

Facility Name & ID Number Gottlieb Memorial Hospital

8008518 Report Period Beginning: July 1, 2016 Ending: June 30, 2017

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	211		8,796	9,007	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	211		8,796	9,007	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.58%

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

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

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

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

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

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

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 8,157

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: July 1, 2016 Ending: June 30, 2017

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		7,379		7,379		7,379	310,299	317,678		1
2	Food Purchase										2
3	Housekeeping							411,412	411,412		3
4	Laundry										4
5	Heat and Other Utilities							327,858	327,858		5
6	Maintenance										6
7	Other (specify):*										7
8	TOTAL General Services		7,379		7,379		7,379	1,049,569	1,056,948		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,791,302	133,518	1,186,148	3,110,968		3,110,968	(87,233)	3,023,735		10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,791,302	133,518	1,186,148	3,110,968		3,110,968	(87,233)	3,023,735		16
	C. General Administration										
17	Administrative	227,907			227,907		227,907	627,685	855,592		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			550	550		550		550		20
21	Clerical & General Office Expenses	40,120	10,336	3,690	54,146		54,146	118,279	172,425		21
22	Employee Benefits & Payroll Taxes							502,231	502,231		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	268,027	10,336	4,240	282,603		282,603	1,248,195	1,530,798		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,059,329	151,233	1,190,388	3,400,950		3,400,950	2,210,531	5,611,481		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						210,444	210,444				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						210,444	210,444				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						28,568	28,568				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers						28,568	28,568				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,059,329	151,233	1,190,388	3,400,950		3,400,950	2,449,543	5,850,493			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 See Page 5A	2,449,543			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 2,449,543		\$	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))	\$ 2,449,543		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

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: July 1, 2016

Ending: June 30, 2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Hospital W/S A-6 Reclass for Drugs Charged	\$ (736)	10	1
2	Hospital W/S A-6 Reclass for Med Supplies	(89,156)	10	2
3	Hospital W/S B Overhead Alloc - Bldg & Fixt	203,982	30	3
4	Hospital W/S B Overhead Alloc - Movbl Equip	6,461	30	4
5	Hospital W/S B Overhead Alloc - Emp Benefits	502,231	22	5
6	Hospital W/S B Overhead Alloc - Admin & Gen	337,735	17	6
7	Hospital W/S B Overhead Alloc - Plant Oper	327,858	5	7
8	Hospital W/S B Overhead Alloc - Housekeeping	411,412	3	8
9	Hospital W/S B Overhead Alloc - Dietary	310,299	1	9
10	Hospital W/S B Overhead Alloc - Cafeteria	118,279	21	10
11	LTC Cost in Hosp Adm for Provider Partici. Fees	28,568	42	11
12	Hospital W/S B Overhead Alloc - Nursing Admin	289,950	17	12
13	Hospital W/S B Overhead Alloc - Central Supply	2,659	10	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,449,543		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2016

Ending:

June 30, 2017

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	310,299	0	0	0	0	0	0	0	0	0	0	310,299	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	411,412	0	0	0	0	0	0	0	0	0	0	411,412	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	327,858	0	0	0	0	0	0	0	0	0	0	327,858	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,049,569	0	1,049,569	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(87,233)	0	0	0	0	0	0	0	0	0	0	(87,233)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(87,233)	0	(87,233)	16									
	C. General Administration													
17	Administrative	627,685	0	0	0	0	0	0	0	0	0	0	627,685	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	118,279	0	0	0	0	0	0	0	0	0	0	118,279	21
22	Employee Benefits & Payroll Taxes	502,231	0	0	0	0	0	0	0	0	0	0	502,231	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	1,248,195	0	1,248,195	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	2,210,531	0	2,210,531	29									

STATE OF ILLINOIS

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2016 Ending:

Summary B

June 30, 2017

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	210,444	0	0	0	0	0	0	0	0	0	0	210,444	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	210,444	0	0	0	0	0	0	0	0	0	0	210,444	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	28,568	0	0	0	0	0	0	0	0	0	0	28,568	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	28,568	0	0	0	0	0	0	0	0	0	0	28,568	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,449,543	0	0	0	0	0	0	0	0	0	0	2,449,543	45

VII. RELATED PARTIES

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

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

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

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

1	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		\$			\$	\$	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.

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, 2016

Ending: ne 30, 2017

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Gottlieb Memorial Hospital

8008518

Report Period Beginning:

July 1, 2016 Ending:

June 30, 2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT Donna Wallace

TELEPHONE (708) 216-6736 FAX #: (708) 216-8340

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Gottlieb Memorial Hospital

8008518 Report Period Beginning:

July 1, 2016 Ending:

June 30, 2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,018 B. General Construction Type: Exterior Frame Number of Stories 1

C. Does the Operating Entity? (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:

	1	2	3	4	
A. Land.	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	\$ 61,937	\$	50	\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
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					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		6,794,006
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

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2016 Ending: June 30, 2017

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					4,858,946	43
44	Various	1996	4,322,888					4,322,888	44
45	Various	1997	3,851,805	11,787		11,787		3,851,805	45
46	Various	1998	7,826,827	174,889		174,889		7,826,827	46
47	Various	1999	3,782,851	182,458		182,458		3,782,851	47
48	Various	2000	6,562,656	492,199		492,199		6,258,070	48
49	Various	2001	4,472,858	335,464		335,464		4,247,355	49
50	Various	2002	3,071,826	232,098		232,098		2,690,566	50
51	Various	2003	1,616,067	128,016		128,016		1,399,464	51
52	Various	2004	2,567,622	203,241		203,241		2,003,475	52
53	Various	2005	4,098,669	324,788		324,788		3,042,086	53
54	Various	2006	1,656,917	66,572		66,572		621,338	54
55	Various	2007	1,091,422	40,123		40,123		368,127	55
56	Various	2008	392,789	21,427		21,427		180,847	56
57	Various	2009	3,415,801	121,618		121,618		1,015,374	57
58	Various	2011	274,704	22,176		22,176		137,939	58
59	Various	2012	6,839,918	383,542		383,542		2,169,082	59
60									60
61	HW TANK SOUTH WING	2013	86,900	7,966	10	7,966		39,829	61
62	NEW CHILLER	2013	53,149	3,248	15	3,248		16,240	62
63	HW TANK SOUTH WING	2013	16,900	1,549	10	1,549		7,746	63
64	ENGINEERING FEES FOR NEW CHILL	2013	14,400	880	15	880		4,400	64
65	BTU BOILER	2013	8,850	406	20	406		2,029	65
66	ENGINEERING FEES FOR NEW CHILL	2013	134	8	15	8		41	66
67	LIFE SAFETY UPGRADES	2013	14,592	2,432	5	2,432		12,160	67
68	HOT WATER TANK SOUTH WING	2013	6,782	565	10	565		2,826	68
69	LIFE SAFETY UPGRADES	2013	4,973	829	5	829		4,145	69
70	TOTAL (lines 4 thru 69)		\$ 116,592,793	\$ 2,863,139		\$ 2,863,139	\$	\$ 104,119,138	70

**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	Totals from Page 12A, Carried Forward		\$ 116,592,793	\$ 2,863,139		\$ 2,863,139	\$	\$ 104,119,138	1
2	<u>NEW CHILLER - CONSTRUCTION</u>	2013	413,944	20,697	15	20,697		103,486	2
3	<u>NEW CHILLER - CONSTRUCTION</u>	2013	139,452	6,973	15	6,973		34,863	3
4	<u>LIFE SAFETY UPGRADES</u>	2013	9,665	1,450	5	1,450		7,249	4
5	<u>LIFE SAFETY UPGRADES</u>	2013	6,143	921	5	921		4,607	5
6	<u>NEW CHILLER - ENGINEERING</u>	2013	3,600	180	15	180		900	6
7	<u>NEW CHILLER - ENGINEERING</u>	2013	2,350	118	15	118		588	7
8	<u>NEW CHILLER - ASBESTOS INSPECT</u>	2013	1,900	95	15	95		475	8
9	<u>NEW CHILLER</u>	2013	205,750	9,144	15	9,144		45,722	9
10	<u>SUITE 312 RENOVATION - CONSTRU</u>	2013	137,075	4,569	20	4,569		18,277	10
11	<u>NEW CHILLER</u>	2013	6,170	274	15	274		1,097	11
12	<u>CHILLER</u>	2013	4,700	209	15	209		836	12
13	<u>LIFE SAFETY UPGRADES - LOEBL -</u>	2013	544	73	5	73		292	13
14	<u>STORAGE GARAGE</u>	2013	43,800	1,022	25	1,022		4,088	14
15	<u>X-RAY UNIT - TOMOGRAPHY</u>	2014	5,500	786	7	786		2,357	15
16	<u>4 CHANNEL BREAST ARRAY MRI COI</u>	2014	35,754	5,108	7	5,108		15,323	16
17	<u>TIS - LAWSON</u>	2014	82,621	11,803	7	11,803		35,409	17
18	<u>TIS - RIVER FOREST EPIC</u>	2014	1,388	198	7	198		594	18
19	<u>TIS - EPIC</u>	2014	249,434	35,633	7	35,633		106,900	19
20	<u>TIS - EPIC EMPLOYED PHYSICIANS</u>	2014	1,955	279	7	279		838	20
21	<u>TIS - EPIC CLIN/REV IMPLEMENTA</u>	2014	177,473	25,353	7	25,353		76,059	21
22	<u>TIS - PEOPLESFT FMS IMPLEMENT</u>	2014	13,598	1,943	7	1,943		5,828	22
23	<u>TIS - PEOPLESFT OPERATING IMP</u>	2014	835	119	7	119		358	23
24	<u>TIS - LAWSON/KRONOS IMPLEM - O</u>	2014	366	52	7	52		157	24
25	<u>MIRA PORTABLE X-RAY UNITS</u>	2014	325,000	46,429	7	46,429		139,286	25
26	<u>IV CART</u>	2014	30,748	3,075	10	3,075		9,225	26
27	<u>X-RAY UNIT TOMOGRAPHY</u>	2014	30,450	4,350	7	4,350		13,050	27
28	<u>RAIS ABBOTT ISTAT</u>	2014	9,140	1,828	5	1,828		5,484	28
29	<u>CART WASHER</u>	2014	4,650	465	10	465		1,395	29
30	<u>NEOWARES - HP</u>	2014	4,830	966	5	966		2,898	30
31	<u>X-RAY UNIT TOMOGRAPHY</u>	2014	248,671	35,524	7	35,524		106,573	31
32	<u>X-RAY UNIT TOMOGRAPHY</u>	2014	320,000	45,714	7	45,714		137,143	32
33	<u>NEW CHILLER</u>	2014	94,986	6,332	15	6,332		18,997	33
34	TOTAL (lines 1 thru 33)		\$ 119,205,285	\$ 3,134,821		\$ 3,134,821	\$	\$ 105,019,492	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	Totals from Page 12B, Carried Forward		\$ 119,205,285	\$ 3,134,821		\$ 3,134,821	\$	\$ 105,019,492	1
2	AUDIOMETER	2014	10,934	1,093	10	1,093		3,280	2
3	PRINTER XEROX 5330	2014	8,720	1,744	5	1,744		5,232	3
4	LAB LABEL PRINTER	2014	750	150	5	150		450	4
5	20% DOWN ON ENTERPRISE LEVEL S	2014	1,825	365	5	365		1,095	5
6	CART WASHER	2014	129,824	12,982	10	12,982		38,947	6
7	INFANT/PATIENT SECURITY SYSTEM	2014	39,147	3,915	10	3,915		11,744	7
8	INFANT/PATIENT SECURITY SYSTEM	2014	1,416	142	10	142		425	8
9	LIFE SAFETY UPGRADES - ARCHITE	2014	3,029	151	20	151		454	9
10	Renovation 5 South	2015	70,225	4,682	15	4,682		11,504	10
11	Marj Weinberg Cancer CtrRen construction	2015	279,055	18,604	15	18,604		44,463	11
12	6 South Renovation	2015	886,131	59,075	15	59,075		143,812	12
13	AIR HANDLER REPLACE S6 & 7	2015	1,249,951	62,498	20	62,498		127,605	13
14	100NX? Sterilizer 10104003	2016	85,000	4,554	84	4,554		9,108	14
15	3D Monitor 32in LMD3251MT/3G	2016	6,061	556	60	556		1,112	15
16	Accumax Mattresses 35inX86in	2016	19,755	1,482	60	1,482		2,964	16
17	Accumax Mattresses 35inX86in	2016	19,755	823	60	823		1,646	17
18	Anesthesia Machine AISYS CS2 m	2016	745,048	75,392	84	75,392		150,784	18
19	AtmosAir9000 Mattress Nonpower	2016	11,070	1,015	60	1,015		2,030	19
20	Barbell set & storage rack	2016	2,668	170	180	170		340	20
21	Barco 2221 21in MDRC	2016	1,040	199	60	199		398	21
22	BladderScan BVI9400&mobile car	2016	14,765	2,830	60	2,830		5,660	22
23	Carescape life upgrade monitor	2016	239,791	18,555	84	18,555		37,110	23
24	Carescape life upgrade monitor	2016	265,318	20,531	84	20,531		41,062	24
25	Container Gray Handle Perforat	2016	1,011	76	60	76		152	25
26	Cystoscope Promo Flex 7FR 15FR	2016	9,390	1,174	36	1,174		2,348	26
27	Data cabling installed for PAC	2016	19,650	450	240	450		900	27
28	DaVinci XI dual console IS4000	2016	2,150,000	140,774	84	140,774		281,548	28
29	DaVinci XI Procedure Tray 1644	2016	5,179	194	120	194		388	29
30	Defibrillator US00588011	2016	16,650	2,636	60	2,636		5,272	30
31	Defibrillator US00588012	2016	16,650	2,636	60	2,636		5,272	31
32	Defibrillator US00588013	2016	16,650	2,636	60	2,636		5,272	32
33	Defibrillator US00588014	2016	16,650	2,636	60	2,636		5,272	33
34	TOTAL (lines 1 thru 33)		\$ 125,548,393	\$ 3,579,541		\$ 3,579,541	\$	\$ 105,967,141	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	Totals from Page 12C, Carried Forward		\$ 125,548,393	\$ 3,579,541		\$ 3,579,541	\$	\$ 105,967,141	1
2	Electrical&Data Cabling Pyxis	2016	39,250	1,227	240	1,227		2,454	2
3	Endoscope 8MM Cannula 8MM	2016	58,101	3,804	84	3,804		7,608	3
4	Endowrist stapler instru start	2016	18,270	1,196	84	1,196		2,392	4
5	Exam&Lab room construction	2016	54,352	2,265	180	2,265		4,530	5
6	Eye Surg Stretcher 1602033030&	2016	11,567	225	180	225		450	6
7	Furnish/Install sump alarms	2016	2,375	73	180	73		146	7
8	Glidescope AVL Premium Cart AN	2016	18,264	989	120	989		1,978	8
9	Glidescope Blade MD096970	2016	500	63	36	63		126	9
10	Gower Chairs-23 Tables-10	2016	43,140	2,037	180	2,037		4,074	10
11	HP Z620V2 V3900X1	2016	2,129	680	36	680		1,360	11
12	ICU Reno-Aluminum Window Syste	2016	33,840	846	180	846		1,692	12
13	ICU Reno-Auto Door Equipment	2016	140,673	5,275	120	5,275		10,550	13
14	ICU Reno-Cambria Countertops	2016	5,184	130	180	130		260	14
15	ICU Reno-Cart Tray Delivery	2016	3,682	138	120	138		276	15
16	ICU Reno-Ceiling Tile	2016	14,339	538	120	538		1,076	16
17	ICU Reno-Ceiling Tile	2016	20,678	969	96	969		1,938	17
18	ICU Reno-Ceramic Flooring	2016	13,199	247	240	247		494	18
19	ICU Reno-Chairs Tables Stools	2016	139,851	3,496	180	3,496		6,992	19
20	ICU Reno-Conduit&Wiring	2016	258,574	4,848	240	4,848		9,696	20
21	ICU Reno-Corner Guards	2016	10,505	394	120	394		788	21
22	ICU Reno-Custom Cabinetry	2016	193,500	4,838	180	4,838		9,676	22
23	ICU Reno-Custom Printed Photos	2016	5,990	449	60	449		898	23
24	ICU Reno-Door Alarm	2016	20,140	755	120	755		1,510	24
25	ICU Reno-Fire Alarm System	2016	5,000	188	120	188		376	25
26	ICU Reno-Fire Resistant Waste	2016	2,971	223	60	223		446	26
27	ICU Reno-Headwall Sys Patient	2016	124,991	3,125	180	3,125		6,250	27
28	ICU Reno-HVAC	2016	685,305	12,849	240	12,849		25,698	28
29	ICU Reno-Ice&Water Dispenser	2016	10,280	386	120	386		772	29
30	ICU Reno-LED TV with Mounts	2016	8,537	640	60	640		1,280	30
31	ICU Reno-Light Fixtures&Bulbs	2016	112,667	4,225	120	4,225		8,450	31
32	ICU Reno-Metal Frames&Hardware	2016	31,727	595	240	595		1,190	32
33	ICU Reno-Metal Storage Cabinet	2016	25,695	642	180	642		1,284	33
34	TOTAL (lines 1 thru 33)		\$ 127,663,669	\$ 3,637,896		\$ 3,637,896	\$	\$ 106,083,851	34

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

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2016 Ending: June 30, 2017

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 12D, Carried Forward		\$ 127,663,669	\$ 3,637,896		\$ 3,637,896	\$	\$ 106,083,851	1
2	ICU Reno-Nurse Call	2016	72,435	2,716	120	2,716		5,432	2
3	ICU Reno-Paging System	2016	27,615	518	240	518		1,036	3
4	ICU Reno-Painting&Wallpapering	2016	53,100	3,983	60	3,983		7,966	4
5	ICU Reno-Patient Lift System	2016	78,752	2,953	120	2,953		5,906	5
6	ICU Reno-Pipe Insulation	2016	45,148	1,129	180	1,129		2,258	6
7	ICU Reno-Plumbing Fixtures-Pip	2016	204,553	3,835	240	3,835		7,670	7
8	ICU Reno-Pneumatic Tube System	2016	45,000	1,125	180	1,125		2,250	8
9	ICU Reno-Projector Screen	2016	1,300	49	120	49		98	9
10	ICU Reno-Signs Indoor Direct&D	2016	16,910	1,268	60	1,268		2,536	10
11	ICU Reno-Sprinkler System	2016	19,620	294	300	294		588	11
12	ICU Reno-Switchgear Electrical	2016	51,690	1,292	180	1,292		2,584	12
13	ICU Reno-Temp Control Computer	2016	45,015	1,688	120	1,688		3,376	13
14	ICU Reno-Terrazo Floor	2016	32,399	810	180	810		1,620	14
15	ICU Reno-Trash Cans	2016	1,097	82	60	82		164	15
16	ICU Renovation-Labor A&E Fees	2016	2,676,102	66,903	180	66,903		133,806	16
17	ICU Reno-Vinyl Tile	2016	59,111	2,217	120	2,217		4,434	17
18	ICU Reno-Window Roller Shades	2016	27,000	2,025	60	2,025		4,050	18
19	ICU Reno-Wood Doors	2016	39,571	989	180	989		1,978	19
20	ICU Reno-Workstation	2016	17,209	645	120	645		1,290	20
21	ICU-Gypsum-Insulatn-Wood Panel	2016	76,000	1,900	180	1,900		3,800	21
22	Install 60amp fusible&60amp 3p	2016	1,081	20	240	20		40	22
23	Insufflator 0620040654	2016	6,267	470	60	470		940	23
24	Lifecycle Bike&Console GED1350	2016	1,300	249	60	249		498	24
25	Medical 3D Recorder HVO3000MT	2016	13,459	1,009	60	1,009		2,018	25
26	Mobile Surgical Cart ELO1528L	2016	2,585	118	120	118		236	26
27	Nurse Call 3West electrical	2016	16,000	1,133	120	1,133		2,266	27
28	Nurse Call 3West replacement	2016	98,704	6,992	120	6,992		13,984	28
29	Pulse 120H Holmium Laser	2016	195,000	17,875	60	17,875		35,750	29
30	Pump plus wiring POB	2016	41,872	1,745	180	1,745		3,490	30
31	Pyxis Platform Upgrade	2016	319,597	4,439	180	4,439		8,878	31
32	Pyxis Platform Upgrade	2016	565,738	7,857	180	7,857		15,714	32
33	Reno 6 south Interior signs	2016	1,484	235	60	235		470	33
34	TOTAL (lines 1 thru 33)		\$ 132,516,383	\$ 3,776,459		\$ 3,776,459	\$	\$ 106,360,977	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	Totals from Page 12E, Carried Forward		\$ 132,516,383	\$ 3,776,459		\$ 3,776,459	\$	\$ 106,360,977	1
2	Renovation 5 South floor prep	2016	10,000	417	180	417		834	2
3	Renovation 6 South	2016	24,614	1,026	180	1,026		2,052	3
4	Renovation 6 South Interior Si	2016	10,002	1,750	60	1,750		3,500	4
5	Repaired Access Keypads all fl	2016	3,236	310	120	310		620	5
6	Replace 60 Keypad Control Pane	2016	16,500	1,581	120	1,581		3,162	6
7	Security Fencing-8ft woven mes	2016	6,910	979	60	979		1,958	7
8	Shelving Units Blue Shelf Bins	2016	35,733	1,266	240	1,266		2,532	8
9	Stretcher Prime 5th Wheel	2016	46,535	2,973	180	2,973		5,946	9
10	Stretcher Prime 5th Wheel with	2016	36,557	2,336	180	2,336		4,672	10
11	Surgeon console chair vinyl co	2016	1,145	22	180	22		44	11
12	Surgical lights aurora 5 light	2016	30,179	922	180	922		1,844	12
13	Surgical Table Armboard Pad lo	2016	37,785	945	180	945		1,890	13
14	TIS Proj CDW EBR Deployment	2016	2,975	273	60	273		546	14
15	TIS Proj ConduitCAT6 patchpane	2016	18,456	577	240	577		1,154	15
16	TIS Proj EPIC sftwre consult f	2016	1,030,001	91,964	84	91,964		183,928	16
17	TIS Proj EPIC/CSI&Jaworski sft	2016	38,953	3,014	84	3,014		6,028	17
18	TIS Proj EPIC/Dearborn&HighPoi	2016	141,659	9,275	84	9,275		18,550	18
19	TIS Proj GCX/CDW Seal Shield	2016	27,923	3,025	60	3,025		6,050	19
20	TIS Proj HP650 G1 no webcam	2016	689	132	60	132		264	20
21	TIS Proj Tangent MedixM24 EBR	2016	470,580	58,823	60	58,823		117,646	21
22	TIS Project C2G 1.5FT USB Ser	2016	576	34	60	34		68	22
23	TIS Project Clarity Fees Barco	2016	12,319	1,687	84	1,687		3,374	23
24	TIS Project EBR Deploy channel	2016	5,179	216	60	216		432	24
25	TIS Project EBR Deploy Honeywe	2016	4,122	103	60	103		206	25
26	TIS Project electrical work fo	2016	60,900	508	180	508		1,016	26
27	TIS Project HP800 G1 Mini	2016	667	39	60	39		78	27
28	TIS Project labor charges	2016	29,528	1,933	84	1,933		3,866	28
29	TIS Project labor charges	2016	35,807	1,918	84	1,918		3,836	29
30	TIS Project labor charges	2016	35,339	1,052	84	1,052		2,104	30
31	TIS Project labor charges	2016	10,588	189	84	189		378	31
32	TIS Project labor charges	2016	242,912	1,446	84	1,446		2,892	32
33	TIS Project NurseCall report s	2016	59,240	11,354	60	11,354		22,708	33
34	TOTAL (lines 1 thru 33)		\$ 135,003,992	\$ 3,978,548		\$ 3,978,548	\$	\$ 106,765,155	34

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

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518

Report Period Beginning:

July 1, 2016 Ending: June 30, 2017

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		\$ 135,003,992	\$ 3,978,548		\$ 3,978,548	\$	\$ 106,765,155	1
2	TIS Project Phases of Care	2016	119,007	10,626	84	10,626		21,252	2
3	TIS Project Phases of Care Lab	2016	(1,000)	(77)	84	(77)		(154)	3
4	TIS Project Phases of Care Lab	2016	1,000	77	84	77		154	4
5	TIS Project Phases of Care Lab	2016	(760)	(50)	84	(50)		(100)	5
6	TIS Project Phases of Care Lab	2016	760	50	84	50		100	6
7	TIS Project Phases of Care Lab	2016	21,840	1,430	84	1,430		2,860	7
8	TIS Project Phases of Care Lab	2016	26,504	1,420	84	1,420		2,840	8
9	TIS Project Phases of Care Lab	2016	15,755	656	84	656		1,313	9
10	TIS Project Phases of Care Lab	2016	2,160	64	84	64		129	10
11	TIS Project Phases of Care Lab	2016	72,276	1,291	84	1,291		2,581	11
12	TIS Project Phases of Care Lab	2016	6,480	39	84	39		77	12
13	TIS Project Phases of Care Ser	2016	8,050	335	60	335		671	13
14	TIS Project Philips Ultrasound	2016	6,825	57	60	57		114	14
15	TIS Project Rubbermaid cart	2016	32,379	6,206	60	6,206		12,412	15
16	TIS Project Samsung 50in Telev	2016	529	4	60	4		9	16
17	TIS Project Sunquest at Gottli	2016	41,295	6,538	60	6,538		13,077	17
18	TIS Project Sunquest at Gottli	2016	41,295	6,538	60	6,538		13,077	18
19	TIS Project Sunquest at Gottli	2016	16,800	1,500	84	1,500		3,000	19
20	TIS Project Sunquest at Gottli	2016	16,800	1,500	84	1,500		3,000	20
21	TIS Project Sunquest at Gottli	2016	22,472	2,006	84	2,006		4,013	21
22	TIS Project Sunquest at Gottli	2016	22,472	2,006	84	2,006		4,013	22
23	TIS Project Sunquest at Gottli	2016	21,359	1,653	84	1,653		3,306	23
24	TIS Project Sunquest at Gottli	2016	21,359	1,653	84	1,653		3,306	24
25	Toshiba CTXR29 Console upgrade	2016	90,000	4,821	84	4,821		9,643	25
26	Trauma cabinet on wheels 28x57	2016	6,491	81	120	81		162	26
27	Ultrasound bk5000 dropin trans	2016	150,703	9,867	84	9,867		19,735	27
28	Ultrasound GE LeR6 Isolation C	2016	63,195	12,112	60	12,112		24,225	28
29	Ureteroscope Promo Flex 7.5FR	2016	20,106	2,513	36	2,513		5,027	29
30	Vision Washer/Disinfector FHO5	2016	79,118	1,978	180	1,978		3,956	30
31	Whirlpool SPA	2016	119,739	1,247	240	1,247		2,495	31
32	Whirlpool SPA-Heat Exchanger	2016	17,200	179	240	179		358	32
33	Whirlpool SPA-labor R&R Benche	2016	1,720	18	240	18		36	33
34	TOTAL (lines 1 thru 33)		\$ 136,067,920	\$ 4,056,890		\$ 4,056,890	\$	\$ 106,921,838	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	Totals from Page 12G, Carried Forward		\$ 136,067,920	\$ 4,056,890		\$ 4,056,890	\$	\$ 106,921,838	1
2	Whirlpool SPA-labor&material 3	2016	9,546	99	240	99		199	2
3	Work station beige metallic gl	2016	7,890	362	120	362		723	3
4	19in Barco LCD Monitor	2017	2,990	573	60	573		573	4
5	360lb Wireless Digital Scale	2017	1,693	162	120	162		162	5
6	AccVein AV400 and Stand	2017	4,683	898	60	898		898	6
7	AccVein AV400 and Stand	2017	4,683	820	60	820		820	7
8	AccVein AV400 and Stand	2017	9,366	1,483	120	1,483		1,483	8
9	ACT Plus Barcode Scanner	2017	495	70	60	70		70	9
10	ACT Plus Perfusion Instrument	2017	4,200	595	60	595		595	10
11	ACTTRAC Elect Contrl Act	2017	470	67	60	67		67	11
12	Adaptor connect Toomey Syringe	2017	93	30	36	30		30	12
13	ADSON FCPS 4-3/4 1X2 SERR MT	2017	40	13	36	13		13	13
14	ADSON FCPS 4-3/4 SERR MATTE	2017	34	11	36	11		11	14
15	AIDA HD Connct with Smartscrn	2017	32,117	6,156	60	6,156		6,156	15
16	Air Balance Test	2017	711	6	60	6		6	16
17	Airdyne 2000 Air Compressor	2017	2,850	89	144	89		89	17
18	Airseal Intell Flow Sys&Valve	2017	29,835	5,718	60	5,718		5,718	18
19	ALLIS FCP 6-1/4 5X6 MATTE	2017	42	13	36	13		13	19
20	ALT HP800 G1 SFF wo WRLS	2017	491	157	36	157		157	20
21	Ankle Arthroscopy Instrmt Set	2017	19,400	6,197	36	6,197		6,197	21
22	Aquilion 64slice CT Scanner	2017	162,825	17,639	60	17,639		17,639	22
23	Architect&Eng Fees	2017	62,874	4,017	540	4,017		4,017	23
24	Architect&Eng Fees	2017	67,726	4,327	360	4,327		4,327	24
25	ARCHITECTURAL & ENGINEERING	2017	76,913	2,777	180	2,777		2,777	25
26	ARCHITECTURAL SERVICES	2017	11,679	32	180	32		32	26
27	Asbestos Abatement Removal	2017	1,480	40	240	40		40	27
28	Assrtmnt Pk Sensa-Cuf Adlt	2017	67	9	84	9		9	28
29	Auto Cashier 20in Stainless st	2017	15,376	1,409	60	1,409		1,409	29
30	Auto Coagltm Timer Medtronic	2017	15,496	2,195	180	2,195		2,195	30
31	BACKHAUS FCPS 3 1/2 SAT	2017	140	45	36	45		45	31
32	Biospy Forceps Dbl Actn Jaws	2017	2,396	765	72	765		765	32
33	Biospy Forceps Ureterosecp	2017	2,898	926	36	926		926	33
34	TOTAL (lines 1 thru 33)		\$ 136,619,419	\$ 4,114,591		\$ 4,114,591	\$	\$ 106,980,000	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	Totals from Page 12H, Carried Forward		\$ 136,619,419	\$ 4,114,591		\$ 4,114,591	\$	\$ 106,980,000	1
2	BK3000 Ultrasound Sys	2017	46,301	6,339	84	6,339		6,339	2
3	Bladder Scan&Cart	2017	14,981	1,159	168	1,159		1,159	3
4	Blanketrol III 233 9ft Hose	2017	7,654	159	120	159		159	4
5	Brother PTP900W Label Printer	2017	310	13	60	13		13	5
6	Bulletin Board cork 24x36	2017	51	1	120	1		1	6
7	CARB EDGE MAYO SCS 6-3/4 STR	2017	184	59	36	59		59	7
8	CARB-BITE WEBSTER NH	2017	153	49	36	49		49	8
9	Cardiac Telemetry Unit	2017	37,016	4,010	60	4,010		4,010	9
10	Carpet Extractor EH2 220	2017	3,226	565	60	565		565	10
11	Ceiling Acoustical Tile	2017	5,197	623	96	623		623	11
12	Ceiling Acoustical Tile	2017	33,750	2,285	96	2,285		2,285	12
13	Ceramic Wall Tile	2017	2,700	73	240	73		73	13
14	Chair 2 seat upholstered	2017	2,700	38	180	38		38	14
15	Chair bariatric	2017	915	13	180	13		13	15
16	Chair guest no arms	2017	1,306	18	180	18		18	16
17	Chair guest side vinyl	2017	4,600	64	180	64		64	17
18	Chair guest with arms	2017	3,529	49	180	49		49	18
19	Chair mixit plastic	2017	12,120	168	180	168		168	19
20	Chair-Adj Arm Synchro-Tilt	2017	1,192	76	180	76		76	20
21	Chair-Sqr Uph bck arms	2017	2,274	145	540	145		145	21
22	Chair-Uph back arms cntrastng	2017	518	33	180	33		33	22
23	Climbmill C5X-06	2017	11,760	1,078	180	1,078		1,078	23
24	Cognitive DLXi Printer 200dpi	2017	550	23	60	23		23	24
25	COLLER CRILE FCPS 6-1/4 CVD	2017	183	58	36	58		58	25
26	Computer Upgrade-Carefusion	2017	11,486	2,201	60	2,201		2,201	26
27	Conduit and Wiring	2017	130,805	6,268	240	6,268		6,268	27
28	Conduit and Wiring	2017	24,480	663	240	663		663	28
29	Conduit to Power Poles	2017	24,060	652	240	652		652	29
30	Construction to replace walkin	2017	9,542	292	180	292		292	30
31	Convection Steamer HY6G	2017	13,353	389	120	389		389	31
32	Other Equip Placed into Service in FY2017	2017	5,269,131	495,832	197	495,832		495,832	32
33	Reconciliation adjustment for non-TCU assets					(4,427,542)	(4,427,542)		33
34	TOTAL (lines 1 thru 33)		\$ 142,295,446	\$ 4,637,986		\$ 210,444	\$ (4,427,542)	\$ 107,503,395	34

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

Facility Name & ID Number Gottlieb Memorial Hospital

8008518

Report Period Beginning:

July 1, 2016

Ending:

June 30, 2017

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 142,357,383	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,637,986	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,444	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,427,542)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 107,503,395	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Gottlieb Memorial Hospital

8008518

Report Period Beginning: July 1, 2016

Ending: June 30, 2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **June 30, 2017** (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	\$ 6,279,008	\$	1
2	Cash-Patient Deposits	19,658,880		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>64,682,236</u>)	18,603,223		3
4	Supply Inventory (priced at _____)	3,397,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	123,409		7
8	Accounts Receivable (owners or related parties)	2,114,314		8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 50,175,834	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	58,259,512		11
12	Long-Term Investments	105,000		12
13	Land	13,505,174		13
14	Buildings, at Historical Cost	69,756,535		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	44,962,534		16
17	Accumulated Depreciation (book methods)	(48,063,833)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,044,475		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____	88,963		22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 140,658,360	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 190,834,194	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,094,192	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	171,021		29
30	Accrued Salaries Payable	5,439,526		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	76,250		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payable to a Third Party</u>	9,443,571		36
37	<u>Other Accrued Expenses</u>	1,458,654		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 74,683,213	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,232,319		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Other LT Liab</u>	4,549,501		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 20,781,820	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 95,465,033	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 95,369,161	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 190,834,194	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,294,666	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,294,666	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,285,765	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,285,765	17
	B. Transfers (Itemize):		
18	Other Adjustments and Transfers	18,788,730	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 18,788,730	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 95,369,161	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: July 1, 2016Ending: June 30, 2017**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	\$ 522,473,444	1
2	Discounts and Allowances for all Levels	(406,708,230)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 115,765,214	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	10,414	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,414	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,244,956	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,244,956	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Revenue</u>	10,917,036	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,917,036	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 128,937,621	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	7,379	31
32	Health Care	3,110,968	32
33	General Administration	282,603	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Other Hospital Expenses not Allocated to the TCU/LTC</u>	122,250,906	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 125,651,856	40
41	Income before Income Taxes (line 30 minus line 40)**	3,285,765	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,285,765	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 20,565,643	44
45	Private Pay - Net Inpatient Revenue	874,452	45
46	Medicare - Net Inpatient Revenue	53,972,198	46
47	Other-(specify) <u>Commercial Payors</u>	40,352,921	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 115,765,214	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, 2016

Ending: June 30, 2017

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	1,872	2,088	\$ 112,840	\$ 54.04	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	22,060	25,061	1,002,410	40.00	3
4	Licensed Practical Nurses	3,475	4,033	104,994	26.03	4
5	CNAs & Orderlies	22,779	25,273	381,461	15.09	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,819	2,117	53,573	25.30	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	1,859	1,904	25,993	13.65	10
11	Social Service Workers	2,898	3,269	104,056	31.83	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	0	0	0		17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	0	0	0		20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	8,735	9,980	274,002	27.46	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	65,495	73,725	\$ 2,059,329 *	\$ 27.93	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

Facility Name & ID Number Gottlieb Memorial Hospital# 8008518Report Period Beginning: July 1, 2016Ending: June 30, 2016**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 28,568
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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