		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Hospital Annex

Address: 430 East 19th Street (Number) Gibson City (City) 60936 (Zip Code)

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		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 10/01/17 to 09/30/18 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) _____ (Date)
(Type or Print Name) Matthew Ertel
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Jason Fender, Senior Associate
(Firm Name & Address) RSM US LLP, 201 N. Harrison Street, Suite 300, Davenport, IA 52801
(Telephone) (563) 888-4072 Fax # (847) 517-7067

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 Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,080	5,486	234	7,800	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,080	5,486	234	7,800	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.19%

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 [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 5 and days of care provided 234

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/2018 Fiscal Year: 9/30/2018

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,730	24,982	38,101	262,813		262,813		262,813			1
2	Food Purchase		121,853		121,853		121,853		121,853			2
3	Housekeeping	48,894	10,497	4,037	63,429		63,429		63,429			3
4	Laundry	33,591	7,229	3,111	43,931		43,931		43,931			4
5	Heat and Other Utilities			56,160	56,160		56,160		56,160			5
6	Maintenance	74,890	18,255	26,069	119,213		119,213		119,213			6
7	Other (specify):*											7
8	**TOTAL General Services**	357,104	182,816	127,479	667,399		667,399		667,399			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	785,436	26,091	50,415	861,942		861,942		861,942			10
10a	Therapy											10a
11	Activities	63,408	1,965	4,593	69,966		69,966		69,966			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	848,844	28,056	55,008	931,908		931,908		931,908			16
	C. General Administration											
17	Administrative	64,064			64,064		64,064		64,064			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	187,521	3,302	335,401	526,224		526,224		526,224			21
22	Employee Benefits & Payroll Taxes			428,951	428,951		428,951		428,951			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,171	106,171		106,171		106,171			26
27	Other (specify):*											27
28	**TOTAL General Administration**	251,585	3,302	870,523	1,125,410		1,125,410		1,125,410			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,457,533	214,174	1,053,010	2,724,717		2,724,717		2,724,717			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Gibson Community Hospital Annex #0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			151,606	151,606		151,606		151,606			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			152,010	152,010		152,010		152,010			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			303,616	303,616		303,616		303,616			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			60,781	60,781		60,781		60,781			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			60,781	60,781		60,781		60,781			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,457,533	214,174	1,417,406	3,089,114		3,089,114		3,089,114			45

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Gibson Community Hospital Annex

ID# 0005868

Report Period Beginning: 10/01/17

Ending: 09/30/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

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

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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 [X]

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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	12/22/2010	$ 8,600,000	$ 5,700,422	12/22/2030	0.0425	$ 152,010	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	$ 5,700,422			$ 152,010	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	$ 5,700,422			$ 152,010	15

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

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

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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.)**	Alloc Fr. Mgmt Co.	$	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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gibson Community Hospital Annex COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0005868

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5589 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 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 [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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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 Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	26			1963	$ 518,269	$ -	50	$ -	$	$ 518,269	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Annex Building Fixtures - Landscaping		1985	1985	675	-	20	-		675	9
10	Land Improvements - Misc Annex		1994	1994	12,888	-	10	-		12,888	10
11	Annex sidewalk & brickwork		1994	1994	4,736	-	15	-		4,736	11
12	Annex pt room door latches		1996	1996	2,016	-	10	-		2,016	12
13	Annex Patio Door		1996	1996	2,742	-	10	-		2,742	13
14	Annex fire door		1996	1996	1,521	-	10	-		1,521	14
15	Annex window replacement		1996	1996	1,616	-	10	-		1,616	15
16	Annex Wanderguard System		1996	1996	2,747	-	15	-		2,747	16
17	Annex water main replacements		1998	1998	3,483	139	25	139		2,504	17
18	Annex doors replacement		2001	2001	4,697	235	20	235		3,642	18
19	Annex Transfer Switch		2001	2001	4,141	207	20	207		3,209	19
20	Land Improvements - North entrance parking lots & landscp		2001	2001	27,547	1,617	10 to 25	1,617		27,547	20
21	Bldg Improvements - Masonry & Steel Structure		2001	2001	245,742	13,852	10 to 40	13,852		224,006	21
22	Bldg Improvements - Service Equipment for Structure		2001	2001	280,829	17,147	10 to 25	17,147		270,064	22
23	Bldg Improvements - Fixed Equipment for structure		2001	2001	12,961		5 to 20			12,961	23
24	Land Improvements - Helipad, landscaping & asphalt		2002	2002	3,025	-	5 to 15	-		3,025	24
25	Bldg Improvements - Annex Hardware, closures		2002	2002	1,847	92	20	92		1,335	25
26	Bldg Improvements - Hospital flooring & doors		2002	2002	6,512	-	10 to 25	-		6,512	26
27	Bldg Improvements - LTC Roofing		2002	2002	41,575	-	10	-		41,575	27
28	Land Impv - Landscaping		2003	2003	765	-	10	-		765	28
29	Bldg Impr- LTC firewalls & doors		2003	2003	36,469	1,458	25	1,458		19,684	29
30	Bldg Imp - Bulk Oxygen area work		2003	2003	413	28	15	28		377	30
31	Bldg Impr -ER Oxygen system		2003	2003	271	13	20	13		176	31
32	Bldg Imp-Cent Supp counters & ceiling		2003	2003	110	7	15	7		95	32
33	Bldg Imp-Lab Central A/C system		2003	2003	1,808	121	15	121		1,633	33
34	Bldg Imp-Nucl Med wiring		2003	2003	162	8	20	8		108	34
35	Bldg Imp-Nucl Med cabinets & counters		2003	2003	36	2	15	2		28	35
36	Bldg Imp-Dietary sewer system & pipes		2003	2003	568	38	15	38		475	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bld Imp-Plant; hot & cold water valves	2003	$ 281	$ 19	15	$ 19	$	$ 275	37
38	Bldg Imp-Laundry pipe insulation	2003	302	20	15	20		290	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		115	40
41	Bldg Imp-Admin walls in east board rm	2003	152	10	15	10		145	41
42	Bldg Imp-Bldg Asbestos removal & tuckpointing	2003	599	-	5	-		599	42
43	Bldg Imp-Bldg fire alarm system & panels	2003	650	-	10	-		650	43
44	Bldg Imp-Bld concrete pad & asbestos abatement	2003	3,324	222	15	222		3,218	44
45	Bldg Imp-Bldg PVC Vents	2003	1,049	52	20	52		755	45
46	Bldg Impr - Hospital M & S flooring	2004	1,039	-	10	-		1,039	46
47	Bldg Impr - LTC Drywall & carpentry	2004	5,958	397	15	397		5,360	47
48	Bldg Impr - ER flooring & plumbing	2004	839	-	10 - 15	-		839	48
49	Bldg Imp - CAT scan cooling & power system	2004	5,104	340	15	340		4,590	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		419	51
52	Bldg Impr - Door Security replacmnt & locks	2004	964	64	15	64		864	52
53	Bldg Impr - Paving patches	2004	517	-	5	-		517	53
54	Bldg Impr - Sewer Storm drains	2004	1,111	56	20	56		755	54
55	Bldg Impr - Sprinkler system	2004	10,404	416	25	416		5,616	55
56	Bldg Impr - Roofing project	2004	18,332	917	20	917		12,379	56
57	Bld Imp-Fire recall proj & transfer switches	2004	2,410	161	15	161		2,173	57
58				-		-			58
59	Land Improvmnts - Paving	2005	779	-	8	-		779	59
60	Land Improvmnts - Parking Lot	2005	23,191	-	10	-		23,191	60
61	Bldg Impr - LTC New Lavatory	2005	1,210	80	15	80		1,001	61
62	Bldg Impr - LTC Sunroom addition	2005	52,187	2,610	20	2,610		32,625	62
63	Bldg Impr - coverd sheet vinyl flooring	2005	294	-	10	-		294	63
64	Bldg Imp - Centr Supply Sterile Rm upgrade	2005	470	31	15	31		388	64
65	Bldg Imp - Laundry Electrical work	2005	136	9	15	9		112	65
66	Bldg Imp - Laundry Washer hook up	2005	168	11	15	11		138	66
67	Bldg Imp - Laundry gas dryer vent	2005	82	-	10	-		82	67
68	Bldg Imp - Laundry Steel Door & locks	2005	136	9	15	9		112	68
69	Bldg Imp - Data Proc Electrical work	2005	99	-	10	-		99	69
70	TOTAL (lines 4 thru 69)		$ 1,352,908	$ 40,427		$ 40,427	$	$ 1,266,683	70

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,352,908	$ 40,427		$ 40,427	$	$ 1,266,683	1
2	Bldg Imp - New Garage Bldg	2005	3,132	157	20	157		1,962	2
3	Bldg I-Install Fire/Emerg Monitor Sys	2005	2,002	133	15	133		1,663	3
4	Bldg Imp -Sleep Mobile Power Unit	2005	373	-	10	-		373	4
5	Bldg Imp -Fire Alarm Sensor	2005	134	-	10	-		134	5
6	Bldg I-Surfc/ foundatn Drainage work	2005	1,324	66	20	66		825	6
7	Bldg Imp -Medical Gas piping	2005	168	11	15	11		138	7
8	Bldg Imp -Mech room water lines	2005	408	-	10	-		408	8
9	Bldg Imp - Electrical work for depts	2005	1,546	103	15	103		1,288	9
10	Bldg Imp - Annex Door Alarms	2006	3,376	-	5	-		3,376	10
11	Bldg Imp - Remodel Annex Kitchen incl prof fees	2006	13,629	681	20	681		7,832	11
12	Bldg Imp - Pro Panel & Electric Boiler	2006	5,137	342	15	342		3,934	12
13	Bldg Imp - Stair Treads	2006	693	-	5	-		693	13
14	Bldg Imp - Repl Cooling System for Walk-In Freezer	2006	1,490	74	20	74		853	14
15	Bldg Imp - Boiler Fuel Replacement	2006	1,556	52	30	52		597	15
16	Bldg Imp - Drainage, Landscaping & Grading	2006	1,580	79	20	79		908	16
17	Bldg Imp - Security for Exterior Doors	2006	121	-	5	-		121	17
18	Bldg Imp - New Steps, Rails & Ramp for Annex Entrance	2006	3,748	187	20	187		2,152	18
19	Bldg Imp - Stmt of Conditions - Bldg Drainage work	2006	29,604	1,480	20	1,480		17,021	19
20	Bldg Imp - Soundproofing for Ortho (PT) Bldg	2006	1,157	-	8	-		1,157	20
21	Bldg Imp - OR / HVAC Humidifier Project	2006	13,664	911	15	911		10,476	21
22	Bldg Imp - Exhaust Duct in Storage closet	2007	727	35	10	35		727	22
23	Bldg Imp - Dietary Cooler / Freezer put on Emerg power	2007	237	16	15	16		167	23
24	Bldg Imp - Install Dish Machine Exhaust	2007	210	10	10	10		210	24
25	Bldg Imp - Boiler Feed Pumps & Piping	2007	2,790	139	20	139		1,461	25
26	Bldg Imp - Fire Supression System & Electrical	2007	1,923	98	10	98		1,923	26
27	Bldg Imp - Video Surveilence access control	2007	7,302	366	10	366		7,302	27
28	Bldg Imp - Ortho/Rehab Bldg Elevator / Bldg Renovations	2007	12,420	621	20	621		6,520	28
29	Bldg Imp - Counter Tops In RT	2007	57	1	10	1		57	29
30	Bldg Imp - Electrical work upgrade - Life Safety	2007	1,046	70	15	70		734	30
31	Bldg Imp - OR Humidifier Upgrade	2007	2,325	155	15	155		1,628	31
32				-		-			32
33	Land Improvement - Parking Lot Replacement	2008	19,168		8			19,168	33
34	TOTAL (lines 1 thru 33)		$ 1,485,955	$ 46,214		$ 46,214	$	$ 1,362,491	34

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,485,955	$ 46,214		$ 46,214	$	$ 1,362,491	1
2	Bldg Imp - Remodel Mail Room	2008	491	33	15	33		313	2
3	Bldg Imp - Remodel Lab	2008	5,999	400	15	400		3,800	3
4				-		-			4
5	Land Imprvmnt - Parking Lot Repaving	2009	787	98	8	98		735	5
6	Land Imprvmnt - Parking Lot Repaving	2009	188	23	8	23		173	6
7	Bldg Imp - Lab Remodel	2009	557	37	15	37		315	7
8	Bldg Imp - Hospital Dept Renovations	2009	3,974	265	15	265		2,252	8
9	Bldg Imp - Pharmacy IV Room work	2009	5,584	372	15	372		3,162	9
10	Bldg Imp - Hospital Dept Renovations	2009	718	48	15	48		408	10
11	Bldg Imp - Material Mgmt Dept Renovations	2009	354	24	15	24		203	11
12	Bldg Imp - OR Dept Renovations	2009	383	26	15	26		220	12
13	Bldg Imp - Radiology Dept Renovations	2009	314	21	15	21		178	13
14	Bldg Imp - Annex Remodeling	2009	70,199	3,510	20	3,510		29,835	14
15	Bldg Imp - Sleep Lab Dept Renovations	2009	19,941	1,329	15	1,329		11,297	15
16	Bldg Imp - PT/OT Bldg Basement Remodel	2009	4,701	313	15	313		2,661	16
17				-		-			17
18	Bldg Imp - Annex Door Alarm	2009	1,781	178	10	178		1,469	18
19	Bldg Imp - Temp controls	2009	39,823	3,982	10	3,982		32,859	19
20	Bldg Impr - Annex Carpet & Vinyl Flooring	2009	860	-	5	-		860	20
21	Bldg Impr - Annex Carpentry Work	2009	16,843	1,123	15	1,123		9,408	21
22	Bldg Impr - Annex Ceiling	2009	7,611	761	10	761		6,280	22
23	Bldg Impr - Annex Roofing Repairs	2009	3,637	364	10	364		3,003	23
24	Bldg Impr - Annex Caulking & Sealants	2009	1,672	-	5	-		1,672	24
25	Bldg Impr - Annex Doors & Frames	2009	38,194	2,546	15	2,546		21,330	25
26	Bldg Impr - Annex Commercial Flooring	2009	54,140	5,414	10	5,414		44,675	26
27	Bldg Impr - Annex Paint / Wall Covering	2009	43,334	-	5	-		43,334	27
28	Bldg Impr - Annex Wall Guards	2009	10,372	1,037	10	1,037		8,557	28
29	Bldg Impr - Annex Air Units	2009	53,053	3,537	15	3,537		29,632	29
30	Bldg Impr - Annex HVAC Pump	2009	6,252	625	10	625		5,158	30
31	Bldg Imp - Insulation	2009	49,461	3,297	15	3,297		27,622	31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 1,927,178	$ 75,577		$ 75,577	$	$ 1,653,902	34

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,927,178	$ 75,577		$ 75,577	$	$ 1,653,902	1
2	Bldg Imp - Annex Remodeling I	2009	949,182	47,459		47,459		450,861	2
3	Bldg Imp - Annex Security Cameras	2010	495	50		50		425	3
4	Bldg Imp - Annex Remodeling II	2010	69,704	1,743		1,743		14,816	4
5	Bldg Imp - Hospital Switch Gear Update	2010	1,255	42		42		357	5
6	Bldg Imp - Hospital Water Softner	2010	536	27		27		230	6
7				-		-			7
8	Bldg Imp - Carpet	2015	11,728	2,346	5	2,346		6,059	8
9				-		-			9
10	No additions in FY13 to FY18			-		-			10
11				-		-			11
12				-		-			12
13				-		-			13
14				-		-			14
15				-		-			15
16				-		-			16
17				-		-			17
18				-		-			18
19				-		-			19
20				-		-			20
21				-		-			21
22				-		-			22
23				-		-			23
24				-		-			24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 2,960,078	$ 127,244		$ 127,244	$	$ 2,126,650	34

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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	$ 97,420	$ 12,259	$ 12,259	$ -	5-20	$ 64,939	71
72	Current Year Purchases	13,334	2,222	2,222	-	5-10	2,222	72
73	Fully Depreciated Assets	332,149			-	5-15	332,149	73
74					-			74
75	TOTALS	$ 442,903	$ 14,481	$ 14,481	$		$ 399,310	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residence	Chrysler Van - 2015	2015	$ 39,522	$ 9,881	$ 9,881	$ -	4	$ 29,642	76
77					-	-	-			77
78					-	-	-			78
79					-	-	-			79
80	TOTALS			$ 39,522	$ 9,881	$ 9,881	$		$ 29,642	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,469,698	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,606	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 151,606	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,555,602	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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: ____ *

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.	/2019	$
13.	/2020	$
14.	/2021	$

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.

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

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.

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

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	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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.

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/18 (last day of reporting year)

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	$ 432,889	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,603,224)	20,389,760		3
4	Supply Inventory (priced at)	878,027		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,233,906		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 22,934,582	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,446,209		12
13	Land	1,102,242		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	71,005,508		16
17	Accumulated Depreciation (book methods)	(41,317,631)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,102,538		21
22	Other Long-Term Assets (spc			22
23	Other(specify): Intangible Assets and Other	542,838		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 41,881,704	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 64,816,286	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,828,577	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,134,578		29
30	Accrued Salaries Payable	3,785,388		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	3rd Party Settlement	1,713,855		36
37	Line Of Credit	5,700,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 22,162,398	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,607,100		39
40	Mortgage Payable			40
41	Bonds Payable	14,821,970		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)**	$ 17,429,070	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 39,591,468	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 25,224,818	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 64,816,286	$	48

***(See instructions.)**

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 24436973	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 24,436,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	787,845	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)**	$ 787,845	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)**	$ 25,224,818	24 *

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

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,469,544	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,469,544	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	90,072,733	28
28a	Hospital Other Revenue	4,866,467	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 94,939,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 98,408,744	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	667,399	31
32	Health Care	931,908	32
33	General Administration	1,125,410	33
	B. Capital Expense		
34	Ownership	303,616	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,781	36
	D. Other Expenses (specify):		
37	Hospital Expenses	94,531,785	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 97,620,899	40
41	**Income before Income Taxes (line 30 minus line 40)****	787,845	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 787,845	43

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

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

^ Entity is a cash basis taxpayer

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,200	1,266	$ 57,286	$ 45.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,621	5,109	188,113	36.82	3
4	Licensed Practical Nurses	5,889	6,462	183,760	28.44	4
5	CNAs & Orderlies	21,303	24,015	356,277	14.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,384	2,582	63,408	24.56	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,692	16,692	199,730	11.97	15
16	Dishwashers					16
17	Maintenance Workers	3,750	3,750	74,890	19.97	17
18	Housekeepers	4,226	4,226	48,894	11.57	18
19	Laundry	2,870	2,870	33,591	11.70	19
20	Administrator	1,174	1,174	64,064	54.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,686	4,686	187,521	40.02	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 C:					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,795	72,832	$ 1,457,534 *	$ 20.01	34

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

** See instructions.

B. CONSULTANT SERVICES

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

Facility Name: Gibson Community Hospital Annex
IDPH License ID Number: 0005868
Fiscal Year End: 09/30/18

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
				#DIV/0!
				#DIV/0!
				#DIV/0!
				#DIV/0!
Total - Line	-	-	-	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
				#DIV/0!
				#DIV/0!
				#DIV/0!
				#DIV/0!
Total - Line	-	-	-	

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Christensen	Administrator		$ 64,064
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,064

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	$ 6,883
Unemployment Compensation Insurance	0
FICA Taxes	91,490
Employee Health Insurance	290,970
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension Expense	37,357
Tuition Reimbursement	2,251
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,951

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
N/A	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Gibson Community Hospital Annex # 0005868 Report Period Beginning: 10/01/17 Ending: 09/30/18

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **No**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,811** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,781**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **85,390**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer, Punke, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.