

Facility Name & ID Number Graham Hospital

8000200 Report Period Beginning: 07/01/14 Ending: 06/30/15

III. STATISTICAL DATA

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

	1	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	38	Skilled (SNF)	38	13,870	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	38	TOTALS	38	13,870	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,384	2,326	3,372	8,082	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,384	2,326	3,372	8,082	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.27%

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)

0

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 5/01/1987

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 32 and days of care provided 3,372

Medicare Intermediary National Government Services

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
	A. General Services										
1	Dietary	150,669		233,933	384,602	384,602		384,602		1	
2	Food Purchase		228,678		228,678	228,678		228,678		2	
3	Housekeeping	170,702		36,170	206,872	206,872		206,872		3	
4	Laundry	9,849		94,005	103,854	103,854		103,854		4	
5	Heat and Other Utilities									5	
6	Maintenance	99,753		224,595	324,348	324,348		324,348		6	
7	Other (specify):*									7	
8	TOTAL General Services	430,973	228,678	588,703	1,248,354	1,248,354		1,248,354		8	
	B. Health Care and Programs										
9	Medical Director									9	
10	Nursing and Medical Records	1,486,183		100,154	1,586,337	1,586,337		1,586,337		10	
10a	Therapy									10a	
11	Activities									11	
12	Social Services									12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Nursing School	72,672		13,555	86,227	86,227		86,227		15	
16	TOTAL Health Care and Programs	1,558,855		113,709	1,672,564	1,672,564		1,672,564		16	
	C. General Administration										
17	Administrative									17	
18	Directors Fees									18	
19	Professional Services									19	
20	Dues, Fees, Subscriptions & Promotions									20	
21	Clerical & General Office Expenses	488,676		91,147	579,823	579,823		579,823		21	
22	Employee Benefits & Payroll Taxes			474,483	474,483	474,483		474,483		22	
23	Inservice Training & Education									23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			241,604	241,604	241,604		241,604		26	
27	Other (specify):*									27	
28	TOTAL General Administration	488,676		807,234	1,295,910	1,295,910		1,295,910		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,478,504	228,678	1,509,646	4,216,828	4,216,828		4,216,828		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	
	D. Ownership											
30	Depreciation			172,528	172,528		172,528	559,599	732,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			172,528	172,528		172,528	559,599	732,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			13,955	13,955		13,955		13,955			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			13,955	13,955		13,955		13,955			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,478,504	228,678	1,696,129	4,403,311		4,403,311	559,599	4,962,910			45

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

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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	559,599			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 559,599		\$	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))	\$ 559,599		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

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Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

1	Adjustment of Allocated Depreciation to actual	\$	1
2	straight line depreciation per page 12&13	559,599	2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	559,599		49

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VII. RELATED PARTIES

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

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

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

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

1	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	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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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	N/A										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

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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 N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
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. (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:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
N/A				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 Graham Hospital COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 8000200

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

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8000200 Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number **Graham Hospital**

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Ending:

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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	37		1971	\$ 1,047,221	\$		\$	\$	\$ 1,047,221
5			1972	866					866
6			1978	187,881					187,881
7			1982	3,684					3,684
8			1977	1,331,168		various	27,895	27,895	1,259,165
Improvement Type**									
9	1975 VARIOUS BUILDING IMPROVEMENTS		1975	30,771		various			30,771
10	1976 VARIOUS BUILDING IMPROVEMENTS		1976	1,880		various			1,880
11	1980 VARIOUS BUILDING IMPROVEMENTS		1980	2,093		various			2,093
12	1982 VARIOUS BUILDING IMPROVEMENTS		1982	1,543		various			1,543
13	1984 VARIOUS BUILDING IMPROVEMENTS		1984	1,169,963		various	16,169	16,169	1,042,875
14	1985 VARIOUS BUILDING IMPROVEMENTS		1985	34,258		various			34,258
15	1987 VARIOUS BUILDING IMPROVEMENTS		1987	89,317		various	109	109	88,933
16	1988 VARIOUS BUILDING IMPROVEMENTS		1988	52,287		various	4	4	52,143
17	1990 VARIOUS BUILDING IMPROVEMENTS		1990	28,254		various	3	3	28,200
18	1991 VARIOUS BUILDING IMPROVEMENTS		1991	125,804		various			125,804
19	1992 VARIOUS BUILDING IMPROVEMENTS		1992	16,693		various			16,693
20	1993 VARIOUS BUILDING IMPROVEMENTS		1993	19,686		various			19,686
21	1994 VARIOUS BUILDING IMPROVEMENTS		1994	76,132		various			76,132
22	1995 VARIOUS BUILDING IMPROVEMENTS		1995	32,594		various			32,594
23	1996 VARIOUS BUILDING IMPROVEMENTS		1996	47,691		various	117	117	47,603
24	1994 VARIOUS BUILDING IMPROVEMENTS		1997	24,479		various	101	101	24,267
25	1998 VARIOUS BUILDING IMPROVEMENTS		1998	26,173		various			26,173
26	1999 VARIOUS BUILDING IMPROVEMENTS		1999	11,097		various	555	555	9,662
27	2000 VARIOUS BUILDING IMPROVEMENTS		2000	800,069		various	19,383	19,383	800,069
28	2001 VARIOUS BUILDING IMPROVEMENTS		2001	112,532		various	1,116	1,116	112,532
29	2002 VARIOUS BUILDING IMPROVEMENTS		2002	578,790		various	37,043	37,043	519,367
30	2003 VARIOUS BUILDING IMPROVEMENTS		2003	356,376		various	24,613	24,613	315,928
31	2004 VARIOUS BUILDING IMPROVEMENTS		2004	466,553		various	35,708	35,708	417,994
32	2005 VARIOUS BUILDING IMPROVEMENTS		2005	953,088		various	63,278	63,278	638,072
33	2006 VARIOUS BUILDING IMPROVEMENTS		2006	2,994,111		various	156,500	156,500	1,621,960
34	2007 VARIOUS BUILDING IMPROVEMENTS		2007	2,221,427		various	93,042	93,042	853,105
35	2008 VARIOUS BUILDING IMPROVEMENTS		2008	1,406,411		various	79,001	79,001	600,336
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

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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	FIRE DOORS-1ST FLOOR	2009	\$ 1,887	\$	15	\$ 126	\$ 126	\$ 818	37
38	PCU AUTOMATIC DOORS	2009	1,927		10	193	193	1,253	38
39	ROOF L	2009	13,668		10	1,367	1,367	8,884	39
40	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONST	2009	7,055		15	470	470	3,057	40
41	08.23-GMG BOND EYE AREA REMODEL-DRYWALL/SNAP	2009	836		15	56	56	363	41
42	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767		10	77	77	499	42
43	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S C	2009	2,106		15	140	140	912	43
44	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONST	2009	1,823		15	122	122	791	44
45	PROJ 09.02-RISK ASSESSMENT MODEL-PAINT/CARPET	2009	3,002		5			3,002	45
46	PROJ 09.03-GMG EXAM ROOM FLOOR-TILE/ADHESIVES	2009	449		10	45	45	292	46
47	PROJ 09.03-GMG EXAM ROOM FLOOR-BLADES/KNOVES/D	2009	606		4			606	47
48	PROJ 09.06-RUSHFORD BUILDING-WIND DAMAGE/CONST	2009	2,540		15	169	169	1,101	48
49	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONS	2009	5,357		15	357	357	2,322	49
50	PROJ 09.08-ACCOUNTING RENOVATION-PAINT/CARPET/	2009	1,892		6	126	126	1,892	50
51	PROJ 08.22-REMODEL PATIENT REGISTRATION-MISC	2009	325		5			325	51
52	PROJ 08.22-REMODEL PATIENT REGISTRATION-CEILING	2009	351		10	35	35	229	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD	2009	8,730		15	582	582	3,783	53
54	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102		15	73	73	477	54
55	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCT	2009	2,663		15	178	178	1,155	55
56	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171		15	78	78	507	56
57	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424		15	228	228	1,483	57
58	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	264		5			264	58
59	PROJ 09.11-GROUND FLOOR CLINIC-BUILDING SUPPLIES	2009	539		5			539	59
60	PROJ 09.11-GROUND FLOOR CLINIC-RICKARD'S LABOR	2009	2,841		15	189	189	1,231	60
61	PROJ 08.06-SPRINKLER WORK-VARIOUS SUPPLIES FOR P	2009	513		5			513	61
62	PROJ 08.06-SPRINKLER WORK-REPLACEMENT CEILING	2009	6,420		8	803	803	5,217	62
63	PROJ 09.09-DR. LOUNGE REMODEL-CARPETING AND VAR	2009	1,636		5			1,636	63
64	PROJ 09.09-DR. LOUNGE REMODEL-HOLTHAUS CO. ROO	2009	1,518		10	152	152	987	64
65	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRU	2009	4,802		15	320	320	2,081	65
66	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584		15	306	306	1,987	66
67	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769		15	251	251	1,633	67
68	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363		15	91	91	590	68
69		1972	5,755		VARIOUS			5,755	69
70	TOTAL (lines 4 thru 69)		\$ 14,346,577	\$		\$ 561,171	\$ 561,171	\$ 10,095,674	70

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

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Report Period Beginning:

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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	Totals from Page 12A, Carried Forward		\$ 14,346,577	\$		\$ 561,171	\$ 561,171	\$ 10,095,674	1
2	1973 FIXED EQUIPMENT	1972	4,926		VARIOUS			4,926	2
3	1975 FIXED EQUIPMENT	1975	989		VARIOUS			989	3
4	1980 FIXED EQUIPMENT	1980	599		VARIOUS			599	4
5	1981 FISED EQUIPMENT	1981	1,188		VARIOUS			1,188	5
6	1987 FIXED EQUIPMENT	1987	37,780		VARIOUS			37,780	6
7	1988 FIXED EQUIPMENT	1988	1,439		VARIOUS			1,439	7
8	1992 FIXED EQUIPMENT	1992	3,936		VARIOUS			3,936	8
9	1994 FIXED EQUIPMENT	1994	4,732		VARIOUS			4,732	9
10	1995 FIXED EQUIPMENT	1995	7,700		VARIOUS	384	384	7,700	10
11	1996 FIXED EQUIPMENT	1996	1,422		VARIOUS			1,422	11
12	1998 FIXED EQUIPMENT	1998	2,006		VARIOUS			2,006	12
13	1999 FIXED EQUIPMENT	1999	2,891		VARIOUS			2,891	13
14	2001 FIXED EQUIPMENT	2001	20,918		VARIOUS			20,918	14
15	2002 FIXED EQUIPMENT	2002	920		VARIOUS			920	15
16	2003 FIXED EQUIPMENT	2003	30,047		VARIOUS	1,631	1,631	28,202	16
17	2005 FIXED EQUIPMENT	2005	10,856		VARIOUS			10,856	17
18	PROJ 04.11 NEW ER - CABLING & DUCTWORK	2006	22,004		10	2,200	2,200	20,901	18
19	PROJ 04.11 NEW ER - FIRE & SECURITY SYSTEM	2006	12,357		10	1,236	1,236	11,741	19
20	PROJ 04.11 NEW ER - WALLSLIDE & SUCTION UNITS	2006	5,999		10	600	600	5,700	20
21	PROJ 04.11 NEW ER - SHELVES, DOORS, DIVIDERS	2006	11,707		10	1,171	1,171	11,124	21
22	PROJ 05.04 LAB RENOVATION - DATA CABLING	2006	2,251		10	225	225	1,913	22
23	PROJ 05.10 - 1ST PHASE MED/SURG-PERSONAL PROTECTIO	2007	1,364		5			1,364	23
24	PROJ 06.03 - ADMINISTRATION BOARDROOM - COUNTER	2007	4,359		10	436	436	3,706	24
25	PROJ 06.03 - ADMIN. BOARD RM-LAMINATED CASEWORK	2007	15,097		15	1,006	1,006	8,552	25
26	PROJ 04.16 - PYXIS - CABINETS	2007	442		15	29	29	248	26
27	PROJ 07.08 - THIRD FLOOR ONCOLOGY ROOM - CABINET	2007	2,406		10	241	241	2,048	27
28	PROJ 06.03 - ADMINISTRATION BOARDROOM - DROP-IN S	2007	1,539		10	154	154	1,309	28
29	07.10-HEARTCARE MIDWEST-CABINETS & COUNTERTOP	2008	5,545		15	370	370	2,774	29
30	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387		15	26	26	195	30
31	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTOP	2008	367		15	24	24	181	31
32	08.04-HR RELOCATION-SINK	2008	304		20	15	15	113	32
33	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERTOP	2008	1,317		15	88	88	660	33
34	TOTAL (lines 1 thru 33)		\$ 14,566,371	\$		\$ 571,007	\$ 571,007	\$ 10,298,707	34

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

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Report Period Beginning:

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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	Totals from Page 12B, Carried Forward		\$ 14,566,371	\$		\$ 571,007	\$ 571,007	\$ 10,298,707	1
2	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINETS	2008	1,126		15	75	75	563	2
3	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTOP	2008	366		15	24	24	181	3
4	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&CO	2008	401		15	27	27	202	4
5	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424		15	95	95	610	5
6	PROJ 09.11-GROUND FLOOR CLINIC-SINK	2009	215		5	21	21	215	6
7	PROJ 09.11-GROUND FLOOR CLINIC-ROOM DARKENING	2009	3,134		20	157	157	1,047	7
8	1971 LAND IMPROVEMENTS	1971	32,916		VARIOUS			32,916	8
9	1976 LAND IMPROVEMENT	1976	82,444		VARIOUS			82,444	9
10	1979 LAND IMPROVEMENTS	1979	30,208		VARIOUS			30,208	10
11	1981 LAND IMPROVEMENTS	1981	65,066		VARIOUS			65,066	11
12	1984 LAND IMPROVEMENTS	1984	61,686		VARIOUS			61,686	12
13	1991 LAND IMPROVEMENTS	1991	13,023		VARIOUS			13,023	13
14	1992 LAND IMPROVEMENTS	1992	656		VARIOUS			656	14
15	1993 LAND IMPROVEMENTS	1993	3,134		VARIOUS			3,134	15
16	1994 LAND IMPROVEMENTS	1994	3,983		VARIOUS			3,983	16
17	1995 LAND IMPROVEMENTS	1995	1,178		VARIOUS			1,178	17
18	1996 LAND IMPROVEMENTS	1996	3,963		VARIOUS			3,963	18
19	1998 LAND IMPROVEMENTS	1998	442		VARIOUS			442	19
20	2001 LAND IMPROVEMENTS	2001	6,453		VARIOUS			6,453	20
21	2002 LAND IMPROVEMENTS	2002	11,727		VARIOUS	775	775	11,626	21
22	2003 LAND IMPROVEMENTS	2003	36,978		VARIOUS			36,978	22
23	2004 LAND IMPROVEMENTS	2004	83,693		VARIOUS	5,580	5,580	64,163	23
24	2005 LAND IMPROVEMENTS	2005	84,686		VARIOUS	5,687	5,687	56,872	24
25	PROJ 07.03 - SOUTH PARKING LOT	2007	9,186		8	1,148	1,148	9,186	25
26	PROJ 07.07 - SOUTH PARKING LOT STAIRS-RICKARD'S/CC	2007	9,465		15	631	631	5,364	26
27	PROJ 07.07 - SOUTH PARKING LOT STAIRS - GRAVEL	2007	141		5			141	27
28	PROJ 06.09-HOME HEALTH MOVE-DEMO OF HOUSE IN SC	2007	3,528		15	235	235	1,998	28
29	SOUTH PATIO IMPROVEMENTS	2008	1,603		15	107	107	802	29
30	PAVING OF CLINIC PARKING LOT	2008	4,353		8	544	544	4,080	30
31	2010 Land Impr - Paving, Rock, Resurface, etc..	2010	15,449		30	515	515	3,598	31
32	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082		20	54	54	378	32
33	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939		25	118	118	649	33
34	TOTAL (lines 1 thru 33)		\$ 15,143,019	\$		\$ 586,800	\$ 586,800	\$ 10,802,512	34

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

Facility Name & ID Number Graham Hospital

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Report Period Beginning:

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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	Totals from Page 12C, Carried Forward		\$ 15,143,019	\$		\$ 586,800	\$ 586,800	\$ 10,802,512	1
2	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INTI	2010	385		40	10	10	55	2
3	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723		25	29	29	159	3
4	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257		40	731	731	4,021	4
5	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889		40	322	322	1,771	5
6	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTER	2010	2,576		40	64	64	354	6
7	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLO	2010	6,806		10	681	681	3,744	7
8	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENG	2010	1,510		40	38	38	208	8
9	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUP	2010	7,453		40	186	186	1,024	9
10	AMBULANCE BUILDING - WALNUT ST.	2010	1,089		40	27	27	149	10
11	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602		10	460	460	2,531	11
12	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963		15	131	131	720	12
13	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301		15	153	153	843	13
14	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061		10	1,706	1,706	9,383	14
15	ROOF M REPLACEMENT - MRI ROOF	2010	6,935		10	694	694	3,815	15
16	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & C	2010	4,786		15	319	319	1,755	16
17	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943		15	196	196	1,079	17
18	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPL	2010	2,485		15	166	166	912	18
19	PROJ. 10.04-EXT. CARE RENOVATIONS-RICKARD'S LABOR	2010	15,761		40	394	394	2,167	19
20	PROJ. 10.04 EXT. CARE RENOVATIONS-FLAD & ASSOCIAT	2010	2,340		40	58	58	321	20
21	PROJ. 10.04-EXT. CARE RENOVATIONS-KIRWAN ENVIRON	2010	183		40	5	5	26	21
22	PROJ. 10.04-EXT. CARE RENOVATIONS-FLOOR TILING	2010	2,730		20	137	137	751	22
23	PROJ. 10.04-EXT. CARE RENOVATIONS-PAINT/TRIM/WALL	2010	1,576		5	315	315	1,576	23
24	PROJ. 10.04 - EXT. CARE RENOVATIONS-HANDRAILS/COUN	2010	1,663		15	111	111	610	24
25	PROJ. 10.04 - EXT. CARE RENOVATIONS- WASTE	2010	368		40	9	9	50	25
26	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751		40	15,969	15,969	87,829	26
27	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCIA	2010	21,283		40	532	532	2,926	27
28	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739		40	1,343	1,343	7,389	28
29	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIRC	2010	1,006		40	25	25	138	29
30	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973		5	595	595	2,973	30
31	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927		10	193	193	1,060	31
32	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LABO	2010	770		40	19	19	106	32
33	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617		10	62	62	340	33
34	TOTAL (lines 1 thru 33)		\$ 15,994,470	\$		\$ 612,480	\$ 612,480	\$ 10,943,297	34

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

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Report Period Beginning:

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Ending:

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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	Totals from Page 12D, Carried Forward		\$ 15,994,470	\$		\$ 612,480	\$ 612,480	\$ 10,943,297	1
2	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPLI	2010	16,751		20	838	838	4,607	2
3	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083		20	1,054	1,054	5,798	3
4	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVI	2010	38,130		15	2,542	2,542	13,981	4
5	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVI	2010	34,111		25	1,364	1,364	7,504	5
6	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR A	2010	2,487		20	124	124	684	6
7	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR AN	2010	4,482		25	179	179	986	7
8	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINE	2010	2,571		25	103	103	566	8
9	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SE	2010	2,274		25	91	91	500	9
10	PROJ. 10.04-EXT. CARE RENOVATIONS-ELECTRICAL SUPP	2010	1,085		10	108	108	596	10
11	PROJ. 10.04-EXT. CARE RENOVATIONS-MED GAS OUTLETS	2010	653		15	44	44	240	11
12	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL	2010	27,126		25	1,085	1,085	5,968	12
13	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530		25	101	101	556	13
14	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637		25	25	25	140	14
15	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010		20	101	101	553	15
16	TABLES - (5)	2011	4,431		15	295	295	1,329	16
17	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494		5	2,499	2,499	11,245	17
18	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BU	2011	6,920		5	1,384	1,384	6,228	18
19	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONT	2011	1,053,994		40	26,350	26,350	118,575	19
20	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269		40	657	657	2,955	20
21	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063		40	27	27	120	21
22	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897		40	1,022	1,022	4,600	22
23	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750		40	219	219	984	23
24	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310		40	33	33	147	24
25	PROJ. 09.07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTIO	2011	635,931		40	15,898	15,898	71,542	25
26	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472		40	37	37	165	26
27	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750		8	1,469	1,469	6,609	27
28	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364		20	168	168	757	28
29	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUM	2011	8,120		20	406	406	1,827	29
30	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S AN	2011	1,609		20	80	80	361	30
31	PROJ. 10.16-SIX SIGMA ELECTRICITY PROJECT-ELECTRIC	2011	33,624		10	3,362	3,362	15,130	31
32	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732		20	143	143	573	32
33	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295		8	1,518	1,518	6,073	33
34	TOTAL (lines 1 thru 33)		\$ 18,032,425	\$		\$ 675,806	\$ 675,806	\$ 11,235,196	34

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

Facility Name & ID Number Graham Hospital

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Report Period Beginning:

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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	Totals from Page 12E, Carried Forward		\$ 18,032,425	\$		\$ 675,806	\$ 675,806	\$ 11,235,196	1
2	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426		2	107	107	426	2
3	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000		8	938	938	3,751	3
4	LANDSCAPING EP COLEMAN BUILDING	2012	9,287		10	464	464	1,857	4
5	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330		2	83	83	330	5
6	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600		8	288	288	1,151	6
7	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740		8	546	546	2,185	7
8	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900		8	1,244	1,244	4,976	8
9	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500		8	219	219	876	9
10	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208		10	810	810	3,241	10
11	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTRU	2012	2,498		10	125	125	500	11
12	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543		5	4,954	4,954	19,817	12
13	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE ST	2012	490		5	49	49	196	13
14	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL	2012	2,385		5	239	239	955	14
15	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393		15	380	380	1,519	15
16	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284		15	76	76	304	16
17	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433		15	114	114	457	17
18	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LAB	2012	3,308		15	110	110	441	18
19	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142		15	105	105	419	19
20	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145		40	14,477	14,477	57,907	20
21	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872		15	96	96	383	21
22	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052		10	205	205	615	22
23	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL	2013	5,691		20	285	285	854	23
24	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411		25	176	176	529	24
25	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - W	2013	671		10	67	67	201	25
26	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592		15	239	239	718	26
27	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940		15	63	63	188	27
28	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055		15	70	70	211	28
29	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787		20	40	40	60	29
30	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122		15	8	8	12	30
31	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPING	2014	215		25	8	8	12	31
32	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79		10	8	8	12	32
33	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRAD	2014	36,383		20	1,820	1,820	2,730	33
34	TOTAL (lines 1 thru 33)		\$ 19,405,907	\$		\$ 704,219	\$ 704,219	\$ 11,343,029	34

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

Facility Name & ID Number Graham Hospital

#

8000200

Report Period Beginning:

07/01/14

Ending:

06/30/15

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	Totals from Page 12F, Carried Forward	\$ 19,405,907	\$		\$ 704,219	\$ 704,219	\$ 11,343,029	
2	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014 5,284		20	264		396	
3	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014 14,291		20	714		1,072	
4	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014 6,563		20	328		492	
5	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHOP/	2014 2,107		20	106		158	
6	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014 5,772		20	289		313	
7	GHA/HH PARKING LOT SEALCOAT/REPAIR	2015 6,829		2	1,707		1,707	
8	GMG/EP COLEMAN/WELLNESS PARKING LOT SEAL COAT/RE	2015 5,023		2	1,256		1,256	
9	RISEATLAS 625QM CEILING LIFT	2015 19,373		10	969		969	
10								
11								
12	Telemetry Electrical Cable Pull and Receptacle Install	2015 3,457		20	86		86	
13	14.13 - TRANSFORMER REPLACEMENT	2015 43,590		20	1,090		1,090	
14	14.15 - JOINT COMMISSION ELECTRICAL/PLUMBING REPAIRS	2015 6,278		20	157		157	
15	14.15 - JOINT COMMISSION AIR HANDLER REPAIR	2015 378		10	19		19	
16	14.15 - JOINT COMMISSION DOOR CLOSER REPLACEMENT	2015 995		15	33		33	
17	15.03 - WATER SOFTENER REPLACEMENT	2015 4,674		10	234		234	
18								
19	15-01 - Patient Registration - ELECTRICAL/DATA CABLE PULL/IN	2015 2,685		20	67		67	
20	15-07 - Chiller Rebuild - TRANE CONTRACTED WORK	2015 54,304		20	1,358		1,358	
21	14.10 - 2nd Floor Hallway Remodel	2015 7,446		5	745		745	
22	14.15 - JOINT COMMISSION BUILDING REPAIRS	2015 463		5	46		46	
23	HOSPITAL TUCKPOINT AND SKYLIGHT GLASS REPAIR	2015 27,029		40	338		338	
24	PROJECT 14.04 - PHARMACY RENOVATIONS - PJ HOERR CON	2015 26,155		40	327		327	
25								
26								
27	15-01 - Patient Registration - MISC BUILDING SUPPLIES	2015 6,561		5	656		656	
28	15-01 - Patient Registration - PJ HOERR CONTRACT WORK	2015 334,913		40	4,186		4,186	
29								
30	Allocated Depreciation	2015		172,528		(172,528)		
31								
32								
33								
34	TOTAL (lines 1 thru 33)	\$ 19,990,079	\$ 172,528		\$ 719,194	\$ 531,691	\$ 11,358,734	

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

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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	\$ 429,181	\$	\$ 12,710	\$ 12,710	5-15	\$ 386,124	71
72	Current Year Purchases	8,916		223	223	10	223	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 438,097	\$	\$ 12,933	\$ 12,933		\$ 386,347	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)	\$ 20,428,176	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 172,528	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 732,127	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 559,599	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,745,081	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Graham Hospital

8000200

Report Period Beginning: 07/01/14

Ending: 06/30/15

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>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /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 _____.

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: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$	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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number Graham Hospital# 8000200Report Period Beginning: 07/01/14

Ending:

06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,544,071	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	9,612,498		3
4	Supply Inventory (priced at)	1,345,498		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,394,051		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current</u>	2,960,831		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,856,949	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,050,535		13
14	Buildings, at Historical Cost	64,374,472		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	40,992,964		16
17	Accumulated Depreciation (book methods)	(56,643,256)		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 (spec <u>Assets Limited as to U</u>)	65,817,077		22
23	Other(specify): <u>Trust Fund</u>	8,541,051		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 128,132,843	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 148,989,792	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,495,819	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	860,000		29
30	Accrued Salaries Payable	4,206,755		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>3rd Party Settlement</u>	2,552,361		36
37	<u>Self Insurance Costs</u>	3,013,998		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,128,933	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,895,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Interest rate swap agreements</u>	5,397,604		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 31,292,604	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 44,421,537	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 104,568,255	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 148,989,792	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 99,209,273	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 99,209,273	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,228,526	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Other Non-Op Rev	2,284,817	15
16	Other (describe) Increase in Temp. Resticted Assets Net	(154,361)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 5,358,982	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)	\$ 104,568,255	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,018,821	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,018,821	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Hospital Misc Rev</u>	3,371,687	28
28a	<u>Hospital Rev</u>	70,888,987	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,260,674	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 77,279,495	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,248,354	31
32	Health Care	1,672,564	32
33	General Administration	1,295,910	33
B. Capital Expense			
34	Ownership	172,528	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	13,955	36
D. Other Expenses (specify):			
37	<u>Hospital Expenses</u>	69,647,658	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 74,050,969	40
41	Income before Income Taxes (line 30 minus line 40)**	3,228,526	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,228,526	43

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

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

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

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

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

Facility Name & ID Number Graham Hospital

8000200

Report Period Beginning:

07/01/14

Ending:

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
N/A			\$	Workers' Compensation Insurance		\$	IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed _____)	
				Employee Meals			<u>Patient Background Checks</u>	
				Illinois Municipal Retirement Fund (IMRF)*				
				<u>Allocated Benefits</u>		<u>474,483</u>		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												N/A
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Graham Hospital# 8000200

Report Period Beginning:

07/01/14

Ending:

06/30/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? 5-15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 13,955
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey LLP
- (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.