

Facility Name & ID Number Gibson Community Hospital Annex

0005868 Report Period Beginning: Oct. 1, 2004 Ending: Sept. 30, 2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	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	26	TOTALS	26	9,490	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	365	8,697	0	9,062	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	365	8,697		9,062	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.49%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/1963

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2005 Fiscal Year: 9/30/2005

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

STATE OF ILLINOIS

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2004 Ending: Sept. 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	120,785	9,047	5,979	135,811		135,811	135,811			1
2	Food Purchase		47,488		47,488		47,488	47,488			2
3	Housekeeping	11,347	4,008	139	15,494		15,494	15,494			3
4	Laundry	14,999	6,458	2,173	23,630		23,630	23,630			4
5	Heat and Other Utilities			29,635	29,635		29,635	29,635			5
6	Maintenance	20,412	8,816	13,869	43,097		43,097	43,097			6
7	Other (specify):*										7
8	TOTAL General Services	167,543	75,817	51,795	295,155		295,155	295,155			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	530,904	35,326	93,999	660,229	(14,235)	645,994	645,994			10
10a	Therapy										10a
11	Activities	15,882	2,749	(127)	18,504		18,504	18,504			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	546,786	38,075	93,872	678,733	(14,235)	664,498	664,498			16
	C. General Administration										
17	Administrative	39,325			39,325		39,325	39,325			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	70,221	6,237	184,039	260,497		260,497	260,497			21
22	Employee Benefits & Payroll Taxes			272,128	272,128		272,128	272,128			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,413	35,413		35,413	35,413			26
27	Other (specify):*										27
28	TOTAL General Administration	109,546	6,237	491,580	607,363		607,363	607,363			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	823,875	120,129	637,247	1,581,251	(14,235)	1,567,016	1,567,016			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.

Facility Name & ID Number

Gibson Community Hospital Annex

#0005868

Report Period Beginning:

Oct. 1, 2004

Ending:

Sept. 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			95,550	95,550		95,550	95,550				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,759	58,759		58,759	58,759				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			154,309	154,309		154,309	154,309				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					14,235	14,235	14,235				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					14,235	14,235	14,235				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	823,875	120,129	791,556	1,735,560		1,735,560	1,735,560				45

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

Facility Name & ID Number **Gibson Community Hospital Annex**

0005868

Report Period Beginning: **Oct. 1, 2004**

Ending: **Sept. 30, 2005**

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	OHF 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)	\$		\$	30

OHF 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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		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	Provider Participation Fee	X		14,235	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 14,235		47

Gibson Community Hospital Annex

ID# 0005868

Report Period Beginning: Oct. 1, 2004

Ending: Sept. 30, 2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	N/A	\$	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
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	0	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	NONE								\$	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 Gibson Community Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2004 Ending: pt. 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	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 Gibson Community Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2004 Ending: Sept. 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	UMB Revenue & Ref Bonds		X	Facility Improvements	\$3,010.00	12/1/99	\$ 8,415,000	\$	12/1/2019	6.2500	\$ 33,110	1								
2	Hosp Cp Imp & Ref Rev bonds		X	Facility Impr & Refunding	\$3,010.00	09/12/05	12,675,000	12,675,000	12/1/2019	4.5500	25,649	2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$6,020.00		\$ 21,090,000	\$ 12,675,000			\$ 58,759	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 21,090,000	\$ 12,675,000			\$ 58,759	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

Facility Name & ID Number **Gibson Community Hospital Annex**# **0005868** Report Period Beginning: **Oct. 1, 2004** Ending: **Sept. 30, 2005****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 2004 report.			\$	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	_____	8	
		2001	_____	9	
		2002	_____	10	
		2003	_____	11	
		2004	_____	12	
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gibson Community Hospital Annex COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0005868

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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? YES NO

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,589 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 2C. 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).

Gibson Area Hospital and Health Services includes a General Short-Term Hospital (Critical Access Hospital for Medicare), with 25 General Service Beds, 16 hospital long term care beds and the 26 Long Term Care beds for the Annex section. Total square feet for FYE 2005 was 109,400 of which 9,465 was for the 26 Annex beds and related Activities area.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Hospital & Annex</u>	<u>62,367</u>	<u>1952</u>	<u>\$ 27,195</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	62,367		\$ 27,195	3

Facility Name & ID Number Gibson Community Hospital Annex

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Report Period Beginning:

Oct. 1, 2004 Ending: Sept. 30, 2005

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	26		1963	\$ 518,269	\$ 6,416	50	\$ 6,416	\$	\$ 416,832	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Annex Building Fixtures - Landscaping		1985	675	29	20	29		675	9
10	Land Improvements - Misc Annex		1994	12,888		10			12,888	10
11	Annex sidewalk & brickwork		1994	4,736	316	15	316		3,792	11
12	Annex pt room door latches		1996	2,016	198	10	198		2,016	12
13	Annex Patio Door		1996	2,742	275	10	275		2,742	13
14	Annex fire door		1996	1,521	153	10	153		1,521	14
15	Annex window replacement		1996	1,616	160	10	160		1,616	15
16	Annex Wanderguard System		1996	2,747	183	15	183		1,648	16
17	Annex water main replacements		1998	3,483	139	25	139		975	17
18	Annex doors replacement		2001	4,697	235	20	235		1,057	18
19	Annex Transfer Switch		2001	4,141	207	20	207		932	19
20	Land Improvements - North entrance parking lots & landscpg		2001	27,547	1,758	10 to 25	1,758		8,350	20
21	Bldg Improvements - Masonry & Steel Structure		2001	245,742	14,605	10 to 40	14,605		69,375	21
22	Bldg Improvements - Service Equipment for Structure		2001	280,829	17,147	10 to 25	17,147		81,447	22
23	Bldg Improvements - Fixed Equipment for structure		2001	12,961	1,116	5 to 20	1,116		5,301	23
24	Land Improvements - Hellpad, landscaping & asphalt		2002	3,025	346	5 to 15	346		1,212	24
25	Bldg Improvements - Annex Hardware, closures		2002	1,847	92	20	92		323	25
26	Bldg Improvements - Hospital flooring & doors		2002	6,512	567	10 to 25	567		1,985	26
27	Bldg Improvements - LTC Roofing		2002	41,575	4,158	10	4,158		14,552	27
28	Land Impv - Landscaping		2003	765	77	10	77		192	28
29	Bldg Impr- LTC firewalls & doors		2003	36,469	1,458	25	1,458		3,646	29
30	Bldg Imp - Bulk Oxygen area work		2003	413	28	15	28		69	30
31	Bldg Impr -ER Oxygen system		2003	271	13	20	13		33	31
32	Bldg Imp-Cent Supp counters & ceiling		2003	110	7	15	7		18	32
33	Bldg Imp-Lab Central A/C system		2003	1,808	121	15	121		302	33
34	Bldg Imp-Nucl Med wiring		2003	162	8	20	8		20	34
35	Bldg Imp-Nucl Med cabinets & counters		2003	36	2	15	2		6	35
36	Bldg Imp-Dietary sewer system & pipes		2003	568	38	15	38		95	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Bld Imp-Plant; hot & cold water valves	2003	\$ 281	\$ 19	15	\$ 19		\$ 47	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		50	38
39	Bldg Imp-pt registration carpet	2003	155	31	5	31		78	39
40	Bldg Imp-pt registration wiring & wall materials	2003	152	8	20	8		19	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		25	41
42	Bldg Imp-Bldg Asbestos removal & tuckpointing	2003	599	120	5	120		300	42
43	Bldg Imp-Bldg fire alarm system & panels	2003	650	65	10	65		162	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		554	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		131	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039	104	10	104		156	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		596	47
48	Bldg Impr - ER flooring & plumbing	2004	839	81	10 - 15	81		122	48
49	Bldg Imp - CAT scan cooling & power system	2004	5,104	340	15	340		510	49
50	Bldg Impr - Plant Heat exchanger	2004	178	35	5	35		53	50
51	Bldg Impr - Data Proc A/C System	2004	465	31	15	31		47	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		96	52
53	Bldg Impr - Paving patches	2004	517	103	5	103		155	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		83	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		624	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		1,375	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		241	57
58									58
59	Land Improvmnts - Paving	2005	779	49	8	49		49	59
60	Land Improvmnts - Parking Lot	2005	23,191	1,160	10	1,160		1,160	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	40	15	40		40	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	1,305	20	1,305		1,305	62
63	Bldg Impr - covered sheet vinyl flooring	2005	294	15	10	15		15	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	16	15	16		16	64
65	Bldg Imp - Laundry Electrical work	2005	136	4	15	4		4	65
66	Bldg Imp - Laundry Washer hook up	2005	168	6	15	6		6	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	4	10	4		4	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	4	15	4		4	68
69	Bldg Imp - Data Proc Electrical work	2005	99	5	10	5		5	69
70	TOTAL (lines 4 thru 69)		\$ 1,352,908	\$ 55,712		\$ 55,712		\$ 641,652	70

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

STATE OF ILLINOIS

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning:

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Oct. 1, 2004 Ending: Sept. 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 1,352,908	\$ 55,712		\$ 55,712		\$ 641,652		1
2	Bldg Imp - New Garage Bldg	2005 3,132	78	20	78		78		2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005 2,002	67	15	67		67		3
4	Bldg Imp -Sleep Mobile Power Unit	2005 373	19	10	19		19		4
5	Bldg Imp -Fire Alarm Sensor	2005 134	7	10	7		7		5
6	Bldg I-Surfc/ foundatn Drainage work	2005 1,324	33	20	33		33		6
7	Bldg Imp -Medical Gas piping	2005 168	6	15	6		6		7
8	Bldg Imp -Mech room water lines	2005 408	20	10	20		20		8
9	Bldg Imp - Electrical work for depts	2005 1,546	52	15	52		52		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	TOTAL (lines 1 thru 33)	\$ 1,361,995	\$ 55,994		\$ 55,994		\$ 641,934		34

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

C. Equipment Depreciation-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	\$ 400,447	\$ 37,677	\$ 37,677	\$	5 - 15	\$ 299,397	71
72	Current Year Purchases	26,102	1,879	1,879		3 - 15	1,879	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 426,549	\$ 39,556	\$ 39,556	\$		\$ 301,276	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,815,739	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,550	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,550	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 943,210	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

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

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. 0
 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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
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	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,508,000</u>)	4,445,893	3
4	Supply Inventory (priced at <u>Cost</u>)	383,006	4
5	Short-Term Investments		5
6	Prepaid Insurance	347,442	6
7	Other Prepaid Expenses	680,040	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Third Prty Settlements</u>	354,762	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,211,143	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	176,252	13
14	Buildings, at Historical Cost	13,597,596	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	10,909,637	16
17	Accumulated Depreciation (book methods)	(13,144,582)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds	13,035,923	21
22	Other Long-Term Assets (spe <u>CIP</u>)	739,242	22
23	Other(specify): <u>Bond Issue Costs</u>	321,047	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,635,115	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 31,846,258	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 781,114	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	961,957	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>Bank overdraft</u>	349,604	36
37	<u>Current Mst of LT Debt</u>	827,186	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,919,861	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable	12,232,853	41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,232,853	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,152,714	46
47	TOTAL EQUITY (page 18, line 24)	\$ 16,693,544	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 31,846,258	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,978,830	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,978,830	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,714,714	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)	\$ 1,714,714	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)	\$ 16,693,544	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning: Oct. 1, 2004

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Ending: Sept. 30, 2005

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 42,232,633	1
2	Discounts and Allowances for all Levels	(14,665,160)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 27,567,473	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	188,792	24
25	Interest and Other Investment Income***	177,691	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 366,483	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Grant Income</u>	22,846	28
28a	<u>Other Misc Income</u>	625,278	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 648,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 28,582,080	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	295,155	31
32	Health Care	664,498	32
33	General Administration	607,363	33
B. Capital Expense			
34	Ownership	154,309	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	14,235	36
D. Other Expenses (specify):			
37	<u>Hospital Only Portion of Expenses</u>	25,131,806	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 26,867,366	40
41	Income before Income Taxes (line 30 minus line 40)**	1,714,714	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,714,714	43

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

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

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

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

Facility Name & ID Number **Gibson Community Hospital Annex**

0005868

Report Period Beginning: Oct. 1, 2004

Ending:

Sept. 30, 2005

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	1,182	1,337	\$ 34,295	\$ 25.65	1
2	Assistant Director of Nursing	3,204	3,375	77,313	22.91	2
3	Registered Nurses	2,343	2,514	51,088	20.32	3
4	Licensed Practical Nurses	6,912	7,499	127,491	17.00	4
5	CNAs & Orderlies	21,893	24,107	240,717	9.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,199	1,319	15,882	12.04	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	759	866	21,506	24.83	12
13	Food Service Supervisor	397	421	7,872	18.70	13
14	Head Cook	787	916	11,590	12.65	14
15	Cook Helpers/Assistants	8,379	9,356	77,716	8.31	15
16	Dishwashers	316	323	2,101	6.50	16
17	Maintenance Workers	1,300	1,300	20,412	15.70	17
18	Housekeepers	1,354	1,496	11,347	7.58	18
19	Laundry	1,499	1,685	14,999	8.90	19
20	Administrator	1,337	1,337	39,325	29.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,782	3,782	70,221	18.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	56,643	61,633	\$ 823,875 *	\$ 13.37	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Gibson Community Hospital Annex# 0005868Report Period Beginning: Oct. 1, 2004Ending: Sept. 30, 2004**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,480 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 14,235
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 41,707 Has any meal income been offset against related costs? YES Indicate the amount. \$ 79,069
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Eck, Schafer, Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.