



Facility Name & ID Number Gibson Community Hospital Annex# 0005868 Report Period Beginning: Oct. 1, 2006 Ending: Sept. 30, 2007

## 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 bedsN/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	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	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	<u>26</u>	TOTALS	<u>26</u>	<u>9,490</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,084</u>	<u>8,084</u>	<u>0</u>	<u>9,168</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,084</u>	<u>8,084</u>		<u>9,168</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

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/AF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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: YE 9/30/2007 Fiscal Year: YE 9/30/2007

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

## 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	
	<b>A. General Services</b>											
1	Dietary	120,946	5,855	3,809	130,610		130,610		130,610			1
2	Food Purchase		52,772		52,772		52,772		52,772			2
3	Housekeeping	17,820	5,808	105	23,733		23,733		23,733			3
4	Laundry	24,119	8,531	2,300	34,950		34,950		34,950			4
5	Heat and Other Utilities			48,947	48,947		48,947		48,947			5
6	Maintenance	32,770	11,923	23,019	67,712		67,712		67,712			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	195,655	84,889	78,180	358,724		358,724		358,724			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	584,796	29,587	131,022	745,405	(14,235)	731,170		731,170			10
10a	Therapy											10a
11	Activities	18,622	4,462	2,384	25,468		25,468		25,468			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	603,418	34,049	133,406	770,873	(14,235)	756,638		756,638			16
	<b>C. General Administration</b>											
17	Administrative	43,272			43,272		43,272		43,272			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	113,467	5,640	180,780	299,887		299,887		299,887			21
22	Employee Benefits & Payroll Taxes			301,070	301,070		301,070		301,070			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,803	51,803		51,803		51,803			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	156,739	5,640	533,653	696,032		696,032		696,032			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	955,812	124,578	745,239	1,825,629	(14,235)	1,811,394		1,811,394			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, 2006 Ending: Sept. 30, 2007Page 4  
Sept. 30, 2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			102,225	102,225		102,225	102,225				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,299	40,299		40,299	40,299				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			142,524	142,524		142,524	142,524				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>					14,235	14,235	14,235				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	955,812	124,578	887,763	1,968,153		1,968,153	1,968,153				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, 2006

Ending:

Sept. 30, 2007

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 14,235		47

BHF USE ONLY					
48		49		50	
				51	
					52

Gibson Community Hospital Annex

ID# 0005868

Report Period Beginning: Oct. 1, 2006

Ending: Sept. 30, 2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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	<b>Total</b>	0	49





Facility Name & ID Number Gibson Community Hospital Annex

# 0005868

Report Period Beginning: Oct. 1, 2006 Ending: Sept. 30, 2007

**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
None		None		None		

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		\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name &amp; ID Number

Gibson Community Hospital Annex

#

0005868

Report Period Beginning:

Oct. 1, 2006

Ending:

Sept. 30, 2007

## 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 Gibson Community Hospital Annex

# 0005868 Report Period Beginning: Oct. 1, 2006 Ending: Oct. 30, 2007

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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	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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Hosp Cp Imp & Ref Rev Bonds		X	Facility Impr & Refunding	\$9,517.75	9/12/2005	\$ 12,675,000	\$ 11,860,000	12/01/2019	4.5500	\$ 40,299	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$9,517.75		\$ 12,675,000	\$ 11,860,000			\$ 40,299	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 12,675,000	\$ 11,860,000			\$ 40,299	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2007 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	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:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 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.

**2006 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 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>_____</u>	\$ <u>_____</u>

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Gibson Community Hospital Annex

# 0005868 Report Period Beginning:

Oct. 1, 2006 Ending: Sept. 30, 2007

**X. BUILDING AND GENERAL INFORMATION:**

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

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).

Gibson Area Hospital and Health Services includes a General Short-Term Hospital with 25 General Service beds, 16 Long Term care beds and the 26 Long Term beds for the Annex. Total square feet for FYE 9/30/07 was 123,076 of which 13378 was for the 42 SNF & LTC Bed areas.

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 &amp; Annex</u>	<u>62,367</u>	<u>1952</u>	<u>\$ 27,195</u>	1
2					2
3	<b>TOTALS</b>	<b>62,367</b>		<b>\$ 27,195</b>	<b>3</b>

Facility Name &amp; ID Number Gibson Community Hospital Annex

# 0005868

Report Period Beginning:

Oct. 1, 2006 Ending: Sept. 30, 2007

**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		
	Beds*	FOR BHF 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	\$	\$ 429,664	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Annex Building Fixtures - Landscaping		1985	675		20			675	9
10		Land Improvements - Misc Annex		1994	12,888		10			12,888	10
11		Annex sidewalk & brickwork		1994	4,736	316	15	316		4,424	11
12		Annex pt room door latches		1996	2,016		10			2,016	12
13		Annex Patio Door		1996	2,742		10			2,742	13
14		Annex fire door		1996	1,521		10			1,521	14
15		Annex window replacement		1996	1,616		10			1,616	15
16		Annex Wanderguard System		1996	2,747	183	15	183		2,014	16
17		Annex water main replacements		1998	3,483	139	25	139		1,253	17
18		Annex doors replacement		2001	4,697	235	20	235		1,527	18
19		Annex Transfer Switch		2001	4,141	207	20	207		1,346	19
20		Land Improvements - North entrance parking lots & landscpg		2001	27,547	1,758	10 to 25	1,758		11,866	20
21		Bldg Improvements - Masonry & Steel Structure		2001	245,742	14,605	10 to 40	14,605		98,585	21
22		Bldg Improvements - Service Equipment for Structure		2001	280,829	17,147	10 to 25	17,147		115,741	22
23		Bldg Improvements - Fixed Equipment for structure		2001	12,961	837	5 to 20	837		6,975	23
24		Land Improvements - Helipad, landscaping & asphalt		2002	3,025	346	5 to 15	346		1,904	24
25		Bldg Improvements - Annex Hardware, closures		2002	1,847	92	20	92		507	25
26		Bldg Improvements - Hospital flooring & doors		2002	6,512	567	10 to 25	567		3,119	26
27		Bldg Improvements - LTC Roofing		2002	41,575	4,158	10	4,158		22,868	27
28		Land Impv - Landscaping		2003	765	77	10	77		346	28
29		Bldg Impr- LTC firewalls & doors		2003	36,469	1,458	25	1,458		6,562	29
30		Bldg Imp - Bulk Oxygen area work		2003	413	28	15	28		125	30
31		Bldg Impr -ER Oxygen system		2003	271	13	20	13		59	31
32		Bldg Imp-Cent Supp counters & ceiling		2003	110	7	15	7		32	32
33		Bldg Imp-Lab Central A/C system		2003	1,808	121	15	121		544	33
34		Bldg Imp-Nucl Med wiring		2003	162	8	20	8		36	34
35		Bldg Imp-Nucl Med cabinets & counters		2003	36	2	15	2		10	35
36		Bldg Imp-Dietary sewer system & pipes		2003	568	38	15	38		171	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 &amp; ID Number Gibson Community Hospital Annex

# 0005868

Report Period Beginning:

Oct. 1, 2006 Ending: Sept. 30, 2007

## 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	\$	\$ 85	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		90	38
39	Bldg Imp-pt registration carpet	2003	155	31	5	31		140	39
40	Bldg Imp-pt registration wiring & wall materials	2003	152	8	20	8		35	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		45	41
42	Bldg Imp-Bldg Asbestos removal & tuckpointing	2003	599	120	5	120		540	42
43	Bldg Imp-Bldg fire alarm system & panels	2003	650	65	10	65		292	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		998	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		235	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039	104	10	104		364	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		1,390	47
48	Bldg Impr - ER flooring & plumbing	2004	839	81	10 - 15	81		284	48
49	Bldg Imp - CAT scan cooling & power system	2004	5,104	340	15	340		1,190	49
50	Bldg Impr - Plant Heat exchanger	2004	178	35	5	35		123	50
51	Bldg Impr - Data Proc A/C System	2004	465	31	15	31		109	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		224	52
53	Bldg Impr - Paving patches	2004	517	103	5	103		361	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		195	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		1,456	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		3,209	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		563	57
58									58
59	Land Improvmnts - Paving	2005	779	97	8	97		243	59
60	Land Improvmnts - Parking Lot	2005	23,191	2,319	10	2,319		5,798	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	81	15	81		202	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	2,609	20	2,609		6,523	62
63	Bldg Impr - coverd sheet vinyl flooring	2005	294	29	10	29		73	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	31	15	31		78	64
65	Bldg Imp - Laundry Electrical work	2005	136	9	15	9		22	65
66	Bldg Imp - Laundry Washer hook up	2005	168	11	15	11		28	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	8	10	8		20	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	9	15	9		22	68
69	Bldg Imp - Data Proc Electrical work	2005	99	10	10	10		25	69
70	TOTAL (lines 4 thru 69)		\$ 1,352,908	\$ 57,223		\$ 57,223	\$	\$ 756,098	70

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

Facility Name &amp; ID Number Gibson Community Hospital Annex

# 0005868

Report Period Beginning:

Oct. 1, 2006 Ending: Sept. 30, 2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,352,908	\$ 57,223		\$ 57,223	\$	\$ 756,098	1
2	Bldg Imp - New Garage Bldg	2005	3,132	157	20	157		392	2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005	2,002	133	15	133		333	3
4	Bldg Imp -Sleep Mobile Power Unit	2005	373	37	10	37		93	4
5	Bldg Imp -Fire Alarm Sensor	2005	134	13	10	13		33	5
6	Bldg I-Surfc/ foundatn Drainage work	2005	1,324	66	20	66		165	6
7	Bldg Imp -Medical Gas piping	2005	168	11	15	11		28	7
8	Bldg Imp -Mech room water lines	2005	408	41	10	41		102	8
9	Bldg Imp - Electrical work for depts	2005	1,546	103	15	103		258	9
10									10
11	Bldg Imp - Annex Door Alarms	2006	3,376	675	5	675		1,013	11
12	Bldg Imp - Remodel Annex Kitchen incl prof fees	2006	13,630	682	20	682		1,023	12
13	Bldg Imp - Pro Panel & Electric Boiler	2006	5,137	342	15	342		513	13
14	Bldg Imp - Stair Treads	2006	278	56	5	56		84	14
15	Bldg Imp - Repl Cooling System for Walk-In Freezer	2006	1,490	74	20	74		111	15
16	Bldg Imp - Boiler Fuel Replacement	2006	1,556	52	30	52		78	16
17	Bldg Imp - Drainage, Landscaping & Grading	2006	31,183	1,559	20	1,559		2,339	17
18	Bldg Imp - Security for Exterior Doors	2006	121	24	5	24		36	18
19	Bldg Imp - New Steps, Rails & Ramp for Annex Entrance	2006	29,074	1,454	20	1,454		2,181	19
20	Bldg Imp - Soundproofing for Ortho Bldg	2006	1,157	144	8	144		216	20
21									21
22	Bldg Imp - Exhaust Duct in Storage closet	2007	727	36	10	36		36	22
23	Bldg Imp - Dietary Cooler / Freezer put on Emerg power	2007	237	8	15	8		8	23
24	Bldg Imp - Install Dish Machine Exhaust	2007	210	10	10	10		10	24
25	Bldg Imp - Boiler Feed Pumps & Piping	2007	2,790	70	20	70		70	25
26	Bldg Imp - Fire Supression System & Electrical	2007	1,923	96	10	96		96	26
27	Bldg Imp - Video Surveillance access control	2007	7,302	365	10	365		365	27
28	Bldg Imp - Ortho/Rehab Bldg Elevator / Bldg Renovations	2007	12,420	310	20	310		310	28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,474,606	\$ 63,741		\$ 63,741	\$	\$ 765,991	34

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2006 Ending: Sept. 30, 2007

XI. OWNERSHIP COSTS (continued)

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	\$ 433,230	\$ 38,253	\$ 38,253	\$	5 - 15	\$ 372,743	71
72	Current Year Purchases	2,302	231	231		5	231	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 435,532	\$ 38,484	\$ 38,484	\$		\$ 372,974	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)	\$ 1,937,333	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,225	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)	\$ 1,138,965	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	<b>TOTAL</b>				\$			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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 \_\_\_\_\_.

\_\_\_\_\_ 0

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: \$ 0 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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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 prescrpts							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	<b>TOTAL</b>			\$		\$	\$		\$	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.

Facility Name &amp; ID Number Gibson Community Hospital Annex

# 0005868

Report Period Beginning: Oct. 1, 2006

Ending:

Sept. 30, 2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Sept. 30, 2007 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 937,940	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 1,261,000 )	4,758,359		3
4	Supply Inventory (priced at Cost )	377,093		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	346,273		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Receivables</u>	1,960,439		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,380,104	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,311,993		12
13	Land	176,252		13
14	Buildings, at Historical Cost	17,675,051		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	14,578,645		16
17	Accumulated Depreciation (book methods)	(15,886,925)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Bond Costs</u> )	293,269		22
23	Other(specify): <u>CIP</u>	2,478,474		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 26,626,759	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 35,006,863	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,312,312	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,251,342		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	154,158		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Current Portion of LTD</u>	693,306		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,411,118	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	10,867,449		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 10,867,449	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 15,278,567	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 19,728,296	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 35,006,863	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,705,067	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,705,067	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	2,023,229	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)	\$ 2,023,229	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 19,728,296	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Gibson Community Hospital Annex# 0005868Report Period Beginning: Oct. 1, 2006Ending: Sept. 30, 2007**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 55,006,598	1
2	Discounts and Allowances for all Levels	(23,267,221)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 31,739,377	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,229,496	24
25	Interest and Other Investment Income***	282,978	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,512,474	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other Misc Income</b>	921,121	28
28a	<b>Grant Income</b>	54,423	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 975,544	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 34,227,395	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	358,724	31
32	Health Care	756,638	32
33	General Administration	696,032	33
<b>B. Capital Expense</b>			
34	Ownership	142,524	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	14,235	36
<b>D. Other Expenses (specify):</b>			
37	<b>Hospital Only Portion of Expenses</b>	30,236,013	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 32,204,166	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,023,229	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,023,229	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, 2006

Ending:

Sept. 30, 2007

**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	996	1,069	\$ 31,929	\$ 29.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,735	7,460	163,906	21.97	3
4	Licensed Practical Nurses	6,139	6,652	121,923	18.33	4
5	CNAs & Orderlies	21,511	23,551	267,038	11.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,274	1,407	18,622	13.24	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	47	53	1,800	33.96	12
13	Food Service Supervisor	737	826	17,607	21.32	13
14	Head Cook	737	846	12,379	14.63	14
15	Cook Helpers/Assistants	8,080	8,910	84,774	9.51	15
16	Dishwashers	535	578	4,386	7.59	16
17	Maintenance Workers	1,889	1,889	32,770	17.35	17
18	Housekeepers	1,968	2,124	17,820	8.39	18
19	Laundry	2,092	2,330	24,119	10.35	19
20	Administrator	1,378	1,378	43,272	31.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,341	6,341	113,467	17.89	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)	60,459	65,414	\$ 955,812 *	\$ 14.61	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

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

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
R. Duane Cooper	Administrator	0	\$ 43,272	Workers' Compensation Insurance	\$ 20,724	IDPH License Fee	\$	
				Unemployment Compensation Insurance	802	Advertising: Employee Recruitment		
				FICA Taxes	62,878	Health Care Worker Background Check		
				Employee Health Insurance	147,222	(Indicate # of checks performed _____)		
				Employee Meals	46,099	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	20,158			
				Tuition Reimbursement	3,187			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 43,272			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>								
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$				\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							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	\$
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. 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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,586 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. \$ 46,099 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 94,475
- (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 \$5,000, 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.