

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>8000200</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Graham Hospital</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/15</u> to <u>06/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>210 West Walnut St</u> <u>Canton</u> <u>61520</u> Number City Zip Code																																																			
County: <u>Fulton</u>																																																			
Telephone Number: <u>(309) 944-6431</u> Fax # <u>(309)-649-5411</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>7/02/1987</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>201 N. Harrison Street, Suite 300, Davenport, IA 52801</u></td></tr><tr><td>(Telephone) <u>(563) 888-4404</u> Fax # <u>(563) 324-6939</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>201 N. Harrison Street, Suite 300, Davenport, IA 52801</u>	(Telephone) <u>(563) 888-4404</u> Fax # <u>(563) 324-6939</u>																																						
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Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code <u>501c</u>																																																			
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																																	
Name: <u>Julie Reeder</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																																	
Telephone Number: <u>(309) 647-5240</u>		201 S. Grand Avenue East																																																	
Email Address: _____		Springfield, IL 62763-0001																																																	
		Phone # (217) 782-1630																																																	

#	8000200	Report Period Beginning:	07/01/15	Ending:	06/30/16
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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

Yes

YES

NO

X

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

YES

NO

X

Date started

5/1/1987

YES

Date

NO

X

YES

X

NO

9

If YES, enter number

of beds certified

32

and days of care provided

2,453

National Government Services

MODIFIED

ACCRUAL

X

CASH*

--	--

CASH*

--	--

YES

X

NO ☐**Fiscal Year:** 6/30/2016

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

	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	1,171	2,142	2,453	5,766	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,171	2,142	2,453	5,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.46%

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/15 Ending: 06/30/16
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	84,330		145,771	230,101		230,101		230,101			1
2	Food Purchase		298,978		298,978		298,978		298,978			2
3	Housekeeping	174,521		37,966	212,487		212,487		212,487			3
4	Laundry	10,665		96,817	107,482		107,482		107,482			4
5	Heat and Other Utilities											5
6	Maintenance	87,198		198,178	285,376		285,376		285,376			6
7	Other (specify):*											7
8	TOTAL General Services	356,714	298,978	478,732	1,134,424		1,134,424		1,134,424			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,715,011		67,128	1,782,139		1,782,139		1,782,139			10
10a	Therapy											10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Nursing School	48,956		8,476	57,432		57,432		57,432			15
16	TOTAL Health Care and Programs	1,763,967		75,604	1,839,571		1,839,571		1,839,571			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	471,853		81,698	553,551		553,551		553,551			21
22	Employee Benefits & Payroll Taxes			432,771	432,771		432,771		432,771			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			296,963	296,963		296,963		296,963			26
27	Other (specify):*											27
28	TOTAL General Administration	471,853		811,432	1,283,285		1,283,285		1,283,285			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,592,534	298,978	1,365,768	4,257,280		4,257,280		4,257,280			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			165,524	165,524		165,524	573,174	738,698			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			165,524	165,524		165,524	573,174	738,698			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			21,264	21,264		21,264		21,264			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			21,264	21,264		21,264		21,264			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,592,534	298,978	1,552,556	4,444,068		4,444,068	573,174	5,017,242			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	573,174			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 573,174		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 573,174		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjustment of Allocated Depreciation to actual	\$		1
2	straight line depreciation per page 12&13	573,174		2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	573,174		49

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

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

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

Facility Name & ID Number Graham Hospital # 8000200 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2	See attached Medicare worksheet B part 1 for allocations from hospital.								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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

FACILITY NAME	<u>Graham Hospital Association</u>	COUNTY	<u>Fulton</u>
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CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(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				\$		\$	

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

C. Tax Bills

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.**

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:

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

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	4
5				1972	866					866	5
6				1978	187,881					187,881	6
7				1982	3,684					3,684	7
8				1977	1,331,168		various	27895	27,895	1,287,060	8
	Improvement Type**										
9	1975 VARIOUS BUILDING IMPROVEMENTS			1975	30,771		various			30,771	9
10	1976 VARIOUS BUILDING IMPROVEMENTS			1976	1,880		various			1,880	10
11	1980 VARIOUS BUILDING IMPROVEMENTS			1980	2,093		various			2,093	11
12	1982 VARIOUS BUILDING IMPROVEMENTS			1982	1,543		various			1,543	12
13	1984 VARIOUS BUILDING IMPROVEMENTS			1984	1,169,963		various	16,169	16,169	1,059,044	13
14	1985 VARIOUS BUILDING IMPROVEMENTS			1985	34,258		various			34,258	14
15	1987 VARIOUS BUILDING IMPROVEMENTS			1987	89,317		various	109	109	89,042	15
16	1988 VARIOUS BUILDING IMPROVEMENTS			1988	52,287		various	4	4	52,147	16
17	1990 VARIOUS BUILDING IMPROVEMENTS			1990	28,254		various	3	3	28,203	17
18	1991 VARIOUS BUILDING IMPROVEMENTS			1991	125,804		various			125,804	18
19	1992 VARIOUS BUILDING IMPROVEMENTS			1992	16,693		various			16,693	19
20	1993 VARIOUS BUILDING IMPROVEMENTS			1993	19,686		various			19,686	20
21	1994 VARIOUS BUILDING IMPROVEMENTS			1994	76,132		various			76,132	21
22	1995 VARIOUS BUILDING IMPROVEMENTS			1995	32,594		various			32,594	22
23	1996 VARIOUS BUILDING IMPROVEMENTS			1996	47,691		various	88	88	47,691	23
24	1994 VARIOUS BUILDING IMPROVEMENTS			1997	24,479		various	101	101	24,368	24
25	1998 VARIOUS BUILDING IMPROVEMENTS			1998	26,173		various			26,173	25
26	1999 VARIOUS BUILDING IMPROVEMENTS			1999	11,097		various	555	555	10,217	26
27	2000 VARIOUS BUILDING IMPROVEMENTS			2000	800,069		various	19,383	19,383	800,069	27
28	2001 VARIOUS BUILDING IMPROVEMENTS			2001	112,532		various	1,116	1,116	112,532	28
29	2002 VARIOUS BUILDING IMPROVEMENTS			2002	578,790		various	37,043	37,043	556,410	29
30	2003 VARIOUS BUILDING IMPROVEMENTS			2003	356,376		various	24,613	24,613	340,541	30
31	2004 VARIOUS BUILDING IMPROVEMENTS			2004	466,553		various	35,708	35,708	453,702	31
32	2005 VARIOUS BUILDING IMPROVEMENTS			2005	953,088		various	63,278	63,278	701,350	32
33	2006 VARIOUS BUILDING IMPROVEMENTS			2006	2,994,111		various	156,500	156,500	1,778,460	33
34	2007 VARIOUS BUILDING IMPROVEMENTS			2007	2,221,427		various	93,042	93,042	946,147	34
35	2008 VARIOUS BUILDING IMPROVEMENTS			2008	1,406,411		various	79,001	79,001	679,337	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Graham Hospital

8000200

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	\$ 944	37
38	PCU AUTOMATIC DOORS	2009	1,927		10	193	193	1,446	38
39	ROOF L	2009	13,668		10	1,367	1,367	10,251	39
40	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONST	2009	7,055		15	470	470	3,527	40
41	08.23-GMG BOND EYE AREA REMODEL-DRYWALL/SNAP	2009	836		15	56	56	419	41
42	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767		10	77	77	576	42
43	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S C	2009	2,106		15	140	140	1,052	43
44	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONST	2009	1,823		15	122	122	913	44
45	PROJ 09.02-RISK ASSESSMENT REMODEL-PAINT/CARPET	2009	3,002		5			3,002	45
46	PROJ 09.03-GMG EXAM ROOM FLOOR-TILE/ADHESIVES	2009	449		10	45	45	337	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	1,270	48
49	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONS	2009	5,357		15	357	357	2,679	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	264	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD	2009	8,730		15	582	582	4,365	53
54	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102		15	73	73	550	54
55	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCT	2009	2,663		15	178	178	1,333	55
56	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171		15	78	78	585	56
57	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424		15	228	228	1,711	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	1,420	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	6,020	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	1,139	64
65	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRU	2009	4,802		15	320	320	2,401	65
66	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584		15	306	306	2,293	66
67	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769		15	251	251	1,884	67
68	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363		15	91	91	681	68
69		1972	5,755		VARIOUS			5,755	69
70	TOTAL (lines 4 thru 69)		\$ 14,346,577	\$		\$ 561,142	\$ 561,142	\$ 10,636,191	70

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

Facility Name & ID Number Graham Hospital

8000200

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	\$		\$ 561,142	\$ 561,142	\$ 10,636,191	1
2	1973 FIXED EQUIPMENT	1972	4,926		VARIOUS			4,926	2
3	1975 FIXED EQUIPMENT	1975	989		VARIOUS			989	3
4	1980 FIXED EQUIPMENT	1980	599		VARIOUS			599	4
5	1981 FISED EQUIPMENT	1981	1,188		VARIOUS			1,188	5
6	1987 FIXED EQUIPMENT	1987	37,780		VARIOUS			37,780	6
7	1988 FIXED EQUIPMENT	1988	1,439		VARIOUS			1,439	7
8	1992 FIXED EQUIPMENT	1992	3,936		VARIOUS			3,936	8
9	1994 FIXED EQUIPMENT	1994	4,732		VARIOUS			4,732	9
10	1995 FIXED EQUIPMENT	1995	7,700		VARIOUS			7,700	10
11	1996 FIXED EQUIPMENT	1996	1,422		VARIOUS			1,422	11
12	1998 FIXED EQUIPMENT	1998	2,006		VARIOUS			2,006	12
13	1999 FIXED EQUIPMENT	1999	2,891		VARIOUS			2,891	13
14	2001 FIXED EQUIPMENT	2001	20,918		VARIOUS			20,918	14
15	2002 FIXED EQUIPMENT	2002	920		VARIOUS			920	15
16	2003 FIXED EQUIPMENT	2003	30,047		VARIOUS	1,631	1,631	29,833	16
17	2005 FIXED EQUIPMENT	2005	10,856		VARIOUS			10,856	17
18	PROJ 04.11 NEW ER - CABLING & DUCTWORK	2006	22,004		10	1,103	1,103	22,004	18
19	PROJ 04.11 NEW ER - FIRE & SECURITY SYSTEM	2006	12,357		10	616	616	12,357	19
20	PROJ 04.11 NEW ER - WALLSLIDE & SUCTION UNITS	2006	5,999		10	299	299	5,999	20
21	PROJ 04.11 NEW ER - SHELVES, DOORS, DIVIDERS	2006	11,707		10	583	583	11,707	21
22	PROJ 05.04 LAB RENOVATION - DATA CABLING	2006	2,251		10	225	225	2,138	22
23	PROJ 05.10 - 1ST PHASE MED/SURG-PERSONAL PROTECTI	2007	1,364		5			1,364	23
24	PROJ 06.03 - ADMINISTRATION BOARDROOM - COUNTER	2007	4,359		10	436	436	4,142	24
25	PROJ 06.03 - ADMIN. BOARD RM-LAMINATED CASEWORK	2007	15,097		15	1,006	1,006	9,558	25
26	PROJ 04.16 - PYXIS - CABINETS	2007	442		15	29	29	277	26
27	PROJ 07.08 - THIRD FLOOR ONCOLOGY ROOM - CABINET	2007	2,406		10	241	241	2,289	27
28	PROJ 06.03 - ADMINISTRATION BOARDROOM - DROP-IN S	2007	1,539		10	154	154	1,463	28
29	07.10-HEARTCARE MIDWEST-CABINETS & COUNTERTOP	2008	5,545		15	370	370	3,144	29
30	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387		15	26	26	221	30
31	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTO	2008	367		15	24	24	205	31
32	08.04-HR RELOCATION-SINK	2008	304		20	15	15	128	32
33	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERT	2008	1,317		15	88	88	748	33
34	TOTAL (lines 1 thru 33)		\$ 14,566,371	\$		\$ 567,988	\$ 567,988	\$ 10,846,070	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:

07/01/15

Ending:

06/30/16

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	\$		\$ 567,988	\$ 567,988	\$ 10,846,070	1
2	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINETS	2008	1,126		15	75	75	638	2
3	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTOP	2008	366		15	24	24	205	3
4	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&CO	2008	401		15	27	27	229	4
5	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424		15	95	95	705	5
6	PROJ 09.11-GROUND FLOOR CLINIC-SINK	2009	215		5			215	6
7	PROJ 09.11-GROUND FLOOR CLINIC-ROOM DARKENING	2009	3,134		20	157	157	1,204	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	101	101	11,727	21
22	2003 LAND IMPROVEMENTS	2003	36,978		VARIOUS			36,978	22
23	2004 LAND IMPROVEMENTS	2004	83,693		VARIOUS	5,580	5,580	69,743	23
24	2005 LAND IMPROVEMENTS	2005	84,686		VARIOUS	5,687	5,687	62,559	24
25	PROJ 07.03 - SOUTH PARKING LOT	2007	9,186		8			9,186	25
26	PROJ 07.07 - SOUTH PARKING LOT STAIRS-RICKARD'S/CC	2007	9,465		15	631	631	5,995	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	2,233	28
29	SOUTH PATIO IMPROVEMENTS	2008	1,603		15	107	107	909	29
30	PAVING OF CLINIC PARKING LOT	2008	4,353		8	273	273	4,353	30
31	2010 Land Impr - Paving, Rock, Resurface, etc..	2010	15,449		30	515	515	4,113	31
32	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082		20	54	54	432	32
33	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939		25	118	118	767	33
34	TOTAL (lines 1 thru 33)		\$ 15,143,019	\$		\$ 581,667	\$ 581,667	\$ 11,363,554	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:

07/01/15

Ending:

06/30/16

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	\$		\$ 581,667	\$ 581,667	\$ 11,363,554	1
2	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INT	2010	385		40	10	10	65	2
3	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723		25	29	29	188	3
4	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257		40	731	731	4,752	4
5	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889		40	322	322	2,093	5
6	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTER	2010	2,576		40	64	64	418	6
7	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLO	2010	6,806		10	681	681	4,425	7
8	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENG	2010	1,510		40	38	38	246	8
9	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUP	2010	7,453		40	186	186	1,210	9
10	AMBULANCE BUILDING - WALNUT ST.	2010	1,089		40	27	27	176	10
11	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602		10	460	460	2,991	11
12	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963		15	131	131	851	12
13	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301		15	153	153	996	13
14	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061		10	1,706	1,706	11,089	14
15	ROOF M REPLACEMENT - MRI ROOF	2010	6,935		10	694	694	4,509	15
16	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & C	2010	4,786		15	319	319	2,074	16
17	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943		15	196	196	1,275	17
18	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPL	2010	2,485		15	166	166	1,078	18
19	PROJ. 10.04-EXT. CARE RENOVATIONS-RICKARD'S LABO	2010	15,761		40	394	394	2,561	19
20	PROJ. 10.04 EXT. CARE RENOVATIONS-FLAD & ASSOCIAT	2010	2,340		40	58	58	379	20
21	PROJ. 10.04-EXT. CARE RENOVATIONS-KIRWAN ENVIRON	2010	183		40	5	5	31	21
22	PROJ. 10.04-EXT. CARE RENOVATIONS-FLOOR TILING	2010	2,730		20	137	137	888	22
23	PROJ. 10.04-EXT. CARE RENOVATIONS-PAINT/TRIM/WALI	2010	1,576		5			1,576	23
24	PROJ. 10.04 - EXT. CARE RENOVATIONS-HANDRAILS/COU	2010	1,663		15	111	111	721	24
25	PROJ. 10.04 - EXT. CARE RENOVATIONS- WASTE	2010	368		40	9	9	59	25
26	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751		40	15,969	15,969	103,798	26
27	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCI	2010	21,283		40	532	532	3,458	27
28	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739		40	1,343	1,343	8,732	28
29	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIR	2010	1,006		40	25	25	163	29
30	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973		5			2,973	30
31	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927		10	193	193	1,253	31
32	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LAB	2010	770		40	19	19	125	32
33	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617		10	62	62	402	33
34	TOTAL (lines 1 thru 33)		\$ 15,994,470	\$		\$ 606,437	\$ 606,437	\$ 11,529,109	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:

07/01/15

Ending:

06/30/16

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		\$ 15,994,470	\$		\$ 606,437	\$ 606,437	\$ 11,529,109	1
2	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPL	2010	16,751		20	838	838	5,445	2
3	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083		20	1,054	1,054	6,852	3
4	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVI	2010	38,130		15	2,542	2,542	16,523	4
5	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVIC	2010	34,111		25	1,364	1,364	8,868	5
6	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR A	2010	2,487		20	124	124	808	6
7	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR AN	2010	4,482		25	179	179	1,165	7
8	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINE	2010	2,571		25	103	103	669	8
9	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SE	2010	2,274		25	91	91	591	9
10	PROJ. 10.04-EXT. CARE RENOVATIONS-ELECTRICAL SUPE	2010	1,085		10	108	108	704	10
11	PROJ. 10.04-EXT. CARE RENOVATIONS-MED GAS OUTLET	2010	653		15	44	44	284	11
12	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL	2010	27,126		25	1,085	1,085	7,053	12
13	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530		25	101	101	657	13
14	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637		25	25	25	165	14
15	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010		20	101	101	654	15
16	TABLES - (5)	2011	4,431		15	295	295	1,624	16
17	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494		5	1,249	1,249	12,494	17
18	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BU	2011	6,920		5	692	692	6,920	18
19	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONT	2011	1,053,994		40	26,350	26,350	144,925	19
20	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269		40	657	657	3,612	20
21	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063		40	27	27	147	21
22	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897		40	1,022	1,022	5,622	22
23	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750		40	219	219	1,203	23
24	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310		40	33	33	180	24
25	PROJ. 09.07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTIO	2011	635,931		40	15,898	15,898	87,440	25
26	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472		40	37	37	202	26
27	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750		8	1,469	1,469	8,078	27
28	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364		20	168	168	925	28
29	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUM	2011	8,120		20	406	406	2,233	29
30	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S AN	2011	1,609		20	80	80	441	30
31	PROJ. 10.16-SIX SIGMA ELECTRICITY PROJECT-ELECTRI	2011	33,624		10	3,362	3,362	18,492	31
32	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732		20	143	143	716	32
33	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295		8	1,518	1,518	7,591	33
34	TOTAL (lines 1 thru 33)		\$ 18,032,425	\$		\$ 667,821	\$ 667,821	\$ 11,882,392	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:

07/01/15

Ending:

06/30/16

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	\$		\$ 667,821	\$ 667,821	\$ 11,882,392	1
2	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426		2			426	2
3	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000		8	938	938	4,689	3
4	LANDSCAPING EP COLEMAN BUILDING	2012	9,287		10	464	464	2,321	4
5	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330		2			330	5
6	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600		8	288	288	1,439	6
7	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740		8	546	546	2,731	7
8	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900		8	1,244	1,244	6,220	8
9	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500		8	219	219	1,095	9
10	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208		10	810	810	4,051	10
11	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTR	2012	2,498		10	125	125	625	11
12	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543		5	4,954	4,954	24,771	12
13	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE ST	2012	490		5	49	49	245	13
14	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL	2012	2,385		5	239	239	1,194	14
15	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393		15	380	380	1,899	15
16	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284		15	76	76	380	16
17	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433		15	114	114	571	17
18	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LAB	2012	3,308		15	110	110	551	18
19	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142		15	105	105	524	19
20	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145		40	14,477	14,477	72,384	20
21	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872		15	96	96	479	21
22	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052		10	205	205	820	22
23	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL	2013	5,691		20	285	285	1,139	23
24	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411		25	176	176	705	24
25	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - V	2013	671		10	67	67	268	25
26	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592		15	239	239	957	26
27	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940		15	63	63	251	27
28	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055		15	70	70	281	28
29	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787		20	40	40	100	29
30	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122		15	8	8	20	30
31	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPIN	2014	215		25	8	8	20	31
32	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79		10	8	8	20	32
33	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRAD	2014	36,383		20	1,820	1,820	4,550	33
34	TOTAL (lines 1 thru 33)		\$ 19,405,907	\$		\$ 696,044	\$ 696,044	\$ 12,018,448	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:

07/01/15

Ending:

06/30/16

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	\$		\$ 696,044	\$ 696,044	\$ 12,018,448	1
2	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014	5,284		20	264	264	660	2
3	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014	14,291		20	714	714	1,786	3
4	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014	6,563		20	328	328	820	4
5	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHOP/	2014	2,107		20	106	106	264	5
6	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014	5,772		20	289	289	602	6
7	GHA/HH PARKING LOT SEALCOAT/REPAIR	2015	6,829		2	3,415	3,415	5,122	7
8	GMG/EP COLEMAN/WELLNESS PARKING LOT SEAL COAT/RI	2015	5,023		2	2,512	2,512	3,768	8
9	RISEATLAS 625QM CEILING LIFT	2015	19,373		10	1,937	1,937	2,906	9
10									10
11									11
12	Telemetry Electrical Cable Pull and Receptacle Install	2015	3,457		20	173	173	259	12
13	14.13 - TRANSFORMER REPLACEMENT	2015	43,590		20	2,179	2,179	3,269	13
14	14.15 - JOINT COMMISSION ELECTRICAL/PLUMBING REPAIR	2015	6,278		20	314	314	471	14
15	14.15 - JOINT COMMISSION AIR HANDLER REPAIR	2015	378		10	38	38	57	15
16	14.15 - JOINT COMMISSION DOOR CLOSER REPLACEMENT	2015	995		15	66	66	99	16
17	15.03 - WATER SOFTENER REPLACEMENT	2015	4,674		10	467	467	701	17
18									18
19	15-01 - Patient Registration - ELECTRICAL/DATA CABLE PULL/IT	2015	2,685		20	134	134	201	19
20	15-07 - Chiller Rebuild - TRANE CONTRACTED WORK	2015	54,304		20	2,715	2,715	4,073	20
21	14.10 - 2nd Floor Hallway Remodel	2015	7,446		5	1,489	1,489	2,234	21
22	14.15 - JOINT COMMISSION BUILDING REPAIRS	2015	463		5	93	93	139	22
23	HOSPITAL TUCKPOINT AND SKYLIGHT GLASS REPAIR	2015	27,029		40	676	676	1,014	23
24	PROJECT 14.04 - PHARMACY RENOVATIONS - PJ HOERR CON	2015	26,155		40	654	654	981	24
25									25
26									26
27	15-01 - Patient Registration - MISC BUILDING SUPPLIES	2015	6,561		5	1,312	1,312	1,968	27
28	15-01 - Patient Registration - PJ HOERR CONTRACT WORK	2015	334,913		40	8,373	8,373	12,559	28
29									29
30	Project 16-07, 16-08, 16-10, 16-16 - Parking lost asphalt recoat, repair	2016	17,438		15	581	581	581	30
31	concrete apron repair, sidewalk repair								31
32	Allocated Depreciation	2016		165,524			(165,524)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 20,007,517	\$ 165,524		\$ 724,873	\$ 559,349	\$ 12,062,982	34

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

XI. OWNERSHIP COSTS (continued)
C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 438,097	\$	\$ 13,825	\$ 13,825	5-15	\$ 400,172	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 438,097	\$	\$ 13,825	\$ 13,825		\$ 400,172	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)	\$ 20,445,614	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,524	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 738,698	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 573,174	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,463,154	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.

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:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

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

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	\$ 4,272,635	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	9,830,526		3
4	Supply Inventory (priced at)	1,399,058		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,473,321		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current</u>	3,558,240		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,533,780	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,083,867		13
14	Buildings, at Historical Cost	64,352,966		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	49,390,788		16
17	Accumulated Depreciation (book methods)	(58,618,412)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Assets Limited as to U</u>)	65,790,622		22
23	Other(specify): <u>Trust Fund</u>	7,810,382		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 133,810,213	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 154,343,993	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,186,810	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,255,000		29
30	Accrued Salaries Payable	3,493,980		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>	543,847		36
37	<u>Self Insurance Costs</u>	2,942,671		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 13,422,308	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	31,173,515		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>	7,058,880		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 38,232,395	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 51,654,703	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 102,689,290	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 154,343,993	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 104,568,255	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 104,568,255	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(649,455)	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	(709,761)	15
16	Other (describe) Increase in Temp. Resticted Assets Net	(519,749)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,878,965)	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)	\$ 102,689,290	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Graham Hospital

8000200

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	\$ 2,717,270	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,717,270	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>	3,373,701	28
28a	<u>Hospital Rev</u>	71,502,023	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,875,724	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 77,592,994	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,134,424	31
32	Health Care	1,839,571	32
33	General Administration	1,283,285	33
	B. Capital Expense		
34	Ownership	165,524	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	21,264	36
	D. Other Expenses (specify):		
37	<u>Hospital Expenses</u>	73,798,379	37
38	<u>Rounding</u>	2	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 78,242,449	40
41	Income before Income Taxes (line 30 minus line 40)**	(649,455)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (649,455)	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.

###

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

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			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*					
				Allocated Benefits		432,771			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$						
B. Administrative - Other									
Description			Amount				Less: Public Relations Expense		()
			\$				Non-allowable advertising		()
							Yellow page advertising		()
							TOTAL (agree to Sch. V, line 20, col. 8)		\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 432,771			
(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)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$				TOTAL		\$

*** Attach copy of IMRF notifications**

****See instructions.**

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. \$ 21,264
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 benefit 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: RSM US 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