

Facility Name & ID Number Gibson Community Hsp Annex

0005868 Report Period Beginning: 10/1/2015 Ending: 9/30/2016

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	9,516	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	9,516	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	0	8,701	0	8,701	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		8,701		8,701	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.44%

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

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

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

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/16 Fiscal Year: 9/30/16

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	201,714	28,333	10,409	240,456		240,456	240,456			1
2	Food Purchase		123,415		123,415		123,415	123,415			2
3	Housekeeping	48,572	9,895	1,365	59,832		59,832	59,832			3
4	Laundry	42,721	24,006	1,647	68,374		68,374	68,374			4
5	Heat and Other Utilities			59,225	59,225		59,225	59,225			5
6	Maintenance	58,584	22,187	48,263	129,034		129,034	129,034			6
7	Other (specify):*										7
8	TOTAL General Services	351,591	207,836	120,909	680,336		680,336	680,336			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	915,408	29,356	64,237	1,009,001		1,009,001	1,009,001			10
10a	Therapy										10a
11	Activities	65,293	336	4,276	69,905		69,905	69,905			11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	980,701	29,692	68,513	1,078,906		1,078,906	1,078,906			16
	C. General Administration										
17	Administrative	75,453			75,453		75,453	75,453			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	152,047	5,034	204,390	361,471		361,471	361,471			21
22	Employee Benefits & Payroll Taxes			366,266	366,266		366,266	366,266			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,638	96,638		96,638	96,638			26
27	Other (specify):*										27
28	TOTAL General Administration	227,500	5,034	667,294	899,828		899,828	899,828			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,559,792	242,562	856,716	2,659,070		2,659,070	2,659,070			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.

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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			150,184	150,184		150,184		150,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,349	162,349		162,349		162,349			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			312,533	312,533		312,533		312,533			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			70,217	70,217		70,217		70,217			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			70,217	70,217		70,217		70,217			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,559,792	242,562	1,239,466	3,041,820		3,041,820		3,041,820			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>				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					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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	
							52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	N/A	\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	\$			\$	\$	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.

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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	N/A										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

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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

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

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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Hosp Cp Imp & Ref Rev Bonds		X	Facility Impr & Refunding	\$53,397.19	12/22/2010	\$ 8,600,000	\$ 6,457,880	12/22/2030	0.0425	\$ 162,349	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$53,397.19		\$ 8,600,000	\$ 6,457,880			\$ 162,349	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 8,600,000	\$ 6,457,880			\$ 162,349	15								

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

* 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gibson Community Hsp Annex COUNTY +PG1'D19

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 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.**

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,589 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 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 was 129,974 of which 13,378 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>HOSPITAL AND ANNEX</u>	<u>62,367</u>	<u>1952</u>	<u>\$ 27,195</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>62,367</u>		<u>\$ 27,195</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	26		1963	\$ 518,269	\$	50	\$	\$	\$ 518,269	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		15			2,747	16
17	Annex water main replacements		1998	3,483	139	25	139		2,226	17
18	Annex doors replacement		2001	4,697	235	20	235		3,172	18
19	Annex Transfer Switch		2001	4,141	207	20	207		2,795	19
20	Land Improvements - North entrance parking lots & landscap		2001	27,547	1,758	10 to 25	1,758		24,172	20
21	Bldg Improvements - Masonry & Steel Structure		2001	245,742	13,852	10 to 40	13,852		196,302	21
22	Bldg Improvements - Service Equipment for Structure		2001	280,829	17,147	10 to 25	17,147		235,770	22
23	Bldg Improvements - Fixed Equipment for structure		2001	12,961	749	5 to 20	749		12,302	23
24	Land Improvements - Helipad, landscaping & asphalt		2002	3,025		5 to 15			3,025	24
25	Bldg Improvements - Annex Hardware, closures		2002	1,847	92	20	92		1,151	25
26	Bldg Improvements - Hospital flooring & doors		2002	6,512		10 to 25			6,512	26
27	Bldg Improvements - LTC Roofing		2002	41,575		10			41,575	27
28	Land Impv - Landscaping		2003	765		10			765	28
29	Bldg Impr- LTC firewalls & doors		2003	36,469	1,458	25	1,458		16,768	29
30	Bldg Imp - Bulk Oxygen area work		2003	413	28	15	28		321	30
31	Bldg Impr -ER Oxygen system		2003	271	13	20	13		150	31
32	Bldg Imp-Cent Supp counters & ceiling		2003	110	7	15	7		81	32
33	Bldg Imp-Lab Central A/C system		2003	1,808	121	15	121		1,391	33
34	Bldg Imp-Nucl Med wiring		2003	162	8	20	8		92	34
35	Bldg Imp-Nucl Med cabinets & counters		2003	36	2	15	2		24	35
36	Bldg Imp-Dietary sewer system & pipes		2003	568	38	15	38		399	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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Bld Imp-Plant; hot & cold water valves	2003	\$ 281	\$ 19	15	\$ 19		\$ 237	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		250	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		99	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		125	41
42	Bldg Imp-Bldg Asbestos removal & tuckpointing	2003	599		5			599	42
43	Bldg Imp-Bldg fire alarm system & panels	2003	650		10			650	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		2,774	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		651	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039		10			1,039	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		4,566	47
48	Bldg Impr - ER flooring & plumbing	2004	839		10 - 15			839	48
49	Bldg Imp - CAT scan cooling & power system	2004	5,104	340	15	340		3,910	49
50	Bldg Impr - Plant Heat exchanger	2004	178		5			178	50
51	Bldg Impr - Data Proc A/C System	2004	465	31	15	31		357	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		736	52
53	Bldg Impr - Paving patches	2004	517		5			517	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		643	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		4,784	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		10,545	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		1,851	57
58								-	58
59	Land Improvmnts - Paving	2005	779		8			779	59
60	Land Improvmnts - Parking Lot	2005	23,191	1,159	10	1,159		23,191	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	80	15	80		841	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	2,610	20	2,610		27,405	62
63	Bldg Impr - coverd sheet vinyl flooring	2005	294	18	10	18		294	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	31	15	31		326	64
65	Bldg Imp - Laundry Electrical work	2005	136	9	15	9		94	65
66	Bldg Imp - Laundry Washer hook up	2005	168	11	15	11		116	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	6	10	6		82	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	9	15	9		94	68
69	Bldg Imp - Data Proc Electrical work	2005	99	4	10	4		99	69
70	TOTAL (lines 4 thru 69)		\$ 1,352,908	\$ 42,504		\$ 42,504	\$	\$ 1,185,029	70

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

Facility Name & ID Number Gibson Community Hsp Annex

0005868

Report Period Beginning:

10/1/2015

Ending:

9/30/2016

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,352,908	\$ 42,504		\$ 42,504	\$	\$ 1,185,029	1
2	Bldg Imp - New Garage Bldg	2005	3,132	157	20	157		1,648	2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005	2,002	133	15	133		1,397	3
4	Bldg Imp -Sleep Mobile Power Unit	2005	373	21	10	21		373	4
5	Bldg Imp -Fire Alarm Sensor	2005	134	10	10	10		134	5
6	Bldg I-Surfc/ foundatn Drainage work	2005	1,324	66	20	66		693	6
7	Bldg Imp -Medical Gas piping	2005	168	11	15	11		116	7
8	Bldg Imp -Mech room water lines	2005	408	19	10	19		408	8
9	Bldg Imp - Electrical work for depts	2005	1,546	103	15	103		1,082	9
10	Bldg Imp - Annex Door Alarms	2006	3,376		5			3,376	10
11	Bldg Imp - Remodel Annex Kitchen incl prof fees	2006	13,629	681	20	681		6,470	11
12	Bldg Imp - Pro Panel & Electric Boiler	2006	5,137	342	15	342		3,250	12
13	Bldg Imp - Stair Treads	2006	693		5			693	13
14	Bldg Imp - Repl Cooling System for Walk-In Freezer	2006	1,490	74	20	74		705	14
15	Bldg Imp - Boiler Fuel Replacement	2006	1,556	52	30	52		493	15
16	Bldg Imp - Drainage, Landscaping & Grading	2006	1,580	79	20	79		750	16
17	Bldg Imp - Security for Exterior Doors	2006	121		5			121	17
18	Bldg Imp - New Steps, Rails & Ramp for Annex Entrance	2006	3,748	187	20	187		1,778	18
19	Bldg Imp - Stmt of Conditions - Bldg Drainage work	2006	29,604	1,480	20	1,480		14,061	19
20	Bldg Imp - Soundproofing for Ortho (PT) Bldg	2006	1,157		8			1,157	20
21	Bldg Imp - OR / HVAC Humidifier Project	2006	13,664	911	15	911		8,654	21
22	Bldg Imp - Exhaust Duct in Storage closet	2007	727	73	10	73		619	22
23	Bldg Imp - Dietary Cooler / Freezer put on Emerg power	2007	237	16	15	16		135	23
24	Bldg Imp - Install Dish Machine Exhaust	2007	210	21	10	21		179	24
25	Bldg Imp - Boiler Feed Pumps & Piping	2007	2,790	139	20	139		1,183	25
26	Bldg Imp - Fire Supression System & Electrical	2007	1,923	192	10	192		1,633	26
27	Bldg Imp - Video Surveillance access control	2007	7,302	730	10	730		6,206	27
28	Bldg Imp - Ortho/Rehab Bldg Elevator / Bldg Renovations	2007	12,420	621	20	621		5,278	28
29	Bldg Imp - Counter Tops In RT	2007	57	6	10	6		50	29
30	Bldg Imp - Electrical work upgrade - Life Safety	2007	1,046	70	15	70		594	30
31	Bldg Imp - OR Humidifier Upgrade	2007	2,325	155	15	155		1,318	31
32								-	32
33	Land Improvement - Parking Lot Replacement	2008	19,168	2,396	8	2,396		17,970	33
34	TOTAL (lines 1 thru 33)		\$ 1,485,955	\$ 51,249		\$ 51,249	\$	\$ 1,267,553	34

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

Facility Name & ID Number Gibson Community Hsp Annex

0005868

Report Period Beginning:

10/1/2015

Ending:

9/30/2016

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,485,955	\$ 51,249		\$ 51,249	\$	\$ 1,267,553	1
2	Bldg Imp - Remodel Mail Room	2008	491	33	15	33		247	2
3	Bldg Imp - Remodel Lab	2008	5,999	400	15	400		3,000	3
4								-	4
5	Land Imprvmnt - Parking Lot Repaving	2009	787	98	8	98		539	5
6	Land Imprvmnt - Parking Lot Repaving	2009	188	23	8	23		127	6
7	Bldg Imp - Lab Remodel	2009	557	37	15	37		241	7
8	Bldg Imp - Hospital Dept Renovations	2009	3,974	265	15	265		1,722	8
9	Bldg Imp - Pharmacy IV Room work	2009	5,584	372	15	372		2,418	9
10	Bldg Imp - Hospital Dept Renovations	2009	718	48	15	48		312	10
11	Bldg Imp - Material Mgmt Dept Renovations	2009	354	24	15	24		155	11
12	Bldg Imp - OR Dept Renovations	2009	383	26	15	26		168	12
13	Bldg Imp - Radiology Dept Renovations	2009	314	21	15	21		136	13
14	Bldg Imp - Annex Remodeling	2009	70,199	3,510	20	3,510		22,815	14
15	Bldg Imp - Sleep Lab Dept Renovations	2009	19,941	1,329	15	1,329		8,639	15
16	Bldg Imp - PT/OT Bldg Basement Remodel	2009	4,701	313	15	313		2,035	16
17								-	17
18	Bldg Imp - Annex Door Alarm	2009	1,781	178	10	178		1,113	18
19	Bldg Imp - Temp controls	2009	39,823	3,982	10	3,982		24,895	19
20	Bldg Impr - Annex Carpet & Vinyl Flooring	2009	860		5			860	20
21	Bldg Impr - Annex Carpentry Work	2009	16,843	1,123	15	1,123		7,162	21
22	Bldg Impr - Annex Ceiling	2009	7,611	761	10	761		4,758	22
23	Bldg Impr - Annex Roofing Repairs	2009	3,637	364	10	364		2,275	23
24	Bldg Impr - Annex Caulking & Sealants	2009	1,672		5			1,672	24
25	Bldg Impr - Annex Doors & Frames	2009	38,194	2,546	15	2,546		16,238	25
26	Bldg Impr - Annex Commercial Flooring	2009	54,140	5,414	10	5,414		33,847	26
27	Bldg Impr - Annex Paint / Wall Covering	2009	43,334		5			43,334	27
28	Bldg Impr - Annex Wall Guards	2009	10,372	1,037	10	1,037		6,483	28
29	Bldg Impr - Annex Air Units	2009	53,053	3,537	15	3,537		22,558	29
30	Bldg Impr - Annex HVAC Pump	2009	6,252	625	10	625		3,908	30
31	Bldg Imp - Insulation	2009	49,461	3,297	15	3,297		21,028	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,927,178	\$ 80,612		\$ 80,612	\$	\$ 1,500,238	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,927,178	\$ 80,612		\$ 80,612	\$	\$ 1,500,238	1
2	Bldg Imp - Annex Remodeling I	2009	949,182	47,459		47,459		355,943	2
3	Bldg Imp - Annex Security Cameras	2010	495	50		50		325	3
4	Bldg Imp - Annex Remodeling II	2010	69,704	1,743		1,743		11,330	4
5	Bldg Imp - Hospital Switch Gear Update	2010	1,255	42		42		273	5
6	Bldg Imp - Hospital Water Softner	2010	536	27		27		176	6
7									7
8									8
9	No additions in FY11 to FY16								9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,948,350	\$ 129,933		\$ 129,933	\$	\$ 1,868,285	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 101,050	\$ 9,342	\$ 9,342	\$	5-20	\$ 71,993	71
72	Current Year Purchases	22,536	1,028	1,028		5-10	1,028	72
73	Fully Depreciated Assets	321,520				5-15	321,520	73
74								74
75	TOTALS	\$ 445,106	\$ 10,370	\$ 10,370	\$		\$ 394,541	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residence	Chrysler Van - 2015	2015	\$ 39,522	\$ 9,881	\$ 9,881	\$	4	\$ 12,351	76
77										77
78										78
79										79
80	TOTALS			\$ 39,522	\$ 9,881	\$ 9,881	\$		\$ 12,351	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)	\$ 3,460,173	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,184	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)	\$ 2,275,177	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.

Facility Name & ID Number Gibson Community Hsp Annex

0005868

Report Period Beginning: 10/1/2015

Ending: 9/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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 Hsp Annex

0005868

Report Period Beginning: 10/1/2015

Ending:

9/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2016

(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	\$ 795,741	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>10,962,000</u>)	22,788,200		3
4	Supply Inventory (priced at)	657,151		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,122,239		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other AR</u>	663,725		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 26,027,056	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,835,764		12
13	Land	1,005,624		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	62,147,385		16
17	Accumulated Depreciation (book methods)	(34,357,598)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,935,082		21
22	Other Long-Term Assets (spe <u>Bond Exp</u>	200,412		22
23	Other(specify): <u>Patient List</u>	560,598		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 38,327,267	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 64,354,323	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,705,024	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,281,796		29
30	Accrued Salaries Payable	3,855,954		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>3rd Party Settlement</u>	3,407,891		36
37	<u>Line of credit</u>	8,300,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 24,550,665	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,130,375		39
40	Mortgage Payable			40
41	Bonds Payable	13,572,480		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)	\$ 15,702,855	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 40,253,520	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 24,100,803	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 64,354,323	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 23,477,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 23,477,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	623,768	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)	\$ 623,768	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)	\$ 24,100,803	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,709,587	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,709,587	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Hospital Net Revenue</u>	79,259,241	28
28a	<u>Hospital Other Revenue</u>	1,998,052	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 81,257,293	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 84,966,880	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	680,336	31
32	Health Care	1,078,906	32
33	General Administration	899,828	33
B. Capital Expense			
34	Ownership	312,533	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	70,217	36
D. Other Expenses (specify):			
37	<u>Hospital Expenses</u>	81,301,292	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 84,343,112	40
41	Income before Income Taxes (line 30 minus line 40)**	623,768	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 623,768	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Hsp Annex

0005868

Report Period Beginning: 10/1/2015

Ending: 9/30/2016

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	1,163	1,344	\$ 61,505	\$ 45.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,498	6,009	257,675	42.88	3
4	Licensed Practical Nurses	7,087	7,896	224,897	28.48	4
5	CNAs & Orderlies	23,215	25,004	371,331	14.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,528	2,722	65,293	23.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,877	18,877	201,714	10.69	15
16	Dishwashers					16
17	Maintenance Workers	4,269	4,269	58,584	13.72	17
18	Housekeepers	4,674	4,674	48,572	10.39	18
19	Laundry	3,586	3,586	42,721	11.91	19
20	Administrator	1,237	1,237	75,453	61.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,377	4,377	162,242	37.07	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)	76,511	79,995	\$ 1,569,986 *	\$ 19.63	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	
Karen Christensen	Administrator		\$ 75,453	Workers' Compensation Insurance	\$ 25,134	IDPH License Fee	\$	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment		
				FICA Taxes	70,042	Health Care Worker Background Check		
				Employee Health Insurance	248,760	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension Expense	20,130			
				Tuition Reimbursement	2,200			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,453	TOTAL (agree to Schedule V, line 22, col.8)		\$ 366,266		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$	N/A		\$	Out-of-State Travel	\$
							N/A	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Gibson Community Hsp Annex

0005868

Report Period Beginning: 10/1/2015

Ending: 9/30/2016

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. No
- (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? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,811 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. \$ 70,217
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 107,217
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees