRADE-CONSTRUC	2012	163,437	8,172	20	8,172		28,601	3
4	SUITE 201/202 REHAB - CONSTRUC	2012	135,242	6,762	20	6,762		23,667	4
5	STE 201/202 REHAB - CONSTRUCTI	2012	107,999	5,400	20	5,400		18,900	5
6	ELECTRIC FEED UPGRADE - CONSTR	2012	54,580	2,729	20	2,729		9,552	6
7	AIR HANDLER PROJECT - ENGINEER	2012	42,945	2,147	20	2,147		7,515	7
8	AIR HANDLER PROJECT-GLOSSTEK F	2012	12,100	2,420	5	2,420		8,470	8
9	CHILLER PLANT UPGRADE-ENGINEER	2012	8,459	423	20	423		1,480	9
10	AIR HANDLER PROJECT - CARPET 7	2012	4,140	828	5	828		2,898	10
11	GI LAB WAITING ROOM - ARCHITEC	2012	1,500	75	20	75		263	11
12	ELECTRIC FEED UPGRADE - ELECTR	2012	1,110	56	20	56		194	12
13	ELECTRIC FEED UPGRADE - ENGINE	2012	580	29	20	29		101	13
14	XRAY ROOM #2 - CONSTRUCTION 7/	2012	231,000	11,550	20	11,550		39,463	14
15	SLEEP STUDY RENOVATION - CONST	2012	43,046	2,152	20	2,152		6,995	15
16	MCC PROJECT - ELECTRIC	2012	37,839	1,892	20	1,892		6,149	16
17	HW TANK SOUTH WING	2013	86,900	7,966	10	7,966		23,898	17
18	NEW CHILLER	2013	53,149	3,248	15	3,248		9,744	18
19	HW TANK SOUTH WING	2013	16,900	1,549	10	1,549		4,648	19
20	ENGINEERING FEES FOR NEW CHILL	2013	14,400	880	15	880		2,640	20
21	BTU BOILER	2013	8,850	406	20	406		1,217	21
22	ENGINEERING FEES FOR NEW CHILL	2013	134	8	15	8		25	22
23	LIFE SAFETY UPGRADES	2013	14,592	2,432	5	2,432		7,296	23
24	HOT WATER TANK SOUTH WING	2013	6,782	565	10	565		1,696	24
25	LIFE SAFETY UPGRADES	2013	4,973	829	5	829		2,487	25
26	NEW CHILLER - CONSTRUCTION	2013	413,944	20,697	15	20,697		62,092	26
27	NEW CHILLER - CONSTRUCTION	2013	139,452	6,973	15	6,973		20,918	27
28	LIFE SAFETY UPGRADES	2013	9,665	1,450	5	1,450		4,349	28
29	LIFE SAFETY UPGRADES	2013	6,143	921	5	921		2,764	29
30	NEW CHILLER - ENGINEERING	2013	3,600	180	15	180		540	30
31	NEW CHILLER - ENGINEERING	2013	2,350	118	15	118		353	31
32	NEW CHILLER - ASBESTOS INSPECT	2013	1,900	95	15	95		285	32
33	NEW CHILLER	2013	205,750	9,144	15	9,144		27,433	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 117,313,661	\$ 4,071,724		\$ 3,966,503	\$ (105,221)	\$ 97,832,022	34

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

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12D, Carried Forward</b>		\$ 117,313,661	\$ 4,071,724		\$ 3,966,503	\$ (105,221)	\$ 97,832,022	1
2	SUITE 312 RENOVATION - CONSTRU	2013	137,075	4,569	20	4,569		9,138	2
3	NEW CHILLER	2013	6,170	274	15	274		548	3
4	CHILLER	2013	4,700	209	15	209		418	4
5	LIFE SAFETY UPGRADES - LOEBL -	2013	544	73	5	73		146	5
6	STORAGE GARAGE	2013	43,800	1,022	25	1,022		2,044	6
7	X-RAY UNIT - TOMOGRAPHY	2014	5,500	786	7	786		786	7
8	4 CHANNEL BREAST ARRAY MRI COI	2014	35,754	5,108	7	5,108		5,108	8
9	TIS - LAWSON	2014	82,621	11,803	7	11,803		11,803	9
10	TIS - RIVER FOREST EPIC	2014	1,388	198	7	198		198	10
11	TIS - EPIC	2014	249,434	35,633	7	35,633		35,633	11
12	TIS - EPIC EMPLOYED PHYSICIANS	2014	1,955	279	7	279		279	12
13	TIS - EPIC CLIN/REV IMPLEMENTA	2014	177,473	25,353	7	25,353		25,353	13
14	TIS - PEOPLESFT FMS IMPLEMENT	2014	13,598	1,943	7	1,943		1,943	14
15	TIS - PEOPLESFT OPERATING IMP	2014	835	119	7	119		119	15
16	TIS - LAWSON/KRONOS IMPLEM - O	2014	366	52	7	52		52	16
17	MIRA PORTABLE X-RAY UNITS	2014	325,000	46,429	7	46,429		46,429	17
18	IV CART	2014	30,748	3,075	10	3,075		3,075	18
19	X-RAY UNIT TOMOGRAPHY	2014	30,450	4,350	7	4,350		4,350	19
20	RAIS ABBOTT ISTAT	2014	9,140	1,828	5	1,828		1,828	20
21	CART WASHER	2014	4,650	465	10	465		465	21
22	NEOWARES - HP	2014	4,830	966	5	966		966	22
23	X-RAY UNIT TOMOGRAPHY	2014	248,671	35,524	7	35,524		35,524	23
24	X-RAY UNIT TOMOGRAPHY	2014	320,000	45,714	7	45,714		45,714	24
25	NEW CHILLER	2014	94,986	6,332	15	6,332		6,332	25
26	AUDIOMETER	2014	10,934	1,093	10	1,093		1,093	26
27	PRINTER XEROX 5330	2014	8,720	1,744	5	1,744		1,744	27
28	LAB LABEL PRINTER	2014	750	150	5	150		150	28
29	20% DOWN ON ENTERPRISE LEVEL S	2014	1,825	365	5	365		365	29
30	CART WASHER	2014	129,824	12,982	10	12,982		12,982	30
31	INFANT/PATIENT SECURITY SYSTEM	2014	39,147	3,915	10	3,915		3,915	31
32	INFANT/PATIENT SECURITY SYSTEM	2014	1,416	142	10	142		142	32
33	LIFE SAFETY UPGRADES - ARCHITE	2014	3,029	151	20	151		151	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 119,338,993	\$ 4,324,372		\$ 4,219,151	\$ (105,221)	\$ 98,090,818	34

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

Facility Name & ID Number Gottlieb Memorial Hospital

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>Totals from Page 12E, Carried Forward</b>		\$ 119,338,993	\$ 4,324,372		\$ 4,219,151	\$ (105,221)	\$ 98,090,818	1
2	Renovation 5 South	2015	70,225	4,682	15	4,682		2,141	2
3	Marj Weinberg Cancer CtrRen construction	2015	279,055	18,604	15	18,604		7,255	3
4	6 South Renovation	2015	886,131	59,075	15	59,075		25,662	4
5	AIR HANDLER REPLACE S6 & 7	2015	1,249,951	62,498	20	62,498		2,610	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	Reconcile to TCU current year depr expense as allocated			(4,129,318)		(4,024,097)	105,221		33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 121,824,354	\$ 339,912		\$ 339,912	\$ 0	\$ 98,128,485	34

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

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	\$ See	\$	\$	\$		\$	71
72	Current Year Purchases	Previous						72
73	Fully Depreciated Assets	Schedule						73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 121,886,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 339,912	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 339,912	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)	\$ 98,128,485	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	N/A	\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_

Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

**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 checked="" 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	N/A	hrs	\$				\$		\$							1
2	Licensed Speech and Language Development Therapist		hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist		hrs														4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy		# of prescrpts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):																13
14	<b>TOTAL</b>			\$				\$		\$							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# 8008518Report Period Beginning: July 1, 2014Ending: June 30, 2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2015 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,482,026	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1,264,480</u> )	17,408,675		3
4	Supply Inventory (priced at )	3,176,000		4
5	Short-Term Investments	15,133,519		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	548,199		7
8	Accounts Receivable (owners or related parties)	48,332,247		8
9	Other(specify):	11,237,326		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 100,317,992	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	78,822,238		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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 (specify):			22
23	Other(specify):	3,930,071		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 82,752,309	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 183,070,301	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 40,743,188	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,062,909		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payable to Third Party</u>	9,589,236		36
37	<u>Accrued Taxes, Security Deposit</u>	372,264		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 56,767,597	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Self Ins Reserve</u>			43
44	<u>Accrued Pension and Other</u>	46,825,182		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 46,825,182	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 103,592,779	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 79,477,522	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 183,070,301	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>82,084,302</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>82,084,302</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(3,190,927)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Other Interco Transfers</b>	584,147	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (2,606,780)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>79,477,522</b>	<b>24</b> *

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

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: July 1, 2014Ending: June 30, 2015

**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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 511,370,235		1
2	Discounts and Allowances for all Levels	(405,007,077)		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 106,363,158		3
<b>B. Ancillary Revenue</b>				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$		8
<b>C. Other Operating Revenue</b>				
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$		23
<b>D. Non-Operating Revenue</b>				
24	Contributions			24
25	Interest and Other Investment Income***			25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$		26
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>			27
28	<b>Other Hospital Revenues</b>	13,735,529		28
28a				28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,735,529		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 120,098,687		30

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	7,920		31
32	Health Care	2,651,348		32
33	General Administration	239,831		33
<b>B. Capital Expense</b>				
34	Ownership	18,375		34
<b>C. Ancillary Expense</b>				
35	Special Cost Centers			35
36	Provider Participation Fee			36
<b>D. Other Expenses (specify):</b>				
37	<b>Other Hospital Expenses not Allocated to TCU / LTC</b>	120,372,140		37
38				38
39				39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 123,289,614		40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(3,190,927)		41
42	<b>Income Taxes</b>			42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (3,190,927)		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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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 Gottlieb Memorial Hospital

# 8008518

Report Period Beginning: July 1, 2014

Ending: June 30, 2015

**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	1,375	1,670	\$ 99,323	\$ 59.48	1
2	Assistant Director of Nursing	2,063	2,391	91,050	38.09	2
3	Registered Nurses	29,915	35,070	1,200,603	34.23	3
4	Licensed Practical Nurses	4,371	5,037	108,804	21.60	4
5	CNAs & Orderlies	20,201	23,412	308,694	13.19	5
6	CNA Trainees					6
7	Licensed Therapist	1,904	2,006	38,674	19.28	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,427	1,652	21,249	12.86	10
11	Social Service Workers	2,182	2,557	62,392	24.40	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	5,537	6,381	145,919	22.87	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)	68,974	80,175	\$ 2,076,708 *	\$ 25.90	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	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: July 1, 2014 Ending: June 30, 2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 18,615  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Deloitte
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.