

		FOR BHF USE						

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>8008518</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Gottlieb Memorial Hospital</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2024</u> to <u>June 30, 2025</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>701 W North Avenue</u> <u>Melrose Park</u> <u>60160</u> Number City Zip Code																											
County: <u>Cook</u>																											
Telephone Number: <u>(708) 450-4543</u> Fax # <u>(708) 450-5058</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>6/10/1985</u>		Officer or Administrator of Provider (Signed) _____ <u>10/17/2025</u> (Date) (Type or Print Name) <u>David B. Paluck</u> (Title) <u>Regional Director of Reimbursement</u>																									
Type of Ownership:																											
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (C) 3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (C) 3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> <u>()</u> Fax # <u>()</u> <u>()</u>	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																									
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	☐ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>David B. Paluck</u> Telephone Number: <u>(248) 756-0964</u> Email Address: _____																											
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																									

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberGottlieb Memorial Hospital# 8008518Report Period Beginning: July 1, 2024Ending: June 30, 2025

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

1234

	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.

123456789

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other		Total
				Medicaid Primary	Medicare Primary					
8	SNF	34	435	0	131	100	3,233	3,551	7,484	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	34	435		131	100	3,233	3,551	7,484	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)60.31%

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?YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNOX

I. On what date did you start providing long term care at this location?Date started05/20/1985

J. Was the facility purchased or leased after January 1, 1978?YESDateNONOX

K. Was the facility certified for Medicare during the reporting year?YESXNONOXIf YES, enter certified beds. number of certified beds34

Medicare IntermediaryNational Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUALMODIFIEDCASH*ACCRAUCASH*MODIFIEDCASH*

Is your fiscal year identical to your tax year?YESXNONOX

Tax Year:06/30/2025Fiscal Year:06/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary		13,697		13,697		13,697	123,772	137,469		1
2	Food Purchase										2
3	Housekeeping							164,104	164,104		3
4	Laundry										4
5	Heat and Other Utilities							130,776	130,776		5
6	Maintenance										6
7	Other (specify):*										7
8	TOTAL General Services		13,697		13,697		13,697	418,652	432,349		8
	B. Health Care and Programs										
9	Medical Director			31,828	31,828		31,828		31,828		9
10	Nursing and Medical Records	2,055,547	117,867	4,725	2,178,139		2,178,139	(34,795)	2,143,344		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	2,055,547	117,867	36,553	2,209,967		2,209,967	(34,795)	2,175,172		16
	C. General Administration										
17	Administrative	312,716	2,568	399,486	714,770		714,770	104,749	819,519		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses		16,183	12,179	28,362		28,362	47,179	75,541		21
22	Employee Benefits & Payroll Taxes							576,960	576,960		22
23	Inservic 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	312,716	18,751	411,665	743,132		743,132	728,888	1,472,020		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,368,263	150,315	448,218	2,966,796		2,966,796	1,112,744	4,079,540		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							83,942	83,942			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							83,942	83,942			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											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,368,263	150,315	448,218	2,966,796		2,966,796	1,196,686	4,163,482			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	1,196,686			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,196,686		\$	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	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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 1,196,686		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

Report Period Beginning:

Ending:

ID# 8008518

July 1, 2024

June 30, 2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Hospital W/S A-6 Reclass for Drugs Charged	(294)	10	2
3	Hospital W/S A-6 Reclass for Med Supplies	(35,563)	10	3
4	Hospital W/S B Overhead Alloc - Bldg & Fixt	81,364	30	4
5	Hospital W/S B Overhead Alloc - Movbl Equip	2,577	30	5
6	Hospital W/S B Overhead Alloc - Emp Benefits	576,960	22	6
7	Hospital W/S B Overhead Alloc - Admin & Gen	(21,733)	17	7
8	Hospital W/S B Overhead Alloc - Plant Oper	130,776	5	8
9	Hospital W/S B Overhead Alloc - Housekeeping	164,104	3	9
10	Hospital W/S B Overhead Alloc - Dietary	123,772	1	10
11	Hospital W/S B Overhead Alloc - Cafeteria	47,179	21	11
12	LTC Cost in Hosp Adm for Provider Partici. Fees	10,827	17	12
13	Hospital W/S B Overhead Alloc - Nursing Admin	115,655	17	13
14	Hospital W/S B Overhead Alloc - Central Supply	1,061	10	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	1,196,686		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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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.

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

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							\$		\$			\$								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. \$ _____ 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.)

B. Real Estate Taxes

Assessed Value from Real Estate Tax Bill:	2024	8
Real Estate Tax Bill for Calendar Year:	2020	9
	2021	10
	2022	11
	2023	12
	2024	13

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Gottlieb Memorial Hospital</u>	COUNTY	<u>Cook</u>
---------------	-----------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT David B Paluck

TELEPHONE (248) 756-0964 FAX #: (708) 216-8340

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:10,600

B. General Construction Type:ExteriorFrame

Number of Stories1

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 ground (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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Hospital and Parking	1,458,000	1961	\$ 61,937	1
2					2
3	TOTALS	1,458,000		\$ 61,937	3

	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				1961	\$61,937	\$	50	\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1962	5,314					5,314	9
10	Various			1963	57,578					57,578	10
11	Various			1964	154					154	11
12	Various			1965	839,469					839,469	12
13	Various			1966	18,069					18,069	13
14	Various			1967	99,677					99,677	14
15	Various			1969	243,126					243,126	15
16	Various			1970	10,866					10,866	16
17	Various			1971	410,569					410,569	17
18	Various			1972	63,023					63,023	18
19	Various			1973	36,443					36,443	19
20	Various			1974	70,028					70,028	20
21	Various			1975	2,422					2,422	21
22	Various			1976	3,446,023					3,446,023	22
23	Various			1977	7,474,834					7,474,834	23
24	Various			1978	172,682					172,682	24
25	Various			1979	159,159					159,159	25
26	Various			1980	729,897					729,897	26
27	Various			1981	1,633,608					1,633,608	27
28	Various			1982	4,159,391					4,159,391	28
29	Various			1983	3,028,019					3,028,019	29
30	Various			1984	245,719					245,719	30
31	Various			1985	7,212,994					6,794,006	31
32	Various			1986	2,251,370					2,251,370	32
33	Various			1987	1,228,658					1,228,658	33
34	Various			1988	1,055,957					1,055,957	34
35	Various			1989	5,888,073					5,888,073	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

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	1990	\$ 5,443,853	\$		\$		\$ 5,443,853	37
38	Various	1991	2,702,153					2,702,153	38
39	Various	1992	2,395,628					2,395,628	39
40	Various	1993	1,601,815					1,601,815	40
41	Various	1994	2,933,038					2,933,038	41
42	Various	1995	4,858,946					4,858,946	42
43	Various	1996	4,322,888					4,322,888	43
44	Various	1997	3,851,805					3,851,805	44
45	Various	1998	7,826,827					7,826,827	45
46	Various	1999	3,782,851					3,782,851	46
47	Various	2000	6,562,656					6,562,656	47
48	Various	2001	4,472,858					4,472,858	48
49	Various	2002	3,071,826					3,071,826	49
50	Various	2003	1,616,067					1,616,067	50
51	Various	2004	2,567,622					2,567,622	51
52	Various	2005	4,098,669					4,098,669	52
53	Various	2006	1,656,917	66,572		66,572		1,153,914	53
54	Various	2007	1,091,422	40,123		40,123		689,109	54
55	Various	2008	392,789	21,427		21,427		352,263	55
56	Various	2009	3,415,801	121,618		121,618		1,988,318	56
57	Various	2011	274,704					274,704	57
58	Various	2012	6,839,918	383,542		383,542		5,237,418	58
59	Various	2013	1,181,773	63,608		63,608		820,760	59
60	Various	2014	1,833,044					1,833,044	60
61	Various	2015	2,485,362	144,859		144,859		1,486,256	61
62	Various	2016	15,339,088	512,424		512,424		12,498,400	62
63	Various	2017	8,692,102	285,167		285,167		7,039,431	63
64	Various	2018	2,283,169	138,971		138,971		1,906,121	64
65	Various	2019	3,044,508	152,851		152,851		1,876,132	65
66	Various	2020	17,879,710	1,322,136		1,322,136		7,059,713	66
67	Various	2021	7,548,734	673,406		673,406		2,895,645	67
68	Various	2022	10,734,133	1,007,012		1,007,012		3,476,703	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 187,407,736	\$ 4,933,717		\$ 4,933,717	\$	\$ 152,821,567	70

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 187,407,736	\$ 4,933,717		\$ 4,933,717	\$	\$ 152,821,567	1
2	IS Hardware Black Box Equipmnt	2023	11,923	2,385	5	2,385		7,054	2
3	Groen Gas Hypersteam Convectn	2023	20,919	2,092	10	2,092		6,189	3
4	HP Work Stations	2023	16,275	1,628	10	1,628		4,815	4
5	Ultrasound Sys bk3000&Transder	2023	106,564	21,313	5	21,313		63,050	5
6	(7) Sara Flex Patient Scales	2023	36,021	5,146	7	5,146		15,223	6
7	AMSCO 53 Reproces Sink 120TRPL	2023	11,900	595	20	595		1,711	7
8	Terrazo Flooring Replacement	2023	20,510	1,367	15	1,367		3,931	8
9	Midmark Table Procedure Chair	2023	11,032	735	15	735		2,114	9
10	HS Smith Platinum Frame Englis	2023	4,676	468	10	468		1,305	10
11	Insignia Series Glute	2023	4,409	441	10	441		1,231	11
12	Insignia Series Asist Dip Chin	2023	4,747	475	10	475		1,325	12
13	Insignia Series Pulldown	2023	4,539	454	10	454		1,267	13
14	Insignia Series Leg Extension	2023	4,695	469	10	469		1,311	14
15	Insignia Series Chest Press	2023	4,747	475	10	475		1,325	15
16	Insignia Series Triceps Press	2023	4,363	436	10	436		1,218	16
17	MTS Abdominal	2023	4,961	496	10	496		1,385	17
18	Hammer Strength Abdomin Crunch	2023	3,824	382	10	382		1,067	18
19	Life Fitness CLST Treadmill	2023	29,240	3,655	8	3,655		10,204	19
20	Cybex 750AT Body Arc Trainer	2023	11,296	1,130	10	1,130		3,153	20
21	Spin Bike Belt Drive Mat Black	2023	2,979	596	5	596		1,663	21
22	Spin Bike Belt Drive Mat Black	2023	2,979	596	5	596		1,663	22
23	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	23
24	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	24
25	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	25
26	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	26
27	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	27
28	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	28
29	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	29
30	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	30
31	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	31
32	Spin Bike Belt Drive Mat Black	2023	2,979	596	60	596		1,663	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 187,760,118	\$ 4,985,006		\$ 4,985,006	\$	\$ 152,970,403	34

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

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		\$ 187,760,118	\$ 4,985,006		\$ 4,985,006		\$ 152,970,403	1
2	Scrubber-Restroom&Pool Cleaner	2023	21,051	1,403	15	1,403		3,918	2
3	EarlyVue VS30 Vitals Monitor	2023	53,308	10,662	5	10,662		29,764	3
4	Stryker OR7 hub voice control	2023	29,941	1,996	15	1,996		5,073	4
5	UroNav R3 System&UroNav 4 Sys	2023	192,721	38,544	5	38,544		97,967	5
6	Patient Monitor MX40 1.4GHZ	2023	3,590	513	7	513		1,303	6
7	Furnish&Install Eye Wash Sink	2023	3,375	225	15	225		553	7
8	Inpat Dialysis-Automatic Door	2023	5,458	546	10	546		1,296	8
9	MINUTEMAN 9GL17in self contain	2023	3,875	258	15	258		614	9
10	POB Conference Room Monitors	2023	99,652	19,930	5	19,930		47,335	10
11	Hemosphere Cardiac Output Unit	2023	43,670	8,734	5	8,734		20,015	11
12	EarlyVue VS30 Vitals Monitor	2023	5,033	1,007	5	1,007		2,307	12
13	EarlyVue VS30 Vitals Monitor	2023	5,033	1,007	5	1,007		2,307	13
14	Plumbing-New Dialysis Boxes	2023	24,250	1,213	20	1,213		2,678	14
15	Admin Access Control 1st Floor	2023	11,955	2,391	5	2,391		5,280	15
16	Lumera700 Anterior Microscope	2023	175,845	35,169	5	35,169		77,665	16
17	SCA200 Scout Handheld Imager	2023	8,550	1,710	5	1,710		3,776	17
18	ECHONOUS Bladder Probe S8-AI	2023	10,550	1,507	7	1,507		3,328	18
19	E14CL4B Biplane EndoTransducer	2023	122,875	17,554	7	17,554		38,764	19
20	ASCO various amps ATS	2023	81,978	5,465	15	5,465		11,614	20
21	Countertop 31LF & Backsplash	2023	20,341	1,356	15	1,356		2,882	21
22	Telemetry MX40 1.4GHz S02 ECG	2023	2,885	577	5	577		1,226	22
23	R7 Handheld Radio&SLR Repeater	2023	57,429	11,486	5	11,486		24,407	23
24	Setup 2000cfm Air Scrubber	2024	12,000	800	15	800		1,567	24
25	Reno/Replace Cath Lab2	2024	800,000	53,333	15	53,333		104,444	25
26	Knee Stool Sedona Mesa Black	2024	3,050	203	15	203		398	26
27	Chiller Pharma KKT ModelCBOX40	2024	249,750	16,650	15	16,650		32,606	27
28	Ped Doors Stairwav Alarm 3West	2024	3,389	389	10	389		762	28
29	Chapel Avigilon&Hanwha Cameras	2024	4,575	915	5	915		1,792	29
30	Stryker Laparoscopic Equipment	2024	1,315,346	131,535	10	131,535		257,588	30
31	Work Station SecureView DX1200	2024	68,800	6,880	10	6,880		13,473	31
32	Samsung 4K TV&Peerless Mount	2024	1,871	374	5	374		733	32
33	Samsung 4K TV&Peerless Mount	2024	1,871	374	5	374		733	33
34	TOTAL (lines 1 thru 33)		\$ 191,204,633	\$ 5,359,712		\$ 5,359,712		\$ 153,768,570	34

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 191,204,633	\$ 5,359,712		\$ 5,359,712		\$ 153,768,570	1
2	Samsung 4K TV&Peerless Mount	2024	1,871	374	5	374		733	2
3	Various moves Cath Lab Dept	2024	1,082	361	3	361		706	3
4	Intellivue MP5 Physiologic Mon	2024	10,248	2,050	5	2,050		4,014	4
5	Intellivue MP5 Physiologic Mon	2024	10,389	2,078	5	2,078		4,069	5
6	Intellivue MP5 Physiologic Mon	2024	10,248	2,050	5	2,050		4,014	6
7	Midmark Table Procedure Chair	2024	11,095	740	15	740		1,449	7
8	Labor Inst&Test Feedwater Ctrl	2024	12,888	1,289	10	1,289		2,417	8
9	Engineer Electrical Infrastruc	2024	10,750	717	15	717		1,284	9
10	Fluoro Uroskon Omnia Max KMAT	2024	411,353	58,765	7	58,765		105,287	10
11	Cystoscope Table Teletom instl	2024	20,145	1,343	15	1,343		2,406	11
12	Hscribe Install&Configure Serv	2024	3,500	700	5	700		1,254	12
13	Elevtr6 GALMOVROperator&Clutch	2024	33,245	1,662	20	1,662		2,840	13
14	EPIQ CVX ULTRASOUND SYSTEM	2024	138,488	27,698	5	27,698		47,317	14
15	Blood Bank Fridge 44.9 cu ft	2024	10,890	1,089	10	1,089		1,860	15
16	Vein Visualization Sys&stand	2024	23,070	4,614	5	4,614		7,882	16
17	Instl Systimax Cat5e&6 Cabling	2024	11,050	737	15	737		1,197	17
18	Renovation 3W-Construction	2024	818,037	55,037	15	55,037		88,621	18
19	Renovation 3W-Architect Fees	2024	87,927	5,862	15	5,862		9,525	19
20	PDC Labor Hours	2024	4,607	326	15	326		499	20
21	Engineering Fees	2024	120,054	8,004	15	8,004		13,006	21
22	Azurion 7 M20 RadFluoro System	2024	1,305,931	186,562	7	186,562		303,163	22
23	EnVisio Navigation System	2024	90,000	18,000	5	18,000		29,250	23
24	Sentimag System&Transport Box	2024	71,825	14,365	5	14,365		23,343	24
25	Neoprobe Console Model2400	2024	45,814	9,163	5	9,163		14,889	25
26	Liposuction PAL650 & Cannulas	2024	38,546	7,709	5	7,709		12,527	26
27	IP Cameras&Aiphone Video Intcm	2024	16,325	3,265	5	3,265		5,034	27
28	Flexible Cystoscope CHNL 7FR 1	2024	14,641	4,880	3	4,880		7,524	28
29	Const Cystoscope Table Replace	2024	444,134	29,609	15	29,609		45,647	29
30	Nicor Meter Concrete Asbly Pad	2024	34,635	2,309	15	2,309		3,560	30
31	Instl Data Outlets Nurse statn	2024	1,815	91	20	91		140	31
32	Gynnie OBGYN Stretcher 500lbs	2024	5,977	398	15	398		614	32
33	Gynnie OBGYN Stretcher 500lbs	2024	5,977	398	15	398		614	33
34	TOTAL (lines 1 thru 33)		\$ 195,031,191	\$ 5,811,954		\$ 5,811,954		\$ 154,515,255	34

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 195,031,191	\$ 5,811,954		\$ 5,811,954		\$ 154,515,255	1
2	Gynnie OBGYN Stretcher 500lbs	2024	5,977	398	15	398		614	2
3	RCA UHD LED TV&Peerless Mount	2024	1,539	308	5	308		475	3
4	Symphony ice&water dispenser	2024	4,020	402	10	402		620	4
5	Lariat Chairs secured to walls	2024	10,524	702	15	702		1,082	5
6	Task Chairs Vinyl Color Mesa	2024	10,930	729	15	729		1,123	6
7	Recliners&Overbed Tables	2024	57,103	3,807	15	3,807		5,869	7
8	Podiatry Chair dark upholstery	2024	7,860	524	15	524		808	8
9	Symphony ice&water dispenser	2024	3,156	316	10	316		487	9
10	Refrigerator undercounter	2024	2,143	214	10	214		330	10
11	PacsCube Catalyst 6000&Dell PC	2024	17,397	3,479	5	3,479		5,074	11
12	Stryker OR Endoscopy Booms	2024	54,110	3,607	15	3,607		5,261	12
13	Condensate Pump VNS-2000-1	2024	15,658	1,044	15	1,044		1,522	13
14	Symphony ice&water dispenser	2024	4,451	445	10	445		649	14
15	System 8 Dual Trigger Rotary	2024	8,381	838	10	838		1,222	15
16	Moses Holmium Laser 2.0 Pulse	2024	203,900	40,780	5	40,780		56,073	16
17	Sign Interior Infor&Install 3W	2024	3,900	780	5	780		1,008	17
18	UltraLow Tissue Freezer 18cuft	2024	15,914	1,591	10	1,591		2,056	18
19	Guardian Pivot Table-Hip Surg	2024	57,000	5,700	10	5,700		7,363	19
20	Transducer RC60XI/5.2 mghz	2024	6,000	857	7	857		1,107	20
21	Glidescope Core 15 FHD Premium	2024	22,458	2,246	10	2,246		2,901	21
22	PDC Labor Hours	2024	15,457	1,030	15	1,030		1,245	22
23	Refrigerator 24in SS Door	2024	948	95	10	95		115	23
24	Trident Full Field Detector	2024	111,990	22,398	5	22,398		27,064	24
25	Icareic200 Tonometer with Case	2024	5,999	600	10	600		725	25
26	Biplane Endo Transducer E14CL4B	2024	16,709	2,387	7	2,387		2,884	26
27	Biplane Endo Transducer E14CL4B	2024	16,709	2,387	7	2,387		2,884	27
28	MX40 1.4GHz MonitoringTelepack	2024	35,936	7,187	5	7,187		8,086	28
29	Endoscopic CO2 Regulation Unit	2024	3,996	400	10	400		450	29
30	AirCurve Vauto with Humidifier	2024	15,000	3,000	5	3,000		3,375	30
31	Glidescope Core 15 FHD Premium	2024	35,787	3,579	10	3,579		4,026	31
32	Fire Door Rear Daycare Red Oak	2024	4,327	300	15	300		300	32
33	Walk-In Lab Cooler Upgrades	2024	11,281	783	15	783		783	33
34	TOTAL (lines 1 thru 33)		\$ 195,817,750	\$ 5,924,868		\$ 5,924,868		\$ 154,662,834	34

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

1		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		\$ 195,817,750	\$ 5,924,868		\$ 5,924,868		\$ 154,662,834	1
2	Reno/Replace Cath Lab2	2024	103,199	7,167	15	7,167		7,167	2
3	PACU Transport Monitor Handhel	2024	2,854	595	5	595		595	3
4	Conference Room Sys Rooms 1&2	2024	4,822	1,005	5	1,005		1,005	4
5	Electromvograph Model EDX	2024	28,238	4,202	7	4,202		4,202	5
6	Hover Lift Maximize with Scale	2024	7,914	824	10	824		824	6
7	ECHONOUS Bladder Probe S9-A1	2024	19,800	2,946	7	2,946		2,946	7
8	Replace Fuel Oil Valves-Boiler	2025	9,778	625	15	625		625	8
9	Task Chairs Armless Vinyl	2025	6,968	445	15	445		445	9
10	Patient Care Recliners	2025	9,767	624	15	624		624	10
11	Hyperthermia Unit Altrix	2025	26,065	2,498	10	2,498		2,498	11
12	LithoClast Trilogy System Kit	2025	79,566	11,272	5	11,272		11,272	12
13	Hyperthermia Unit Altrix	2025	26,065	1,629	10	1,629		1,629	13
14	Avvigo Intravascular Ultrasoun	2025	100,000	12,500	5	12,500		12,500	14
15	Nitrous Oxide Delivery System	2025	7,962	616	7	616		616	15
16	DaVinci Xi Dual Console IS4000	2025	1,953,200	151,140	7	151,140		151,140	16
17	Sonosite ICU LX Ultrasound	2025	71,800	7,778	5	7,778		7,778	17
18	Video Processor Illuminator VP	2025	147,491	15,978	5	15,978		15,978	18
19	Robotic HIF Ultrasound System	2025	625,000	48,363	7	48,363		48,363	19
20	EarlyVue VS30 Vitals Monitor	2025	3,201	347	5	347		347	20
21	NEC 43in Screens for DaVinciXi	2025	3,495	262	5	262		262	21
22	NEC 43in Screens for DaVinciXi	2025	3,495	262	5	262		262	22
23	Sun Nuclear Diagnostic Imaging	2025	3,500	263	5	263		263	23
24	Airseal Insufflator for Robots	2025	26,500	1,988	5	1,988		1,988	24
25	Elevator Room Mini Split 3ton	2025	30,420	1,775	5	1,775		1,775	25
26	Trane Back-Up Chiller for OR	2025	339,867	4,720	15	4,720		4,720	26
27	NEC 43in Screens for DaVinciXi	2025	4,242	177	5	177		177	27
28	South Wing HW Pump replacement	2025	46,223	642	15	642		642	28
29	Complete Gearbox Replacement	2025	41,118	571	15	571		571	29
30	Samsung GM85 Portable Xray	2025	109,500	3,259	7	3,259		3,259	30
31	Samsung GM85 Portable Xray	2025	109,500	3,259	7	3,259		3,259	31
32	Jackson Flat Top Tractn Device	2025	3,149	66	10	66		66	32
33	Air Handler 3RD Floor Mech Rm	2025	1,240,170	7,751	20	7,751		7,751	33
34	TOTAL (lines 1 thru 33)		\$ 201,012,618	\$ 6,220,416		\$ 6,220,416		\$ 154,958,381	34

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

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		\$ 201,012,618	\$ 6,220,416		\$ 6,220,416		\$ 154,958,381	1
2	Fire Pump Controller 125HP	2025	45,325	283	20	283		283	2
3	Mitsubishi Mini Split-Cath Lab	2025	41,990	262	20	262		262	3
4	Underground Fuel Tank 10000gal	2025	401,277	2,508	20	2,508		2,508	4
5	Install SLX Surgical Lights	2025	45,068	376	15	376		376	5
6	Procuity LEX Bed with Isotour	2025	15,798	395	5	395		395	6
7	ERC Coil-MRI of Pelvis Area	2025	21,330	533	5	533		533	7
8	Vvntus Pulmonary Test System	2025	46,087	720	8	720		720	8
9	Scope Buddy Plus SBP-1000	2025	3,037	76	5	76		76	9
10	Reconciliation adjustment for non-TCU assets					(6,141,627)	(6,141,627)		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	TOTAL (lines 1 thru 33)		\$ 201,632,531	\$ 6,225,569		\$ 83,942	\$ (6,141,627)	\$ 154,963,535	34

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

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	2	
		Reference	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)	\$ 201,694,468	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 6,225,569	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,942	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,141,627)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 154,963,535	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

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

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

10. Effective dates of current rental agreement:
- Beginning
- Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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)	\$					

- (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

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	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					Units	Cost										
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	
	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 776,350	\$	1
2	Cash-Patient Deposits	455,719		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 134,653,788)	17,422,912		3
4	Supply Inventory (priced at)	2,724,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	766,802		7
8	Accounts Receivable (owners or related parties)	309,384,631		8
9	Other(specify):	296,219		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 331,826,632	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,518,284		12
13	Land	12,500,000		13
14	Buildings, at Historical Cost	101,060,931		14
15	Leasehold Improvements, at Historical Cost	1,656,928		15
16	Equipment, at Historical Cost	68,782,732		16
17	Accumulated Depreciation (book methods)	(118,206,379)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,289,862		19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	263,402		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 73,865,761	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 405,692,393	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 271,299,382	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	650,807		29
30	Accrued Salaries Payable	5,118,194		30
	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	Other Accrued Expenses	2,339,908		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 279,408,291	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,404,673		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other LT Liab	498,099		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 14,902,772	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 294,311,064	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 111,381,329	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 405,692,393	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$110,340,444	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$110,340,444	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,040,885	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)	\$1,040,885	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)	\$111,381,329	24

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 742,322,539	1
2	Discounts and Allowances for all Levels	(597,805,522)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 144,517,017	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	Other Revenue	8,923,977	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,923,977	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 153,440,994	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	13,697	31
32	Health Care	2,209,967	32
33	General Administration	743,132	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	Other Hospital Expenses not Allocated to the TCU/LTC	150,827,055	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 153,793,851	40
41	Income before Income Taxes (line 30 minus line 40)**	(352,856)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (352,856)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 3,468,659.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	19,802,041.00	45
46	MMAI-Medicaid is the Primary Payer	509,989.00	46
47	MMAI-Medicare is the Primary Payer	2,088,669.00	47
48	Private Pay	1,091,633.00	48
49	Medicare Part A	67,376,899.00	49
50	Other-(specify) All Other	50,179,127.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 144,517,017	56

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	944	942	\$ 68,896	\$ 73.14	1
2	Assistant Director of Nursing	2,982	2,975	117,003	39.33	2
3	Registered Nurses	32,404	32,328	1,628,192	50.36	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	22,046	21,994	461,059	20.96	5
6	CNA Trainees					6
7	Licensed Therapist	276	275	9,601	34.91	7
8	Rehab/Therapy Aides					8
9	Activity Director	8	8	664	83.00	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	552	551	29,023	52.67	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator	2,251	2,246	55,808	24.85	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	201	201	3,582	17.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	61,664	61,520	\$ 2,373,828 *	\$ 38.59	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
Management			\$ 99,419	Workers' Compensation Insurance		\$ 13,704	IDPH License Fee	\$
Other Administrative			171,891	Unemployment Compensation Insurance		12	Advertising: Employee Recruitment	
				FICA Taxes		173,355	Health Care Worker Background Check	
				Employee Health Insurance		207,890	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	
				Pension				
				401K		82,388		
				Life Insurance		2,314		
				Disability Insurance		4,850		
				Tuition Reimbursement		372		
				Employee Recognition			Less: Public Relations Expense	()
				Severance and Other		108	PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
\$ 271,310								
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
\$								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V,	
(For legal fee disclosure, see page 39 of instructions)							line 24, col. 8)	
\$				TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number		Gottlieb Memorial Hospital		STATE OF ILLINOIS		#		8008518		Report Period Beginning:		July 1, 2024		Ending:		June 30, 2024		Page 22															
XX. GENERAL INFORMATION:																																	
(1)		Are nursing employees (RN,LPN,NA) represented by a union?																		No													
(2)		Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.																															
		Association Name																		Amount													
																				Total													
(3)		List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations. The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1																															
																				Total													
(4)		EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)																															
																				Total													
(5)		Indicate the total amount of both disposable and non-disposable incontinent expenses and the location of this expense on Sch. V.																		\$		Line		N/A									
(6)		Have all costs reported on this form been determined using accounting procedures consistent with prior reports?																		Yes		If NO, attach a complete explanation.											
(7)		Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.																		\$		44,131		This amount is to be recorded on line 42 of Schedule V.									
(8)		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.											
(9)		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													
(10)		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.											
(11)		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	
(12)		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							
(13)		Has an audit been performed by an independent certified public accounting firm?																		Yes		Firm Name:		Deloitte									
(14)		Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?																		Yes													
(15)		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:											