

		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>8000200</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Graham Hospital Canton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2024</u> to <u>6/30/2025</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>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: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Julie Reeder</u></td></tr><tr><td>(Title) <u>Vice President of Finance/CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Paul Traczek, CPA Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Wipfli Advisory LLC 4890 Owen Ayres Court, Suite 200, Eau Claire, WI 54701</u></td></tr><tr><td>(Telephone) <u>(715) 858-6619</u> Fax # <u>(715) 832-2345</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Julie Reeder</u>	(Title) <u>Vice President of Finance/CFO</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Paul Traczek, CPA Partner</u>	(Firm Name & Address) <u>Wipfli Advisory LLC 4890 Owen Ayres Court, Suite 200, Eau Claire, WI 54701</u>	(Telephone) <u>(715) 858-6619</u> Fax # <u>(715) 832-2345</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>7/2/1987</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 _____</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 _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Kyle Cook</u> Telephone Number: <u>(309) 647-5240</u>																									
Email Address: _____																									

Facility Name & ID Number

Graham Hospital Canton

#

8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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

1	2	3	4
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	37	Skilled (SNF)	37
2		Skilled Pediatric (SNF/PED)	
3		Intermediate (ICF)	
4		Intermediate/DD	
5		Sheltered Care (SC)	
6		ICF/DD 16 or Less	
7	37	TOTALS	37

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9
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			2,083		4,791	1,119	7,993
9	SNF/PED							
10	ICF							
11	ICF/DD							
12	SC							
13	DD 16 OR LESS							
14	TOTALS			2,083		4,791	1,119	7,993

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

59.19%

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)

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

X

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

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

5/1/1987

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

YES

Date

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

20

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCURAL

X

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

6/30/2025

Fiscal Year:

6/30/2025

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

STATE OF ILLINOIS

Facility Name & ID Number

Graham Hospital Canton

#8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	302,491		21,461	323,952		323,952	0	323,952			1
2	Food Purchase		190,330		190,330		190,330	0	190,330			2
3	Housekeeping	113,361		26,426	139,787		139,787	0	139,787			3
4	Laundry	7,179		460,813	467,992		467,992	0	467,992			4
5	Heat and Other Utilities			72,830	72,830		72,830	0	72,830			5
6	Maintenance	77,283		58,079	135,362		135,362	0	135,362			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	500,314	190,330	639,609	1,330,253	0	1,330,253	0	1,330,253			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	2,212,840		152,058	2,364,898		2,364,898	0	2,364,898			10
10a	Therapy				0		0	0	0			10a
11	Activities				0		0	0	0			11
12	Social Services				0		0	0	0			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,212,840	0	152,058	2,364,898	0	2,364,898	0	2,364,898			16
	C. General Administration											
17	Administrative	207,760		154,965	362,725		362,725	(1,090)	361,635			17
18	Directors Fees				0		0	0	0			18
19	Professional Services				0		0	0	0			19
20	Dues, Fees, Subscriptions & Promotions				0		0	0	0			20
21	Clerical & General Office Expenses	135,173		105,204	240,377		240,377	0	240,377			21
22	Employee Benefits & Payroll Taxes			584,026	584,026		584,026	0	584,026			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar				0		0	0	0			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			55,075	55,075		55,075	0	55,075			26
27	Other (specify):* Central Supply	11,331			11,331		11,331	0	11,331			27
28	TOTAL General Administration	354,264	0	899,270	1,253,534	0	1,253,534	(1,090)	1,252,444			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,067,418	190,330	1,690,937	4,948,685	0	4,948,685	(1,090)	4,947,595			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			251,335	251,335		251,335	0	251,335			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			251,335	251,335	0	251,335	0	251,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			73,610	73,610		73,610	0	73,610			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	73,610	73,610	0	73,610	0	73,610			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,067,418	190,330	2,015,882	5,273,630	0	5,273,630	(1,090)	5,272,540			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 0		\$ 0	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)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 0		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.			\$		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities	(1,090)	17	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	(1,090)		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[illegible]

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)

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Line	Item		Name of Related Organization				
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* 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

Facility Name & ID Number Graham Hospital Canton # 8000200 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

Facility Name & ID Number Graham Hospital Canton # 8000200 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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					\$	\$		0	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						\$	0	\$	0		\$	0	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	0	14
15	TOTALS (line 9+line14)						\$	0	\$	0		\$	0	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	0	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	0	7
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	
		FOR BHF USE ONLY			
		14	FROM R. E. TAX STATEMENT FOR 2024 \$		14
		15	PLUS APPEAL COST FROM LINE 5 \$		15
		16	LESS REFUND FROM LINE 6 \$		16
		17	AMOUNT TO USE FOR RATE CALCULATION \$		17

NOTES:

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	ECF/SNF	16,688		\$	1
2					2
3	TOTALS	16,688		\$ 0	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1,971	\$ 1,047,221	\$		\$	\$	1,047,221	4
5				1,972	866					866	5
6				1,978	187,881					187,881	6
7				1,982	3,684					3,684	7
8				1,977	1,331,168					1,331,168	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			1,169,963	13
14	1985 VARIOUS BUILDING IMPROVEMENTS			1985	34,258		various			34,258	14
15	1987 VARIOUS BUILDING IMPROVEMENTS			1987	89,317		various	0		89,317	15
16	1988 VARIOUS BUILDING IMPROVEMENTS			1988	52,287		various	4	4	52,179	16
17	1990 VARIOUS BUILDING IMPROVEMENTS			1990	28,254		various	3	3	28,227	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			47,691	23
24	1994 VARIOUS BUILDING IMPROVEMENTS			1997	24,479		various			24,479	24
25	1998 VARIOUS BUILDING IMPROVEMENTS			1998	26,173		various			26,173	25
26	1999 VARIOUS BUILDING IMPROVEMENTS			1999	11,097		various			11,097	26
27	2000 VARIOUS BUILDING IMPROVEMENTS			2000	800,069		various			800,069	27
28	2001 VARIOUS BUILDING IMPROVEMENTS			2001	112,532		various			112,532	28
29	2002 VARIOUS BUILDING IMPROVEMENTS			2002	578,790		various			578,790	29
30	2003 VARIOUS BUILDING IMPROVEMENTS			2003	356,376		various			356,376	30
31	2004 VARIOUS BUILDING IMPROVEMENTS			2004	466,553		various			466,553	31
32	2005 VARIOUS BUILDING IMPROVEMENTS			2005	953,088		various	0		953,088	32
33	2006 VARIOUS BUILDING IMPROVEMENTS			2006	2,994,111		various	0		2,994,111	33
34	2007 VARIOUS BUILDING IMPROVEMENTS			2007	2,221,427		various	93,042	93,042	1,783,525	34
35	2008 VARIOUS BUILDING IMPROVEMENTS			2008	1,406,411		various	79,001	79,001	1,390,346	35
36	FIRE DOORS-1ST FLOOR			2009	1,887		15			1,887	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 Canton**# **8000200**

Report Period Beginning:

7/1/2024

Ending:

6/30/2025**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	PCU AUTOMATIC DOORS	2009	\$ 1,927	\$	10	\$	\$	\$ 1,927	37
38	ROOF L	2009	13,668		10			13,668	38
39	08.23-GMG BOND EYE AREA REMODEL-RICKARD'S CONST	2009	7,055		15			7,055	39
40	08.23-GMG BOND EYE AREA REMODEL-DRYWALL/SNAP	2009	836		15			836	40
41	PROJ 08.23-GMG BOND EYE AREA REMODEL-DOORS/TILE	2009	767		10			767	41
42	PROJ 09.01 - COPY ROOM/CLASS ROOM SON-RICKARD'S C	2009	2,106		15			2,106	42
43	PROJ 09.02-RISK ASSESSMENT MODEL-RICKARD'S CONST	2009	1,823		15			1,823	43
44	PROJ 09.02-RISK ASSESSMENT REMODEL-PAINT/CARPET	2009	3,002		5			3,002	44
45	PROJ 09.03-GMG EXAM ROOM FLOOR-TILE/ADHESIVES	2009	449		10			449	45
46	PROJ 09.03-GMG EXAM ROOM FLOOR-BLADES/KNOVES/D	2009	606		4			606	46
47	PROJ 09.06-RUSHFORD BUILDING-WIND DAMAGE/CONST	2009	2,540		15			2,540	47
48	PROJ 09.08-ACCOUNTING RENOVATION-RICKARD'S CONS	2009	5,357		15			5,357	48
49	PROJ 09.08-ACCOUNTING RENOVATION-PAINT/CARPET/	2009	1,892		6			1,892	49
50	PROJ 08.22-REMODEL PATIENT REGISTRATION-MISC	2009	325		5			325	50
51	PROJ 08.22-REMODEL PATIENT REGISTRATION-CEILING	2009	351		10			351	51
52	PROJ 08.22-REMODEL PATIENT REGISTRATION-RICKARD	2009	8,730		15			8,730	52
53	PROJ 08.22-REMODEL PATIENT REGISTRATION-PAINT/	2009	1,102		15			1,102	53
54	PROJ 09.04-DIETARY REMODEL - RICKARD'S CONSTRUCT	2009	2,663		15			2,663	54
55	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	1,171		15			1,171	55
56	PROJ 09.04-DIETARY REMODEL-CASHIER'S STATION	2009	3,424		15			3,424	56
57	PROJ 09.04-DIETARY REMODEL-MISC. BUILDING SUP	2009	264		5			264	57
58	PROJ 09.11-GROUND FLOOR CLINIC-BUILDING SUPPLIES	2009	539		5			539	58
59	PROJ 09.11-GROUND FLOOR CLINIC-RICKARD'S LABOR	2009	2,841		15			2,841	59
60	PROJ 08.06-SPRINKLER WORK-VARIOUS SUPPLIES FOR P	2009	513		5			513	60
61	PROJ 08.06-SPRINKLER WORK-REPLACEMENT CEILING	2009	6,420		8			6,420	61
62	PROJ 09.09-DR. LOUNGE REMODEL-CARPETING AND VAR	2009	1,636		5			1,636	62
63	PROJ 09.09-DR. LOUNGE REMODEL-HOLTHAUS CO. ROO	2009	1,518		10			1,518	63
64	PROJ 09.09-DR. LOUNGE REMODEL-RICKARD'S CONSTRU	2009	4,802		15			4,802	64
65	PROJ 09.09-DR. LOUNGE REMODEL-CONST. SUPPLIES/DR	2009	4,584		15			4,584	65
66	PROJ 09.13-CMS LIFE SAFETY-RICKARD'S	2009	3,769		15			3,769	66
67	PROJ 09.13-CMS LIFE SAFETY-VARIOUS CONST SUPPLIES	2009	1,363		15			1,363	67
68		1972	5,755		VARIOUS			5,755	68
69	1973 FIXED EQUIPMENT	1972	4,926		VARIOUS			4,926	69
70	TOTAL (lines 4 thru 69)		\$ 14,351,503	\$ 0		\$ 172,050	\$ 172,050	\$ 13,897,401	70

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

Facility Name & ID Number **Graham Hospital Canton**# **8000200**

Report Period Beginning:

7/1/2024

Ending:

6/30/2025**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		\$ 14,351,503	\$ 0		\$ 172,050	\$ 172,050	\$ 13,897,401	1
2	1975 FIXED EQUIPMENT	1975	989		VARIOUS			989	2
3	1980 FIXED EQUIPMENT	1980	599		VARIOUS			599	3
4	1981 FISED EQUIPMENT	1981	1,188		VARIOUS			1,188	4
5	1987 FIXED EQUIPMENT	1987	37,780		VARIOUS			37,780	5
6	1988 FIXED EQUIPMENT	1988	1,439		VARIOUS			1,439	6
7	1992 FIXED EQUIPMENT	1992	3,936		VARIOUS			3,936	7
8	1994 FIXED EQUIPMENT	1994	4,732		VARIOUS			4,732	8
9	1995 FIXED EQUIPMENT	1995	7,700		VARIOUS			7,700	9
10	1996 FIXED EQUIPMENT	1996	1,422		VARIOUS			1,422	10
11	1998 FIXED EQUIPMENT	1998	2,006		VARIOUS			2,006	11
12	1999 FIXED EQUIPMENT	1999	2,891		VARIOUS			2,891	12
13	2001 FIXED EQUIPMENT	2001	20,918		VARIOUS			20,918	13
14	2002 FIXED EQUIPMENT	2002	920		VARIOUS			920	14
15	2003 FIXED EQUIPMENT	2003	30,047		VARIOUS			30,047	15
16	2005 FIXED EQUIPMENT	2005	10,856		VARIOUS			10,856	16
17	PROJ 04.11 NEW ER - CABLING & DUCTWORK	2006	22,004		10			22,004	17
18	PROJ 04.11 NEW ER - FIRE & SECURITY SYSTEM	2006	12,357		10			12,357	18
19	PROJ 04.11 NEW ER - WALLSLIDE & SUCTION UNITS	2006	5,999		10			5,999	19
20	PROJ 04.11 NEW ER - SHELVES, DOORS, DIVIDERS	2006	11,707		10			11,707	20
21	PROJ 05.04 LAB RENOVATION - DATA CABLING	2006	2,251		10			2,251	21
22	PROJ 05.10 - 1ST PHASE MED/SURG-PERSONAL PROTECTI	2007	1,364		5			1,364	22
23	PROJ 06.03 - ADMINISTRATION BOARDROOM - COUNTER	2007	4,359		10			4,359	23
24	PROJ 06.03 - ADMIN. BOARD RM-LAMINATED CASEWORK	2007	15,097		15			15,097	24
25	PROJ 04.16 - PYXIS - CABINETS	2007	442		15			442	25
26	PROJ 07.08 - THIRD FLOOR ONCOLOGY ROOM - CABINET	2007	2,406		10			2,406	26
27	PROJ 06.03 - ADMINISTRATION BOARDROOM - DROP-IN S	2007	1,539		10			1,539	27
28	07.10-HEARTCARE MIDWEST-CABINETS & COUNTERTOP	2008	5,545		15			5,545	28
29	07.11-MRI REMODEL-CABINETS & COUNTERTOPS	2008	387		15			387	29
30	08.05-RESPIRATORY REMODEL-CABINETS&COUNTERTO	2008	367		15			367	30
31	08.04-HR RELOCATION-SINK	2008	304		20	15	15	248	31
32	08.04-HR RELOCATION-INSTALL CABINETS & COUNTERT	2008	1,317		15			1,317	32
33	PROJ 08.11-REED/HUFFMAN OFFICE REMODEL-CABINET'S	2008	1,126		15			1,126	33
34	TOTAL (lines 1 thru 33)		\$ 14,567,497	\$ 0		\$ 172,065	\$ 172,065	\$ 14,113,339	34

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

Facility Name & ID Number Graham Hospital Canton

8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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		\$ 14,567,497	\$ 0		\$ 172,065	\$ 172,065	\$ 14,113,339	1
2	PROJ 07.08-3RD FLOOR ONCOLOGY ROOM - COUNTERTOP	2008	366		15			366	2
3	PROJ 08.17-PHARMACY CLEAN AIR ROOM-CABINETS&CO	2008	401		15			401	3
4	PROJ 08.23-GMG BOND EYE AREA REMODEL-CABINETS/	2009	1,424		15			1,424	4
5	PROJ 09.11-GROUND FLOOR CLINIC-SINK	2009	215		5			215	5
6	PROJ 09.11-GROUND FLOOR CLINIC-ROOM DARKENING	2009	3,134		20	157	157	2,617	6
7	1971 LAND IMPROVEMENTS	1971	32,916		VARIOUS			32,916	7
8	1976 LAND IMPROVEMENT	1976	82,444		VARIOUS			82,444	8
9	1979 LAND IMPROVEMENTS	1979	30,208		VARIOUS			30,208	9
10	1981 LAND IMPROVEMENTS	1981	65,066		VARIOUS			65,066	10
11	1984 LAND IMPROVEMENTS	1984	61,686		VARIOUS			61,686	11
12	1991 LAND IMPROVEMENTS	1991	13,023		VARIOUS			13,023	12
13	1992 LAND IMPROVEMENTS	1992	656		VARIOUS			656	13
14	1993 LAND IMPROVEMENTS	1993	3,134		VARIOUS			3,134	14
15	1994 LAND IMPROVEMENTS	1994	3,983		VARIOUS			3,983	15
16	1995 LAND IMPROVEMENTS	1995	1,178		VARIOUS			1,178	16
17	1996 LAND IMPROVEMENTS	1996	3,963		VARIOUS			3,963	17
18	1998 LAND IMPROVEMENTS	1998	442		VARIOUS			442	18
19	2001 LAND IMPROVEMENTS	2001	6,453		VARIOUS			6,453	19
20	2002 LAND IMPROVEMENTS	2002	11,727		VARIOUS			11,727	20
21	2003 LAND IMPROVEMENTS	2003	36,978		VARIOUS			36,978	21
22	2004 LAND IMPROVEMENTS	2004	83,693		VARIOUS			83,693	22
23	2005 LAND IMPROVEMENTS	2005	84,686		VARIOUS			84,686	23
24	PROJ 07.03 - SOUTH PARKING LOT	2007	9,186		8			9,186	24
25	PROJ 07.07 - SOUTH PARKING LOT STAIRS-RICKARD'S/CC	2007	9,465		15			9,465	25
26	PROJ 07.07 - SOUTH PARKING LOT STAIRS - GRAVEL	2007	141		5			141	26
27	PROJ 06.09-HOME HEALTH MOVE-DEMO OF HOUSE IN SC	2007	3,528		15			3,528	27
28	SOUTH PATIO IMPROVEMENTS	2008	1,603		15			1,603	28
29	PAVING OF CLINIC PARKING LOT	2008	4,353		8			4,353	29
30	2010 Land Impr - Paving, Rock, Resurface, etc..	2010	15,449		30	515	515	8,748	30
31	PROJ. 08.15 SURGERY RENOVATION-CURTAINS/TRACKS	2010	1,082		20	54	54	918	31
32	PROJ. 08.06 - SPRINKLER WORK - CAPITALIZED INTERES	2010	2,939		25	118	118	1,829	32
33	PROJ. 08.05-RESPIRATORY REMODEL - CAPITALIZED INT	2010	385		40	10	10	155	33
34	TOTAL (lines 1 thru 33)		\$ 15,143,404	\$ 0		\$ 172,919	\$ 172,919	\$ 14,680,524	34

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

Facility Name & ID Number Graham Hospital Canton

8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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		\$ 15,143,404	\$ 0		\$ 172,919	\$ 172,919	\$ 14,680,524	1
2	PROJ. 08.04-HR RELOCATION - CAPITALIZED INTEREST	2010	723		25	29	29	449	2
3	PROJ. 08.15-SURGERY RENOVATION-RICKARD'S	2010	29,257		40	731	731	11,331	3
4	PROJ. 08.15-SURGERY RENOVATION-FLAD & ASSOCIATES	2010	12,889		40	322	322	4,991	4
5	PROJ. 08.15 SURGERY RENOVATION-CAPITALIZED INTER	2010	2,576		40	64	64	994	5
6	PROJ. 08.15 SURGERY RENOVATION-DOORS/FRAMES/CLO	2010	6,806		10	0		6,806	6
7	PROJ. 08.15 SURGERY RENOVATION-MAURER STUTZ ENG	2010	1,510		40	38	38	588	7
8	PROJ. 08.15 SURGERY RENOVATION-MISC. BUILDING SUP	2010	7,453		40	186	186	2,884	8
9	AMBULANCE BUILDING - WALNUT ST.	2010	1,089		40	27	27	419	9
10	PROJ. 10.02-PCU RAILING/CEILING-CEILING TILES AND	2010	4,602		10	0		4,602	10
11	PROJ. 10.02 - PCU RAILING/CEILING-NEW HAND RAIL EL	2010	1,963		15	64	64	1,963	11
12	PROJ. 08.16 - 2ND SOUTH REMODEL - HANDRAIL/END CAP	2010	2,301		15	81	81	2,301	12
13	DUROLAST ROOFING SYSTEM ON ROOFS P & R	2010	17,061		10	0		17,061	13
14	ROOF M REPLACEMENT - MRI ROOF	2010	6,935		10	0		6,935	14
15	PROJ. 10.07-GIFT SHOP REMODEL-RICKARD'S LABOR & C	2010	4,786		15	160	160	4,786	15
16	PROJ. 10.07-GIFT SHOP REMODEL - ELLSWORTH GLASS &	2010	2,943		15	100	100	2,943	16
17	PROJ. 10.07-GIFT SHOP REMODEL-MISC. BUILDING SUPPL	2010	2,485		15	79	79	2,485	17
18	PROJ. 09.07-OB RENOVATION-1ST PHASE - PJ HOERR CON	2010	638,751		40	15,969	15,969	247,519	18
19	PROJ. 09.07-OB RENOVATION 1ST PHASE-FLAD & ASSOCI	2010	21,283		40	532	532	8,246	19
20	PROJ. 09.07-OB RENOVATION 1ST PHASE - CAPITALIZED	2010	53,739		40	1,343	1,343	20,819	20
21	PROJ. 09.07-OB RENOVATION 1ST PHASE-KIRWAN ENVIR	2010	1,006		40	25	25	388	21
22	PROJ. 09.07-OB RENOVATION 1ST PHASE-MISC. BUILDING	2010	2,973		5			2,973	22
23	PROJ. 09.07-OB RENOVATION 1ST PHASE-DOORS	2010	1,927		10	0		1,927	23
24	PROJ. 09.07-OB RENOVATION 1ST PHASE-RICKARD'S LAB	2010	770		40	19	19	296	24
25	PROJ. 08.19-40 TON CHILLER - CAPITALIZED INTEREST	2010	617		10	0		617	25
26	PROJ. 08.15 SURGERY RENOVATION-ELECTRICAL SUPPL	2010	16,751		20	838	838	12,987	26
27	PROJ. 08.15 SURGERY RENOVATION-TANNOCK ELECTRIC	2010	21,083		20	1,054	1,054	16,338	27
28	PROJ. 08.15 SURGERY RENOVATION-MECHANICAL SERVI	2010	38,130		15	1,271	1,271	38,130	28
29	PROJ. 08.16-2ND SOUTH REMODEL-MECHANICAL SERVIC	2010	34,111		25	1,364	1,364	21,144	29
30	PROJ. 08.16 2ND SOUTH REMODEL-ELECTRICAL LABOR A	2010	2,487		20	124	124	1,924	30
31	PROJ. 08.16-2ND SOUTH REMODEL-RICKARD'S LABOR AN	2010	4,482		25	179	179	2,776	31
32	PROJ. 08.16-2ND SOUTH REMODEL-MISC. MAT. & ENGINE	2010	2,571		25	103	103	1,596	32
33	PROJ. 10.04-EXT. CARE RENOVATIONS - MECHANICAL SE	2010	2,274		25	91	91	1,410	33
34	TOTAL (lines 1 thru 33)		\$ 16,091,738	\$ 0		\$ 197,712	\$ 197,712	\$ 15,131,152	34

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

Facility Name & ID Number Graham Hospital Canton

8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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		\$ 16,091,738	\$ 0		\$ 197,712	\$ 197,712	\$ 15,131,152	1
2	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MECHANICAL	2010	27,126		25	1,085	1,085	16,818	2
3	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-RICKARD'S LA	2010	2,530		25	101	101	1,566	3
4	PROJ. 10.11-2ND EAST SPRINKLER SYSTEM-MISC. MAT'L	2010	637		25	25	25	390	4
5	PROJ. 09.07-OB RENOVATION 1ST PHASE-PUSH TO SET RE	2010	2,010		20	101	101	1,563	5
6	TABLES - (5)	2011	4,431		15	295	295	4,279	6
7	VALANCES/RODS/CUBICLE CURTAINS	2011	12,494		5			12,494	7
8	FACE COVERING OF EAST RECEIVING SIDE HOSPITAL BU	2011	6,920		5			6,920	8
9	PROJ. 09.07 OB RENOVATION 2ND PHASE-PJ HOERR CONT	2011	1,053,994		40	26,350	26,350	382,075	9
10	PROJ. 09.07 OB RENOVATION 2ND PHASE-CAPITALIZED IN	2011	26,269		40	657	657	9,525	10
11	PROJ. 09.07 OB RENOVATION 2ND PHASE-MISC. BUILDING	2011	1,063		40	27	27	390	11
12	PROJ. 10.09 ENDO SUITE DESIGN-PJ HOERR/FLAD DESIGN	2011	40,897		40	1,022	1,022	14,820	12
13	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING-RICK	2011	8,750		40	219	219	3,174	13
14	PROJ. 11.02-'77 AND '59 BUILDING TUCKPOINTING - SU	2011	1,310		40	33	33	477	14
15	PROJ. 09.07 OB REN 3RD PHASE-PJ HOERR CONSTRUCTIO	2011	635,931		40	15,898	15,898	230,522	15
16	PROJ. 09.07 OB REN 3RD PHASE-CAPITALIZED INTEREST	2011	1,472		40	37	37	535	16
17	PROJ 07.13-NEW CLINIC - RESURFACE ALICE INGERSOLL	2011	11,750		8	0		11,750	17
18	PROJ. 09.07 - OB RENOVATION 2ND PHASE - WARNER PLU	2011	3,364		20	168	168	2,437	18
19	PROJ.11.03-PROCEDURE ROOM SURGERY-WARNER PLUM	2011	8,120		20	406	406	5,887	19
20	PROJ. 11.03-PROCEDURE ROOM SURGERY-RICKARD'S AN	2011	1,609		20	80	80	1,161	20
21	PROJ. 10-16-SIX SIGMA ELECTRICITY PROJECT-ELECTRIC	2011	33,624		10	0		33,624	21
22	REMOVED PIT CHANNELS IN ELEVATORS #5 AND #6	2012	5,732		20	143	143	2,003	22
23	PAVING SOUTH PARKING LOT - HOSPITAL	2012	24,295		8	1,518	1,518	21,253	23
24	EP COLEMAN BUILDING PARKING LOT STRIPING	2012	426		2			426	24
25	OVERLAY ASPHALT PARKING LOT AT GMG BUILDING	2012	15,000		8	938	938	13,131	25
26	LANDSCAPING EP COLEMAN BUILDING	2012	9,287		10	464	464	6,497	26
27	PARKING LOT STRIPING - EP COLEMAN NORTH BLDG.	2012	330		2			330	27
28	PHYSICIAN LOT - SEALCOAT/CRACKFILL	2012	4,600		8	288	288	4,031	28
29	WEST LOT STAFF PARKING-SEALCOAT/CRACKFILL	2012	8,740		8	546	546	7,645	29
30	NORTH EP COLEMAN LOT-SEALCOAT/CRACKFILL	2012	19,900		8	1,244	1,244	17,416	30
31	OVERLAY & PATCH ENTRY WAY SOUTH LOT	2012	3,500		8	219	219	3,066	31
32	PROJ. 11.11-SURGERY FLOOR - CRAWFORD'S FLOORING	2012	16,208		10	810	810	11,341	32
33	PROJ. 11.11-SURGERY FLOOR-MISC. SUPPLIES & CONSTR	2012	2,498		10	125	125	1,625	33
34	TOTAL (lines 1 thru 33)		\$ 18,086,555	\$ 0		\$ 250,511	\$ 250,511	\$ 15,960,323	34

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

Facility Name & ID Number Graham Hospital Canton

8000200

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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		\$ 18,086,555	\$ 0		\$ 250,511	\$ 250,511	\$ 15,960,323	1
2	SMOKE STACK REMOVAL-BI-STATE MASONRY	2012	49,543		5			49,543	2
3	RICKARD'S-FRAME FOR EXHAUST FAN AFTER SMOKE ST	2012	490		5	0		490	3
4	DUROLAST ROOFING - COVER SMOKE STACK REMOVAL	2012	2,385		5	0		2,385	4
5	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-RICKARD'S L	2012	11,393		15	380	380	5,319	5
6	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-S&S BUILDER	2012	2,284		15	76	76	1,064	6
7	PROJ. 12.08-HR MOVE TO OLD BUS. OFFICE-MISC. BLDG.	2012	3,433		15	114	114	1,597	7
8	PROJ. 12.11-B. CLARK OFFICE REMODEL-RICKARD'S LAB	2012	3,308		15	110	110	1,541	8
9	PROJ. 12.11-B. CLARK OFFICE REMODEL-MISC. BLDG. SU	2012	3,142		15	105	105	1,469	9
10	PROJ. 11.06-ICU REMODEL-PJ HOERR CONTRACT	2012	1,158,145		40	14,477	14,477	202,677	10
11	PROJ. 11.06-ICU REMODEL-MISC. BLDG. SUPPLIES	2012	2,872		15	96	96	1,343	11
12	PROJ 12.09 ER EXPANSION-2 EXAM LIGHTS	2013	2,052		10			2,052	12
13	PROJ 12.09 ER EXPANSION-MECHANICAL SERV. INSTALL	2013	5,691		20	285	285	3,704	13
14	MECHANICAL SERVICE - SPRINKLER INSTALL - VARIOUS	2013	4,411		25	176	176	2,289	14
15	PROJ. 12.09 ER EXPANSION-THOMPSON ELECTRONICS - V	2013	671		10			671	15
16	AUTOMATIC TRANSFER SWITCH-SN#959837	2013	3,592		15	239	239	3,108	16
17	AUTOMATIC TRANSFER SWITCH SN#961344	2013	940		15	63	63	818	17
18	AUTOMATIC TRANSFER SWITCH SN#961345	2013	1,055		15	70	70	911	18
19	PROJECT 13.11 ENDOSUITE DATA CABLE INSTALL	2014	787		20	40	40	460	19
20	PROJECT 13.11 ENDOSUITE D.P. FILTERS HEPA FILTER	2014	122		15	8	8	92	20
21	PROJECT 13.11 ENDOSUITE ILLINI PLUMBING NEW PIPIN	2014	215		25	8	8	92	21
22	PROJECT 13.11 ENDOSUITE SEICO FIRE ALARM REWIRE	2014	79		10	0		79	22
23	PROJECT 14.03 - DATA ROOM COOLING SYSTEM UPGRAD	2014	36,383		20	1,820	1,820	20,930	23
24	PROJECT 14.05 - AUTOMATIC TRANSFER SWITCH	2014	5,284		20	264	264	3,036	24
25	PROJECT 14.06 - E.R. RADIOLOGY ROOM	2014	14,291		20	714	714	8,212	25
26	PROJECT 14.09 - RADIOLOGY ROOM 5 UPGRADE	2014	6,563		20	328	328	3,772	26
27	PROJECT 14.11 - SPRINKLER SYSTEM UPGRADE GIFTSHO	2014	2,107		20	106	106	1,218	27
28	PROJECT 14.08 - RADIOLOGY ROOM 4 UPGRADE	2014	5,772		20	289	289	3,203	28
29	GHA/HH PARKING LOT SEALCOAT/REPAIR	2015	6,829		2			6,829	29
30	GMG/EP COLEMAN/WELLNESS PARKING LOT SEAL COAT	2015	5,023		2			5,023	30
31	RISEATLAS 625QM CEILING LIFT	2015	19,373		10	971	971	19,373	31
32	Telemetry Electrical Cable Pull and Receptacle Install	2015	3,457		20	173	173	1,816	32
33	14.13 - TRANSFORMER REPLACEMENT	2015	43,590		20	2,179	2,179	22,880	33
34	TOTAL (lines 1 thru 33)		\$ 19,491,837	\$ 0		\$ 273,602	\$ 273,602	\$ 16,338,319	34

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

Facility Name & ID Number **Graham Hospital Canton**# **8000200**

Report Period Beginning:

7/1/2024

Ending:

6/30/2025**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		\$ 19,491,837	\$ 0		\$ 273,602	\$ 273,602	\$ 16,338,319	1
2	14.15 - JOINT COMMISSION ELECTRICAL/PLUMBING REPAIR	2015	6,278		20	314	314	3,297	2
3	14.15 - JOINT COMMISSION AIR HANDLER REPAIR	2015	378		10	17	17	378	3
4	14.15 - JOINT COMMISSION DOOR CLOSER REPLACEMENT	2015	995		15	66	66	693	4
5	15.03 - WATER SOFTENER REPLACEMENT	2015	4,674		10	237	237	4,674	5
6	15-01 - Patient Registration - ELECTRICAL/DATA CABLE PULL/IN	2015	2,685		20	134	134	1,407	6
7	15-07 - Chiller Rebuild - TRANE CONTRACTED WORK	2015	54,304		20	2,715	2,715	28,508	7
8	14.10 - 2nd Floor Hallway Remodel	2015	7,446		5	0		7,446	8
9	14.15 - JOINT COMMISSION BUILDING REPAIRS	2015	463		5	0		463	9
10	HOSPITAL TUCKPOINT AND SKYLIGHT GLASS REPAIR	2015	27,029		40	676	676	7,098	10
11	PROJECT 14.04 - PHARMACY RENOVATIONS - PJ HOERR CON	2015	26,155		40	654	654	6,867	11
12	15-01 - Patient Registration - MISC BUILDING SUPPLIES	2015	6,561		5	0		6,561	12
13	15-01 - Patient Registration - PJ HOERR CONTRACT WORK	2015	334,913		40	8,373	8,373	87,916	13
14	Project 16-07, 16-08, 16-10, 16-16 - Parking lost asphalt recoat, repair	2016	17,438		15	1,163	1,163	11,048	14
15	Project 16-18 - SNF Remodel Paint & Misc Bldng Supplies	2017	29,433		5			29,433	15
16	Project 16-18 - SNF Remodel Contracted Construction	2017	2,048,414		40	51,210	51,210	435,285	16
17	Project 21-04 Building FE Bedpan Storage Racks	2022	743		5			74	17
18	Project 21-04 Building FE Cabinet and PPE Dispensers	2022	1,145		15			38	18
19	Six Framed Pictures	2022	2,250		5			225	19
20	Project 21-04 Building FE Misc Supplies	2022	3,293		5			329	20
21	Project 21-04 Building FE 74-Cubicle Curtains	2022	8,777		5			878	21
22	Project 21-04 Building FE Furniture and Misc for SNF	2022	65,134		10			3,257	22
23	Beds and Accessories	2022	118,148		15			3,938	23
24	Harmonie P300 Hydromassage Tub	2023	14,699		15	84	84	252	24
25	Allocated Depreciation	2025		251,335			(251,335)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 22,273,192	\$ 251,335		\$ 339,245	\$ 87,910	\$ 16,978,384	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	\$ 488,810	\$	\$ 35,430	\$ 35,430	5 - 20	\$ 227,419	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	198,464			0	5 - 20	198,464	73
74					0			74
75	TOTALS	\$ 687,274	\$ 0	\$ 35,430	\$ 35,430		\$ 425,883	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	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)	\$ 22,960,466	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 251,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,675	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 123,340	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,404,267	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:
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: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ 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.	/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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,466,635	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	16,070,414		3
4	Supply Inventory (priced at)	3,383,191		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,395,751		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Receivables</u>	1,996,684		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 27,312,675	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,220,669		13
14	Buildings, at Historical Cost	129,802,263		14
15	Leasehold Improvements, at Historical Cost	13,142,236		15
16	Equipment, at Historical Cost	39,335,023		16
17	Accumulated Depreciation (book methods)	(79,744,704)		17
18	Deferred Charges	878,184		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 use</u>	135,485,216		22
23	Other(specify): <u>Interests in Foundation</u>	19,930,554		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 272,049,441	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 299,362,116	\$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,643,070	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,370,000		29
30	Accrued Salaries Payable	9,321,919		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>Amounts due to Third party payors</u>	4,599,069		36
37	<u>Self Insurance</u>	6,767,293		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 29,701,351	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	70,966,264		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	2,436,820		42
	Other Long-Term Liabilities(specify):			
43	<u>Interest Rate swap</u>	514,184		43
44	<u>Other</u>	146,119		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 74,063,387	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 103,764,738	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ 195,597,378	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 299,362,116	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 182,792,554	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 182,792,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,619,611)	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) Non operating gains & losses	15,436,605	15
16	Other (describe) Other changes to net assets	987,830	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 12,804,824	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 195,597,378	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Graham Hospital Canton**# **8000200**Report Period Beginning: **7/1/2024**Ending: **6/30/2025****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	\$ 2,571,769	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,571,769	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)	\$ 0	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)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Hospital Misc Revenue	9,724,939	28
28a	Hospital Revenue	123,516,174	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 133,241,113	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 135,812,882	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,330,253	31
32	Health Care	2,364,898	32
33	General Administration	1,252,444	33
	B. Capital Expense		
34	Ownership	251,335	34
	C. Ancillary Expense		
35	Special Cost Centers	73,610	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Hospital Expense	134,159,953	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 139,432,493	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,619,611)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,619,611)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer	438,934.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	814,952.00	48
49	Medicare Part A	697,902.00	49
50	Other-(specify) Medicare Advantage Plans and Insured Patients	619,981.00	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)	\$ 2,571,769	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			\$	\$	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 ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)			\$	*	\$

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

* This total must agree with page 4, column 1, line 45.

** See instructions.

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)*			Association Dues (total from pg 22, #4)		0	
					Allocated benefits		584,026				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$							
B. Administrative - Other								Less: Public Relations Expense		()	
Description				Amount				PAC and Lobbying payments		(0)	
				\$				All non-allowable advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 584,026	TOTAL (agree to Sch. V, line 20, col. 8)		\$	
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)					Description		Line #	Amount	Description		Amount
C. Professional Services		Type		Amount					Out-of-State Travel		\$
Vendor/Payee				\$							
									In-State Travel		
									Seminar Expense		
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				\$	TOTAL		\$	TOTAL		\$	
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

**See instructions.

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
	0 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.

<u>0</u>	
<u>0</u>	
<u>0</u>	<u>0</u>
	0 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

<u>0</u>	<u>0</u>
<u>0</u>	<u>0</u>
<u>0</u>	<u>0</u>
	<u>0</u>
	0 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ None 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.

\$ _____

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?

N/A
- (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? 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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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?

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: Wipfli LLP Yes
- (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.