

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0005868

Facility Name: Gibson Community Hosp Annex

Address: 430 East 19th Gibson City 60936

County: Ford

Telephone Number: 217.784.4251 Fax # 217.784.2610

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1963

Type of Ownership:

VOLUNTARY,NON-PROFIT

X

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: Matthew Ertel

Telephone Number: 217.784.2601

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2024 to 9/30/2025 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.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Matthew Ertel

(Title) Chief Financial Officer

Paid Preparer

(Print Name and Title) Ryan Ashland Director

(Firm Name & Address) Eide Bailly 4301 17th Ave S Fargo, ND 58108

(Telephone) 701.239.8500 Fax # NA

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number Gibson Community Hosp Annex # 0005868 Report Period Beginning: 10/1/2024 Ending: 9/30/2025

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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	26	TOTALS	26	9,490	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,535				3,429	409	440	6,813	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,535				3,429	409	440	6,813	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 71.79%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 01/01/1963

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 certified beds.
number of certified beds 5

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 09/30/2025 Fiscal Year: 09/30/2025
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

Gibson Community Hosp Annex

0005868

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

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	293,705	26,999	12,474	333,178		333,178		333,178			1
2	Food Purchase		147,859		147,859		147,859		147,859			2
3	Housekeeping	69,774	9,877	1,159	80,810		80,810		80,810			3
4	Laundry	33,875	6,709	1,945	42,529		42,529		42,529			4
5	Heat and Other Utilities			57,239	57,239		57,239		57,239			5
6	Maintenance	53,668	14,137	40,408	108,214		108,214		108,214			6
7	Other (specify):*											7
8	TOTAL General Services	451,021	205,582	113,226	769,829		769,829		769,829			8
	B. Health Care and Programs											
9	Medical Director			14,792	14,792		14,792		14,792			9
10	Nursing and Medical Records	1,141,520	59,323	282,963	1,483,806		1,483,806		1,483,806			10
10a	Therapy											10a
11	Activities	42,423			42,423		42,423		42,423			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,183,944	59,323	297,755	1,541,022		1,541,022		1,541,022			16
	C. General Administration											
17	Administrative	72,701			72,701		72,701		72,701			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			2,741	2,741		2,741	(959)	1,782			20
21	Clerical & General Office Expenses	235,356	5,815	558,598	799,770		799,770		799,770			21
22	Employee Benefits & Payroll Taxes			773,291	773,291		773,291		773,291			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,852	57,852		57,852		57,852			26
27	Other (specify):*											27
28	TOTAL General Administration	308,058	5,815	1,392,482	1,706,355		1,706,355	(959)	1,705,396			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,943,023	270,719	1,803,463	4,017,206		4,017,206	(959)	4,016,246			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			135,334	135,334		135,334		135,334			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,301	113,301		113,301		113,301			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			248,635	248,635		248,635		248,635			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,452			2,452		2,452		2,452			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,832	69,832		69,832		69,832			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,452		69,832	72,284		72,284		72,284			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,945,475	270,719	2,121,929	4,338,124		4,338,124	(959)	4,337,165			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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (959)	20	1
2	Other Expenses Related to Lobbying Activities			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	(959)		49

Summary A

9/30/2025

[illegible]

Summary B

9/30/2025

[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
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:	
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		N/A	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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)	
15	V		N/A	\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Ownership Listing-2

ID# 0005868

Ending: 9/30/2025

-Owners of companies must be listed instead of company names.

Ownership

[illegible]

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1						Marty Nuss	Board of Directors	1
2						Kathy Bennett	Board of Directors	2
3						Steve Kelly	Board of Directors	3
4						Mike Young	Board of Directors	4
5						Mark Spangler, MD	Board of Directors	5
6						Donald Reese, MD	Board of Directors	6
7						Justin Taylor	Board of Directors	7
8						Michael Young	Board of Directors	8
9						Kevin Seymour	Board of Directors	9
10						Brian Steidinger	Board of Directors	10
11						Mike Petersen	Board of Directors	11
12						Justin Swan	Board of Directors	12
13						Andy Hudson	Board of Directors	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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Gibson Community Hosp Annex # 0005868 Report Period Beginning: 10/1/2024 Ending: 1/30/2025

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 N/A

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

Facility Name & ID Number Gibson Community Hosp Annex # 0005868 Report Period Beginning: 10/1/2024 Ending: 1/30/2025

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 N/A

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	\$55,397.00	12/22/2010	\$ 8,600,000	\$ 2,984,987	12/22/2030	0.0425	\$ 137,785	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$55,397.00		\$ 8,600,000	\$ 2,984,987			\$ 137,785	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	\$ 2,984,987			\$ 137,785	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.)

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gibson Community Hosp Annex COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0005868

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

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? [X] (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? [X] (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 incldues a general short term hospital with 25 beds, 16 long term care beds and 26 long term care beds in the Annex. Total square feet is approximately 130,000 of which 13,378 for was the 42 long term care beds.

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] 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:

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 Community Hosp Annex

0005868

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

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	Bldg Impr ADDITION			1974	4,715		10			4,715	9
10	Land Impr FENCE			1977	885		10			885	10
11	Bldg Impr FIRESTOPS			1979	1,237		20			1,237	11
12	Bldg Impr FIRESTOPS			1980	407		20			407	12
13	Bldg Impr ADDITION			1980	4,534		10			4,534	13
14	Bldg Impr FIRE ALARM			1980	4,646		10			4,646	14
15	Land Impr DRIVEWAY			1981	690		4			690	15
16	Land Impr LANDSCAPING			1985	675		10			280	16
17	Bldg Impr FIRE ALARM			1985	280		10			675	17
18	Land Impr ANNEX PATIO			1987	1,380		15			1,380	18
19	Bldg Impr BEAUTY STOPS			1988	996		10			996	19
20	Bldg Impr CARPET - ANNEX			1989	4,944		5			4,944	20
21	Land Impr ANNEX FENCE/PAVILLION			1994	7,465		8			608	21
22	Land Impr SHRUBS			1994	3,173		5			28,873	22
23	Bldg Impr REMODELING-WALLPAPERING			1994	28,873		5			7,650	23
24	Land Impr SIDEWALK/BRICKWORK			1994	7,650		15			7,465	24
25	Bldg Impr CARPETING-OFFICE/C.ROOM			1994	608		5			3,173	25
26	Bldg Impr PAT. ROOM DOOR LATCHES (24)			1996	3,257		10			3,257	26
27	Bldg Impr PATIO DOOR			1996	4,430		10			4,430	27
28	Bldg Impr FIRE DOOR			1996	2,457		10			2,457	28
29	Bldg Impr WINDOW REPLACEMENT			1996	2,610		10			2,610	29
30	Bldg Impr WANDERGUARD SYSTEM			1996	4,437		15			4,437	30
31	Bldg Impr REPAIRS TO ANNEX WATER MAIN			1999	5,626		25			3,226	31
32	Bldg Impr PAINTING EXTERIOR OF HOSP & ANNEX			1999	3,226		5			5,626	32
33	Bldg Impr DOORS			2001	7,588		20			7,588	33
34	Bldg Impr TRANSFER SWITCH			2001	6,690		20			6,690	34
35	Bldg Impr DOORS, HARDWARE, CLOSURES			2002	2,984		20			2,984	35
36	Bldg Impr ANNEX FIREWALL			2003	16,685	667	25	667		15,015	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Gibson Community Hosp Annex

0005868

Report Period Beginning:

10/1/2024

Ending:

9/30/2025

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	ANNEX FIREWALL	2003	\$ 22,058	\$ 882	25	\$ 882	\$	\$ 19,851	37
38	INSTALL ACCESS DOORS;FIRE WALL	2003	9,608	384	25	384		8,646	38
39	DRYWALL & CARPENTRY	2004	9,624		15			9,624	39
40	NEW LAVATORY	2005	1,954		15			1,954	40
41	ANNEX SUNROOM	2005	84,301	2,108	20	2,108		84,301	41
42	PRO PANEL & ELECTRIC BOILER SERIES	2006	8,299		20			8,299	42
43	PROFESSIONAL FEES - SUNROOM	2006	3,703	185	15	185		3,611	43
44	ANNEX DOOR ALARMS	2006	5,454		20			5,454	44
45	REMODELING ANNEX KITCHEN	2006	18,314	916	5	916		17,857	45
46	EXHAUST DUCT IN STORAGE CLOSET	2007	1,174		10			1,174	46
47	ANNEX AIR UNITS	2008	85,700		10			85,700	47
48	ANNEX CARPENTRY WORK	2008	27,208		10			27,208	48
49	ANNEX CARPET & VINYL	2008	1,389		5			1,389	49
50	ANNEX CAULKING & SEALANTS	2008	2,701		15			2,701	50
51	ANNEX CEILING	2008	12,294		10			12,294	51
52	ANNEX COMMERCIAL FLOORING	2008	87,457		10			87,457	52
53	ANNEX DOOR ALARM	2008	2,877		5			2,877	53
54	ANNEX DOORS & FRAMES	2008	61,697	6	15	6		61,697	54
55	ANNEX HVAC PUMP	2008	10,100		10			10,100	55
56	ANNEX INSULATION	2008	79,898		5			79,898	56
57	ANNEX PAINTING/WALL COVERING	2008	70,000		10			70,000	57
58	ANNEX REMODELING I	2008	1,533,289	76,664	15	76,664		1,264,962	58
59	ANNEX ROOFING REPAIRS	2008	5,875		10			5,875	59
60	ANNEX TEMP CONTROLS	2008	64,329		15			64,329	60
61	ANNEX WALL GAURDS	2008	16,754		20			16,754	61
62	ANNEX REMODELING II	2009	112,598	5,630	20	5,630		92,894	62
63	CARPET	2015	11,728		5			11,728	63
64	Pavement Repair - Annex	2020	25,594	3,199	10	3,199		3,999	64
65	Annex Doors	2024	20,634	2,063	8	2,063		9,285	65
66	Annex Roof Replacement	2025	388,639	29,148	10	29,148		29,148	66
67	Annex Remodel - North Side	2025	37,378	1,869	5	1,869		1,869	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,474,042	\$ 123,721		\$ 123,721	\$	\$ 2,752,681	70

**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	\$ 110,009	\$ 11,456	\$ 11,456	\$	5-20	\$ 56,342	71
72	Current Year Purchases	37,378	156	156		10	156	72
73	Fully Depreciated Assets	426,929					426,929	73
74								74
75	TOTALS	\$ 574,317	\$ 11,613	\$ 11,613	\$		\$ 483,427	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	Residents	Chrysler Van - 2015	2015	\$ 39,522	\$	\$	\$	4	\$ 39,522	76
77										77
78										78
79										79
80	TOTALS			\$ 39,522	\$	\$	\$		\$ 39,522	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,115,076	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 135,334	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,334	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)	\$ 3,275,630	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

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.)

		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): <u>COTA</u>	Line 39, col 1	54	2,452				54	2,452	12
13	Other (specify): _____									13
14	TOTAL			\$ 2,452		\$	\$	54	\$ 2,452	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$2,308,627	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance53,063,392)	32,472,406		3
4	Supply Inventory (priced at)	3,130,215		4
5	Short-Term Investments	304,059		5
6	Prepaid Insurance	2,903,023		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,604,926		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$42,723,256	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,225,144		13
14	Buildings, at Historical Cost	69,777,857		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	62,429,535		16
17	Accumulated Depreciation (book methods)	(72,661,144)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	16,096,888		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	701,949		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$78,570,228	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$121,293,484	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$13,920,169	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,060,483		29
30	Accrued Salaries Payable	8,387,503		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$25,368,155	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,159,885		39
40	Mortgage Payable			40
41	Bonds Payable	29,686,835		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)	\$30,846,720	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$56,214,875	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$65,078,609	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$121,293,484	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 47,429,998	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 47,429,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	17,648,616	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) Rounding	(5)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 17,648,611	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)	\$ 65,078,609	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Gibson Community Hosp Annex

0005868

Report Period Beginning: 10/1/2024

Ending: 9/30/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,140,125	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,140,125	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	Hospital Net Revenue	173,818,474	28
28a	Hospital Other Revenue	11,011,099	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 184,829,572	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 186,969,697	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	769,829	31
32	Health Care	1,541,022	32
33	General Administration	1,706,356	33
	B. Capital Expense		
34	Ownership	244,185	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	69,832	36
	D. Other Expenses (specify):		
37	Hospital Expenses	164,989,858	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 169,321,082	40
41	Income before Income Taxes (line 30 minus line 40)**	17,648,616	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 17,648,616	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify) All payers	2,140,125.15	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,140,125	56

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	1,178	1,280	\$ 62,271	\$ 48.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,863	6,349	284,039	44.74	3
4	Licensed Practical Nurses	7,580	8,368	358,486	42.84	4
5	CNAs & Orderlies	16,637	18,210	436,725	23.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,389	1,594	42,423	26.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,554	15,060	293,705	19.50	15
16	Dishwashers					16
17	Maintenance Workers	2,015	2,239	53,668	23.97	17
18	Housekeepers	3,140	3,489	69,774	20.00	18
19	Laundry	1,614	1,794	33,875	18.89	19
20	Administrator	1,154	1,282	72,701	56.71	20
21	Assistant Administrator					21
22	Other Administrative	4,113	4,570	235,356	51.50	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	54	54	2,452	45.47	33
34	TOTAL (lines 1 - 33)	58,291	64,289	\$ 1,945,475 *	\$ 30.26	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	144	14,792	line 9 col 3	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)	144	\$ 14,792		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	3,312	142,981		52
53	TOTAL (lines 50 - 52)	3,312	\$ 142,981		53

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

** See instructions.

Facility Name & ID Number

Gibson Community Hosp Annex

STATE OF ILLINOIS

0005868

Report Period Beginning:

10/1/2024

Page 21

Ending:

9/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Jennifer Badgley

Administrator

\$ 72,701

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 72,701

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

N/A

\$

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 9,441

Unemployment Compensation Insurance

1,510

FICA Taxes

148,641

Employee Health Insurance

567,639

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Pension Expense

43,853

Tuition Reimbursement

2,193

Other

14

TOTAL (agree to Schedule V, line 22, col.8)

\$ 773,291

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

2,741

Less: Public Relations Expense

()

PAC and Lobbying payments

(959)

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 1,782

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

N/A

In-State Travel

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	1,782
	1,782 Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	959
	959 Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	2,741
	2,741 Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 11,574 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 69,832
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) 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? Yes Indicate the amount. \$ 54,106
- (12) 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. \$
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: Eck, Schafer, Punke LLP Yes
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15) 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.