

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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

<p>I. IDPH License ID Number: <u>0005868</u></p> <p>Facility Name: <u>Gibson Community Hospital Annex</u></p> <p>Address: <u>430 East 19th Street</u> <u>Gibson City</u> <u>60936</u> Number City Zip Code</p> <p>County: <u>Ford</u></p> <p>Telephone Number: <u>(217) 784-4251</u> Fax # <u>(217) 784-2610</u></p> <p>HFS ID Number: <u>370647938008</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1963</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501C(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Patrick Szajkovic, SR, Inc.</u> Telephone Number: <u>(630) 530-7100, Ext. 111</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>Oct. 1, 2008</u> to <u>Sept. 30, 2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) <u>1/28/2010</u></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Mike Meunier</u></td> </tr> <tr> <td></td> <td>(Title) <u>Interim Chief Financial Officer</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) <u>1/28/2010</u></td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Patrick Szajkovic</u> <u>Senior Consultant</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(630) 530-7100</u> Fax # <u>(630) 530-7106</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) <u>1/28/2010</u>		(Type or Print Name) <u>Mike Meunier</u>		(Title) <u>Interim Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date) <u>1/28/2010</u>		(Print Name and Title) <u>Patrick Szajkovic</u> <u>Senior Consultant</u>		(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126</u>		(Telephone) <u>(630) 530-7100</u> Fax # <u>(630) 530-7106</u>
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Facility Name & ID Number Gibson Community Hospital Annex

0005868 Report Period Beginning: Oct. 1, 2008 Ending: Sept. 30, 2009

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	2,863	5,753	0	8,616	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,863	5,753		8,616	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.79%

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: YE 9/30/2009 Fiscal Year: YE 9/30/2009

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

Facility Name & ID Number

Gibson Community Hospital Annex

0005868

Report Period Beginning:

Oct. 1, 2008

Ending:

Sept. 30, 2009

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

	Operating Expenses	Costs Per General Ledger				Reclassification	Reclassified Total	Adjustments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	155,048	7,718	5,266	168,032		168,032		168,032		1
2	Food Purchase		46,615		46,615		46,615		46,615		2
3	Housekeeping	20,555	5,234	154	25,943		25,943		25,943		3
4	Laundry	23,135	9,373	1,951	34,459		34,459		34,459		4
5	Heat and Other Utilities			55,141	55,141		55,141		55,141		5
6	Maintenance	35,731	9,836	33,421	78,988		78,988		78,988		6
7	Other (specify):*										7
8	TOTAL General Services	234,469	78,776	95,933	409,178		409,178		409,178		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	675,670	26,003	134,421	836,094	(14,235)	821,859		821,859		10
10a	Therapy										10a
11	Activities	14,727	525	2,017	17,269		17,269		17,269		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	690,397	26,528	136,438	853,363	(14,235)	839,128		839,128		16
	C. General Administration										
17	Administrative	44,413			44,413		44,413		44,413		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	117,445	5,343	190,081	312,869		312,869		312,869		21
22	Employee Benefits & Payroll Taxes			324,078	324,078		324,078		324,078		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,128	56,128		56,128		56,128		26
27	Other (specify):*										27
28	TOTAL General Administration	161,858	5,343	570,287	737,488		737,488		737,488		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,086,724	110,647	802,658	2,000,029	(14,235)	1,985,794		1,985,794		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, 2008

Ending:

Sept. 30, 2009

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	
	D. Ownership											
30	Depreciation			139,937	139,937		139,937		139,937			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,161	43,161		43,161		43,161			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			183,098	183,098		183,098		183,098			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)	1,086,724	110,647	985,756	2,183,127		2,183,127		2,183,127			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, 2008

Ending:

Sept. 30, 2009

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	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	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.		X	\$		38
39	Provider Participation Fee	X		14,235	10	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 14,235		47

BHF USE ONLY						
48		49		50		51
						52

Gibson Community Hospital Annex

ID# 0005868

Report Period Beginning: Oct. 1, 2008

Ending: Sept. 30, 2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1				1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning: Oct. 1, 2008 Ending: Sept. 30, 2009

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		\$	\$	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	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								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, 2008

Ending: pt. 30, 2009

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	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

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning:

Oct. 1, 2008 Ending:

Sept. 30, 2009

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										
										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	Hosp Cp Imp & Ref Rev Bonds		X	Facility Impr & Refunding	\$9,875.75	9/12/2005	\$ 12,675,000	\$ 9,815,000	12/01/2019	0.0455	\$ 43,161	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$9,875.75		\$ 12,675,000	\$ 9,815,000			\$ 43,161	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 12,675,000	\$ 9,815,000			\$ 43,161	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 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 2009 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:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning:

Oct. 1, 2008 Ending:

Sept. 30, 2009

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 9/30/09 was 129,611 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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning:

Oct. 1, 2008 Ending: Sept. 30, 2009

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	\$	\$ 442,496	4	
5										5	
6										6	
7										7	
8										8	
	Improvement Type**										
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			15			4,736	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		2,380	16
17		Annex water main replacements	1998	3,483	139		25	139		1,531	17
18		Annex doors replacement	2001	4,697	235		20	235		1,997	18
19		Annex Transfer Switch	2001	4,141	207		20	207		1,760	19
20		Land Improvements - North entrance parking lots & landscap	2001	27,547	1,758		10 to 25	1,758		15,382	20
21		Bldg Improvements - Masonry & Steel Structure	2001	245,742	13,852		10 to 40	13,852		127,042	21
22		Bldg Improvements - Service Equipment for Structure	2001	280,829	17,147		10 to 25	17,147		150,035	22
23		Bldg Improvements - Fixed Equipment for structure	2001	12,961	745		5 to 20	745		8,557	23
24		Land Improvements - Helipad, landscaping & asphalt	2002	3,025	214		5 to 15	214		2,464	24
25		Bldg Improvements - Annex Hardware, closures	2002	1,847	92		20	92		691	25
26		Bldg Improvements - Hospital flooring & doors	2002	6,512	567		10 to 25	567		4,253	26
27		Bldg Improvements - LTC Roofing	2002	41,575	4,158		10	4,158		31,184	27
28		Land Impv - Landscaping	2003	765	76		10	76		499	28
29		Bldg Impr- LTC firewalls & doors	2003	36,469	1,458		25	1,458		9,478	29
30		Bldg Imp - Bulk Oxygen area work	2003	413	28		15	28		181	30
31		Bldg Impr -ER Oxygen system	2003	271	13		20	13		85	31
32		Bldg Imp-Cent Supp counters & ceiling	2003	110	7		15	7		46	32
33		Bldg Imp-Lab Central A/C system	2003	1,808	121		15	121		786	33
34		Bldg Imp-Nucl Med wiring	2003	162	8		20	8		52	34
35		Bldg Imp-Nucl Med cabinets & counters	2003	36	2		15	2		14	35
36		Bldg Imp-Dietary sewer system & pipes	2003	568	38		15	38		247	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Gibson Community Hospital Annex

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Report Period Beginning:

Oct. 1, 2008 Ending: Sept. 30, 2009

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Bldg Imp-Plant; hot & cold water valves	2003	\$ 281	\$ 19	15	\$ 19	\$	\$ 123	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		130	38
39	Bldg Imp-pt registration carpet	2003	155		5			155	39
40	Bldg Imp-pt registration wiring & wall materials	2003	152	8	20	8		51	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		65	41
42	Bldg Imp-Bldg Asbestos removal & tuckpointing	2003	599		5			599	42
43	Bldg Imp-Bldg fire alarm system & panels	2003	650	65	10	65		422	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		1,442	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		339	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039	104	10	104		572	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		2,184	47
48	Bldg Impr - ER flooring & plumbing	2004	839	81	10 - 15	81		446	48
49	Bldg Impr - CAT scan cooling & power system	2004	5,104	340	15	340		1,870	49
50	Bldg Impr - Plant Heat exchanger	2004	178	20	5	20		178	50
51	Bldg Impr - Data Proc A/C System	2004	465	31	15	31		171	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		352	52
53	Bldg Impr - Paving patches	2004	517	53	5	53		517	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		307	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		2,288	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		5,043	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		885	57
58									58
59	Land Improvmnts - Paving	2005	779	97	8	97		437	59
60	Land Improvmnts - Parking Lot	2005	23,191	2,319	10	2,319		10,436	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	80	15	80		361	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	2,610	20	2,610		11,745	62
63	Bldg Impr - coverd sheet vinyl flooring	2005	294	29	10	29		131	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	31	15	31		140	64
65	Bldg Imp - Laundry Electrical work	2005	136	9	15	9		40	65
66	Bldg Imp - Laundry Washer hook up	2005	168	11	15	11		50	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	8	10	8		36	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	9	15	9		40	68
69	Bldg Imp - Data Proc Electrical work	2005	99	10	10	10		45	69
70	TOTAL (lines 4 thru 69)		\$ 1,352,908	\$ 55,713		\$ 55,713	\$	\$ 868,954	70

**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, 2008 Ending: Sept. 30, 2009

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	\$ 55,713		\$ 55,713	\$	\$ 868,954	1
2	Bldg Imp - New Garage Bldg	2005	3,132	157	20	157		706	2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005	2,002	133	15	133		599	3
4	Bldg Imp -Sleep Mobile Power Unit	2005	373	37	10	37		167	4
5	Bldg Imp -Fire Alarm Sensor	2005	134	13	10	13		59	5
6	Bldg I-Surfc/ foundatn Drainage work	2005	1,324	66	20	66		297	6
7	Bldg Imp -Medical Gas piping	2005	168	11	15	11		50	7
8	Bldg Imp -Mech room water lines	2005	408	41	10	41		184	8
9	Bldg Imp - Electrical work for depts	2005	1,546	103	15	103		464	9
10	Bldg Imp - Annex Door Alarms	2006	3,376	675	5	675		2,363	10
11	Bldg Imp - Remodel Annex Kitchen incl prof fees	2006	13,629	681	20	681		2,384	11
12	Bldg Imp - Pro Panel & Electric Boiler	2006	5,137	342	15	342		1,198	12
13	Bldg Imp - Stair Treads	2006	693	139	5	139		485	13
14	Bldg Imp - Repl Cooling System for Walk-In Freezer	2006	1,490	74	20	74		261	14
15	Bldg Imp - Boiler Fuel Replacement	2006	1,556	52	30	52		182	15
16	Bldg Imp - Drainage, Landscaping & Grading	2006	1,580	79	20	79		276	16
17	Bldg Imp - Security for Exterior Doors	2006	121	24	5	24		85	17
18	Bldg Imp - New Steps, Rails & Ramp for Annex Entrance	2006	3,748	187	20	187		656	18
19	Bldg Imp - Stmt of Conditions - Bldg Drainage work	2006	29,604	1,480	20	1,480		5,181	19
20	Bldg Imp - Soundproofing for Ortho (PT) Bldg	2006	1,157	145	8	145		506	20
21	Bldg Imp - OR / HVAC Humidifier Project	2006	13,664	911	15	911		3,188	21
22	Bldg Imp - Exhaust Duct in Storage closet	2007	727	73	10	73		182	22
23	Bldg Imp - Dietary Cooler / Freezer put on Emerg power	2007	237	16	15	16		39	23
24	Bldg Imp - Install Dish Machine Exhaust	2007	210	21	10	21		53	24
25	Bldg Imp - Boiler Feed Pumps & Piping	2007	2,790	139	20	139		349	25
26	Bldg Imp - Fire Suplestion System & Electrical	2007	1,923	192	10	192		481	26
27	Bldg Imp - Video Surveilence access control	2007	7,302	730	10	730		1,826	27
28	Bldg Imp - Ortho/Rehab Bldg Elevator / Bldg Renovations	2007	12,420	621	20	621		1,552	28
29	Bldg Imp - Counter Tops In RT	2007	57	6	10	6		14	29
30	Bldg Imp - Electrical work upgrade - Life Safety	2007	1,046	70	15	70		174	30
31	Bldg Imp - OR Humidifier Upgrade	2007	2,325	155	15	155		388	31
32									32
33	Land Improvement - Parking Lot Replacement	2008	19,168	2,396	8	2,396		3,594	33
34	TOTAL (lines 1 thru 33)		\$ 1,485,955	\$ 65,482		\$ 65,482	\$	\$ 896,897	34

**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	
1	Totals from Page 12B, Carried Forward		\$ 1,485,955	\$ 65,482		\$ 65,482	\$	\$ 896,897	1
2	Bldg Imp - Remodel Mail Room	2008	491	33	15	33		49	2
3	Bldg Imp - Remodel Lab	2008	5,999	400	15	400		600	3
4									4
5	Land Imprvmnt - Parking Lot Repaving	2009	787	49	8	49		49	5
6	Land Imprvmnt - Parking Lot Repaving	2009	188	12	8	12		12	6
7	Bldg Imp - Annex Remodeling	2009	1,285,416	32,135	20	32,135		32,135	7
8	Bldg Imp - Lab Remodel	2009	557	19	15	19		19	8
9	Bldg Imp - Hospital Dept Renovations	2009	3,974	132	15	132		132	9
10	Bldg Imp - Pharmacy IV Room work	2009	5,584	186	15	186		186	10
11	Bldg Imp - Hospital Dept Renovations	2009	718	24	15	24		24	11
12	Bldg Imp - Material Mgmt Dept Renovations	2009	354	12	15	12		12	12
13	Bldg Imp - OR Dept Renovations	2009	383	13	15	13		13	13
14	Bldg Imp - Radiology Dept Renovations	2009	314	10	15	10		10	14
15	Bldg Imp - Annex Remodeling	2009	70,199	1,755	20	1,755		1,755	15
16	Bldg Imp - Sleep Lab Dept Renovations	2009	19,941	665	15	665		665	16
17	Bldg Imp - PT/OT Bldg Basement Remodel	2009	4,701	157	15	157		157	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)		\$ 2,885,561	\$ 101,084		\$ 101,084	\$	\$ 932,715	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, 2008

Ending:

Sept. 30, 2009

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	\$ 498,429	\$ 36,998	\$ 36,998	\$	3 - 15	\$ 456,929	71
72	Current Year Purchases	21,802	1,855	1,855		3 - 10	1,855	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 520,231	\$ 38,853	\$ 38,853	\$		\$ 458,784	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,405,792	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,937	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,937	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)	\$ 1,391,499	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:	<u>N/A</u>			\$ _____			3
4	Additions	<u>N/A</u>			\$ _____			4
5					\$ _____			5
6					\$ _____			6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 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	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ 0

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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?</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><u>No untrained CNA's were hired for 2009</u></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	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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$		\$						1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$				\$		\$				\$		14

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

Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning: Oct. 1, 2008

Ending:

Sept. 30, 2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Sept. 30, 2009 (last day of reporting year)

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	\$ 2,733,731	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,742,000)	5,127,472		3
4	Supply Inventory (priced at Cost)	521,707		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	314,389		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Third party & Other AR	1,609,541		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,306,840	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,717,630		12
13	Land	206,354		13
14	Buildings, at Historical Cost	24,397,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	16,765,085		16
17	Accumulated Depreciation (book methods)	(19,652,742)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Bond & othr Costs)	651,837		22
23	Other(specify): CIP	176,609		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,261,997	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 39,568,837	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,649,838	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,598,044		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	137,996		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Current Portion of LT Debt	1,250,934		36
37	Lines of Credit ST Loans	1,000,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,636,812	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,701,780		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)	\$ 12,701,780	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 19,338,592	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 20,230,245	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 39,568,837	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,905,284	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 20,905,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(675,039)	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)	\$ (675,039)	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)	\$ 20,230,245	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Gibson Community Hospital Annex

0005868

Report Period Beginning: Oct. 1, 2008

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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	\$ 75,135,918	1
2	Discounts and Allowances for all Levels	(33,868,477)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 41,267,441	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	294,056	24
25	Interest and Other Investment Income***	103,868	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 397,924	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc. Income	1,476,203	28
28a	Grant Income	86,282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,562,485	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 43,227,850	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	409,178	31
32	Health Care	853,363	32
33	General Administration	737,488	33
	B. Capital Expense		
34	Ownership	183,098	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Hospital Only Portion of Expenses	41,719,762	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 43,902,889	40
41	Income before Income Taxes (line 30 minus line 40)**	(675,039)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (675,039)	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

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Report Period Beginning:

Oct. 1, 2008

Ending:

Sept. 30, 2009

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	1,041	1,212	\$ 38,442	\$ 31.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,149	7,877	192,518	24.44	3
4	Licensed Practical Nurses	6,361	6,873	133,065	19.36	4
5	CNAs & Orderlies	23,713	25,941	311,645	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	975	1,218	14,727	12.09	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	639	724	23,059	31.85	12
13	Food Service Supervisor	816	910	20,822	22.88	13
14	Head Cook	817	930	14,114	15.18	14
15	Cook Helpers/Assistants	8,560	9,589	94,747	9.88	15
16	Dishwashers	229	287	2,306	8.03	16
17	Maintenance Workers	2,109	2,109	35,731	16.94	17
18	Housekeepers	2,205	2,378	20,555	8.64	18
19	Laundry	1,900	2,171	23,135	10.66	19
20	Administrator	1,308	1,308	44,413	33.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,154	6,154	117,445	19.08	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)	63,976	69,681	\$ 1,086,724 *	\$ 15.60	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

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Report Period Beginning: Oct. 1, 2008 Ending: Sept. 30, 2008

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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,359 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. \$ 46,747 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 84,368
- (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
- (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.