

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0005868</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Gibson Area Hospital Annex</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>Oct. 1, 2010</u> to <u>Sept. 30, 2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>430 East 19th Street</u> <u>Gibson City</u> <u>60936</u>			
Number City Zip Code			
County: <u>FORD</u>			
Telephone Number: <u>(217) 784-4251</u> Fax # <u>(217) 784-2610</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>01/01/1963</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code _____			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>JAKE CARNAZZO</u>			
Telephone Number: <u>(502) 992-3476</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>John H. Jacobson</u>	
		(Title) <u>Chief Financial Officer</u>	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>JAKE CARNAZZO</u> <u>DIRECTOR OF REIMBURSEMENT</u>	
		(Firm Name & Address) <u>ALLIANT MANAGEMENT</u> <u>2650 EASTPOINT PARKWAY, SUITE 310</u>	
		(Telephone) <u>(502) 992-3476</u> Fax # <u>(502) 992-3476</u>	
		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	

Facility Name & ID Number Gibson Area Hospital Annex

0005868 Report Period Beginning: Oct. 1, 2010 Ending: Sept. 30, 2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>26</u>	TOTALS	<u>26</u>	<u>9,490</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>586</u>			<u>1,498</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>586</u>			<u>1,498</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 15.79%

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)

NA

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

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 NA

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: YE 9/30/2011 Fiscal Year: YE 9/30/2011

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

Facility Name & ID Number Gibson Area Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2010 Ending: Sept. 30, 2011

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	160,266	105,584	6,374	272,224		272,224		272,224			1
2	Food Purchase											2
3	Housekeeping	26,562	5,105	149	31,816		31,816		31,816			3
4	Laundry	24,100	9,779	1,184	35,063		35,063		35,063			4
5	Heat and Other Utilities			61,081	61,081		61,081		61,081			5
6	Maintenance	48,109	14,165	41,828	104,102		104,102		104,102			6
7	Other (specify):*											7
8	TOTAL General Services	259,037	134,633	110,616	504,286		504,286		504,286			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	770,112	31,870	97,853	899,835		899,835		899,835			10
10a	Therapy											10a
11	Activities	55,382	1,291	3,202	59,875		59,875		59,875			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	825,494	33,161	101,055	959,710		959,710		959,710			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	231,396	6,071	496,039	733,506		733,506		733,506			21
22	Employee Benefits & Payroll Taxes			395,762	395,762		395,762		395,762			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,723	70,723		70,723		70,723			26
27	Other (specify):*											27
28	TOTAL General Administration	231,396	6,071	962,524	1,199,991		1,199,991		1,199,991			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,315,927	173,865	1,174,195	2,663,987		2,663,987		2,663,987			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership											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											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,315,927	173,865	1,174,195	2,663,987		2,663,987		2,663,987			45

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

VI. ADJUSTMENT DETAIL

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

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

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS 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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39	Provider Participation Fee	X		22,995	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)			\$ 22,995		47

Report Period Beginning:

Ending:

ID#0005868

Oct. 1, 2010

Sept. 30, 2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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

Summary A

Sept. 30, 2011

[illegible]

STATE OF ILLINOIS						Summary B
Facility Name & ID Number	Gibson Area Hospital Annex	#	0005868	Report Period Beginning:	Oct. 1, 2010	Ending: Sept. 30, 2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Gibson Area Hospital Annex # 0005868 Report Period Beginning: Oct. 1, 2010 Ending: pt. 30, 2011

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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	\$ 8,390,806	12/22/2030	0.0425	\$	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	\$ 8,390,806			\$	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	\$ 8,390,806			\$	15

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.								
1.	Real Estate Tax accrual used on 2010 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 2011 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:									
	2006							8	
	2007							9	
	2008							10	
	2009							11	
	2010							12	

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Gibson Area Hospital Annex</u>	COUNTY	<u>FORD</u>
---------------	-----------------------------------	--------	-------------

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 2010 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 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,859

B. General Construction Type: Exterior BRICKFrame CONCRETENumber 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: NA

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: NA

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	HOSPITAL AND ANNEX	62,367	1952	\$ 27,195	1
2					2
3	TOTALS	62,367		\$ 27,195	3

Facility Name & ID Number Gibson Area Hospital Annex

0005868

Report Period Beginning:

Oct. 1, 2010 Ending: Sept. 30, 2011

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$	\$ 448,912	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		2,563	16
17	Annex water main replacements			1998	3,483	139	25	139		1,670	17
18	Annex doors replacement			2001	4,697	235	20	235		2,232	18
19	Annex Transfer Switch			2001	4,141	207	20	207		1,967	19
20	Land Improvements - North entrance parking lots & landscp			2001	27,547	1,758	10 to 25	1,758		17,140	20
21	Bldg Improvements - Masonry & Steel Structure			2001	245,742	13,852	10 to 40	13,852		140,894	21
22	Bldg Improvements - Service Equipment for Structure			2001	280,829	17,147	10 to 25	17,147		167,182	22
23	Bldg Improvements - Fixed Equipment for structure			2001	12,961	749	5 to 20	749		9,306	23
24	Land Improvements - Helipad, landscaping & asphalt			2002	3,025	214	5 to 15	214		2,678	24
25	Bldg Improvements - Annex Hardware, closures			2002	1,847	92	20	92		783	25
26	Bldg Improvements - Hospital flooring & doors			2002	6,512	567	10 to 25	567		4,820	26
27	Bldg Improvements - LTC Roofing			2002	41,575	4,158	10	4,158		35,342	27
28	Land Impv - Landscaping			2003	765	76	10	76		575	28
29	Bldg Impr- LTC firewalls & doors			2003	36,469	1,458	25	1,458		10,936	29
30	Bldg Imp - Bulk Oxygen area work			2003	413	28	15	28		209	30
31	Bldg Impr -ER Oxygen system			2003	271	13	20	13		98	31
32	Bldg Imp-Cent Supp counters & ceiling			2003	110	7	15	7		53	32
33	Bldg Imp-Lab Central A/C system			2003	1,808	121	15	121		907	33
34	Bldg Imp-Nucl Med wiring			2003	162	8	20	8		60	34
35	Bldg Imp-Nucl Med cabinets & counters			2003	36	2	15	2		16	35
36	Bldg Imp-Dietary sewer system & pipes			2003	568	38	15	38		285	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 Area Hospital Annex

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Report Period Beginning:

Oct. 1, 2010 Ending: Sept. 30, 2011

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	Bldg Imp-Plant; hot & cold water valves	2003	\$ 281	\$ 19	15	\$ 19	\$	\$ 142	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		150	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		59	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		75	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		487	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		1,664	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		391	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039	104	10	104		676	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		2,581	47
48	Bldg Impr - ER flooring & plumbing	2004	839	81	10 - 15	81		527	48
49	Bldg Imp - CAT scan cooling & power system	2004	5,104	340	15	340		2,210	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		202	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		416	52
53	Bldg Impr - Paving patches	2004	517		5			517	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		363	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		2,704	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		5,960	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		1,046	57
58									58
59	Land Improvmnts - Paving	2005	779	97	8	97		534	59
60	Land Improvmnts - Parking Lot	2005	23,191	2,319	10	2,319		12,756	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	80	15	80		441	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	2,610	20	2,610		14,355	62
63	Bldg Impr - coverd sheet vinyl flooring	2005	294	29	10	29		160	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	31	15	31		171	64
65	Bldg Imp - Laundry Electrical work	2005	136	9	15	9		49	65
66	Bldg Imp - Laundry Washer hook up	2005	168	11	15	11		61	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	8	10	8		44	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	9	15	9		49	68
69	Bldg Imp - Data Proc Electrical work	2005	99	10	10	10		55	69
70	TOTAL (lines 4 thru 69)		\$ 1,352,908	\$ 55,644		\$ 55,644	\$	\$ 924,599	70

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

Facility Name & ID Number Gibson Area Hospital Annex

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Report Period Beginning:

Oct. 1, 2010 Ending: Sept. 30, 2011

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	\$ 55,644		\$ 55,644	\$	\$ 924,599	1
2	Bldg Imp - New Garage Bldg	2005	3,132	157	20	157		863	2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005	2,002	133	15	133		732	3
4	Bldg Imp -Sleep Mobile Power Unit	2005	373	37	10	37		204	4
5	Bldg Imp -Fire Alarm Sensor	2005	134	13	10	13		72	5
6	Bldg I-Surfc/ foundatn Drainage work	2005	1,324	66	20	66		363	6
7	Bldg Imp -Medical Gas piping	2005	168	11	15	11		61	7
8	Bldg Imp -Mech room water lines	2005	408	41	10	41		225	8
9	Bldg Imp - Electrical work for depts	2005	1,546	103	15	103		567	9
10	Bldg Imp - Annex Door Alarms	2006	3,376	675	5	675		3,038	10
11	Bldg Imp - Remodel Annex Kitchen incl prof fees	2006	13,629	681	20	681		3,065	11
12	Bldg Imp - Pro Panel & Electric Boiler	2006	5,137	342	15	342		1,540	12
13	Bldg Imp - Stair Treads	2006	693	139	5	139		624	13
14	Bldg Imp - Repl Cooling System for Walk-In Freezer	2006	1,490	74	20	74		335	14
15	Bldg Imp - Boiler Fuel Replacement	2006	1,556	52	30	52		233	15
16	Bldg Imp - Drainage, Landscaping & Grading	2006	1,580	79	20	79		355	16
17	Bldg Imp - Security for Exterior Doors	2006	121	24	5	24		109	17
18	Bldg Imp - New Steps, Rails & Ramp for Annex Entrance	2006	3,748	187	20	187		843	18
19	Bldg Imp - Stmt of Conditions - Bldg Drainage work	2006	29,604	1,480	20	1,480		6,661	19
20	Bldg Imp - Soundproofing for Ortho (PT) Bldg	2006	1,157	145	8	145		651	20
21	Bldg Imp - OR / HVAC Humidifier Project	2006	13,664	911	15	911		4,099	21
22	Bldg Imp - Exhaust Duct in Storage closet	2007	727	73	10	73		254	22
23	Bldg Imp - Dietary Cooler / Freezer put on Emerg power	2007	237	16	15	16		55	23
24	Bldg Imp - Install Dish Machine Exhaust	2007	210	21	10	21		74	24
25	Bldg Imp - Boiler Feed Pumps & Piping	2007	2,790	139	20	139		488	25
26	Bldg Imp - Fire Supression System & Electrical	2007	1,923	192	10	192		673	26
27	Bldg Imp - Video Surveillance access control	2007	7,302	730	10	730		2,556	27
28	Bldg Imp - Ortho/Rehab Bldg Elevator / Bldg Renovations	2007	12,420	621	20	621		2,173	28
29	Bldg Imp - Counter Tops In RT	2007	57	6	10	6		20	29
30	Bldg Imp - Electrical work upgrade - Life Safety	2007	1,046	70	15	70		244	30
31	Bldg Imp - OR Humidifier Upgrade	2007	2,325	155	15	155		543	31
32									32
33	Land Improvement - Parking Lot Replacement	2008	19,168	2,396	8	2,396		5,990	33
34	TOTAL (lines 1 thru 33)		\$ 1,485,955	\$ 65,413		\$ 65,413	\$	\$ 962,309	34

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

Facility Name & ID Number Gibson Area Hospital Annex

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Report Period Beginning:

Oct. 1, 2010 Ending: Sept. 30, 2011

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	\$ 65,413		\$ 65,413	\$	\$ 962,309	1
2	<u>Bldg Imp - Remodel Mail Room</u>	2008	491	33	15	33		82	2
3	<u>Bldg Imp - Remodel Lab</u>	2008	5,999	400	15	400		1,000	3
4									4
5	<u>Land Imprvmnt - Parking Lot Repaving</u>	2009	787	98	8	98		49	5
6	<u>Land Imprvmnt - Parking Lot Repaving</u>	2009	188	23	8	23		12	6
7	<u>Bldg Imp - Annex Remodeling (SEE 2010 FOR CHANGE)</u>	2009	1,285,416		20			32,135	7
8	<u>Bldg Imp - Lab Remodel</u>	2009	557	37	15	37		56	8
9	<u>Bldg Imp - Hospital Dept Renovations</u>	2009	3,974	265	15	265		397	9
10	<u>Bldg Imp - Pharmacy IV Room work</u>	2009	5,584	372	15	372		558	10
11	<u>Bldg Imp - Hospital Dept Renovations</u>	2009	718	48	15	48		72	11
12	<u>Bldg Imp - Material Mgmt Dept Renovations</u>	2009	354	24	15	24		35	12
13	<u>Bldg Imp - OR Dept Renovations</u>	2009	383	26	15	26		38	13
14	<u>Bldg Imp - Radiology Dept Renovations</u>	2009	314	21	15	21		31	14
15	<u>Bldg Imp - Annex Remodeling</u>	2009	70,199	3,510	20	3,510		5,265	15
16	<u>Bldg Imp - Sleep Lab Dept Renovations</u>	2009	19,941	1,329	15	1,329		1,994	16
17	<u>Bldg Imp - PT/OT Bldg Basement Remodel</u>	2009	4,701	313	15	313		470	17
18									18
19	<u>Bldg Imp - Annex Remodel - Reverse 2009 amnts in 2010</u>	2009	(1,285,416)					(32,135)	19
20	<u>Bldg Imp - Annex Door Alarm</u>	2009	1,781	178	10	178		223	20
21	<u>Bldg Imp - Temp controls</u>	2009	39,823	3,982	10	3,982		4,985	21
22	Bldg Impr - Annex Carpet & Vinyl Flooring	2009	860	172	5	172		194	22
23	Bldg Impr - Annex Carpentry Work	2009	16,843	1,123	15	1,123		1,547	23
24	Bldg Impr - Annex Ceiling	2009	7,611	761	10	761		953	24
25	Bldg Impr - Annex Roofing Repairs	2009	3,637	364	10	364		455	25
26	Bldg Impr - Annex Caulking & Sealants	2009	1,672	334	5	334		377	26
27	Bldg Impr - Annex Doors & Frames	2009	38,194	2,546	15	2,546		3,508	27
28	Bldg Impr - Annex Commercial Flooring	2009	54,140	5,414	10	5,414		6,777	28
29	Bldg Impr - Annex Paint / Wall Covering	2009	43,334	8,667	5	8,667		9,758	29
30	Bldg Impr - Annex Wall Guards	2009	10,372	1,037	10	1,037		1,298	30
31	Bldg Impr - Annex Air Units	2009	53,053	3,537	15	3,537		4,873	31
32	Bldg Impr - Annex HVAC Pump	2009	6,252	625	10	625		783	32
33	<u>Bldg Imp - Insulation</u>	2009	49,461	3,297	15	3,297		4,543	33
34	TOTAL (lines 1 thru 33)		\$ 1,927,178	\$ 103,949		\$ 103,949	\$	\$ 1,012,642	34

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

Facility Name & ID Number Gibson Area Hospital Annex

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Report Period Beginning:

Oct. 1, 2010 Ending: Sept. 30, 2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	
1 Totals from Page 12C, Carried Forward		\$ 1,927,178	\$ 103,949		\$ 103,949	\$	\$ 1,012,642	1
2 Bldg Imp - Annex Remodeling I		2009	47,459		47,459		71,360	2
3 Bldg Imp - Annex Security Cameras		2010	50		50		50	3
4 Bldg Imp - Annex Remodeling II		2010	1,743		1,743		1,743	4
5 Bldg Imp - Hospital Switch Gear Update		2010	42		42		42	5
6 Bldg Imp - Hospital Water Softner		2010	27		27		27	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 TOTAL (lines 1 thru 33)		\$ 1,937,227	\$ 153,270		\$ 153,270	\$	\$ 1,085,864	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	\$ 520,231	\$ 35,112	\$ 35,112	\$	3 - 15	\$ 492,041	71
72	Current Year Purchases	33,040	2,092	2,092		3 - 10	2,092	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 553,271	\$ 37,204	\$ 37,204	\$		\$ 494,133	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$ 2,517,693
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 190,474
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 190,474
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 1,579,997

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (282,335)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,817,607		3
4	Supply Inventory (priced at)	564,954		4
5	Short-Term Investments	7,748,617		5
6	Prepaid Insurance	504,970		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	455,336		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 17,809,149	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	43,358,831		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(24,087,193)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	593,682		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	63,653		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,928,973	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 37,738,122	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,688,733	\$	26
27	Officer's Accounts Payable	790,980		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	386,434		29
30	Accrued Salaries Payable	1,020,516		30
31	Accrued Taxes Payable (excluding real estate taxes)	884,834		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	(967,196)		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,804,301	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,048,479		39
40	Mortgage Payable			40
41	Bonds Payable			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)	\$ 11,048,479	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,852,780	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 21,885,342	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 37,738,122	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,697,967	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 20,697,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,187,375	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,187,375	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)	\$ 21,885,342	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Gibson Area Hospital Annex**# **0005868**Report Period Beginning: **Oct. 1, 2010**Ending: **Sept. 30, 2011**

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	\$ 104,729,731	1
2	Discounts and Allowances for all Levels	(50,979,628)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 53,750,103	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	444,238	24
25	Interest and Other Investment Income***	339,191	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 783,429	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 54,533,532	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	53,346,157	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 53,346,157	40
41	Income before Income Taxes (line 30 minus line 40)**	1,187,375	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,187,375	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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	980	1,039	\$ 39,277	\$ 37.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,979	5,224	204,191	39.09	3
4	Licensed Practical Nurses	6,601	7,148	184,579	25.82	4
5	CNAs & Orderlies	19,235	20,876	342,065	16.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,470	2,653	55,382	20.88	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	8,479	9,618	160,266	16.66	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,424	2,424	48,109	19.85	17
18	Housekeepers	2,403	2,618	26,562	10.15	18
19	Laundry	1,774	1,969	24,100	12.24	19
20	Administrator	8,194	8,827	231,396	26.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified 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)	57,539	62,396	\$ 1,315,927 *	\$ 21.09	34

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
R. Duane Cooper	Administrator		\$ 44,413	Workers' Compensation Insurance		\$ 26,664	IDPH License Fee	\$
				Unemployment Compensation Insurance		3,459	Advertising: Employee Recruitment	
				FICA Taxes		74,167	Health Care Worker Background Check	
				Employee Health Insurance		225,483	(Indicate # of checks performed)	
				Employee Meals		48,482	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension		15,971		
				Tuition		4,342		
				Allocation		(2,806)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 395,762	TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			(agree to Sch. V, line 24, col. 8)	
							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0005868

Report Period Beginning: Oct. 1, 2010

Ending: Sept. 30, 201

Page 23

Sept. 30, 20:

- (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. NA
- (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? NA
- (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? NA
- (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. \$??? 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. NA
- (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. NA
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 22,295
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. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ NA
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? NA
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
- 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? YED
Firm Name: _____
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.