

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0049981</u></p> <p>Facility Name: <u>Gilman Healthcare Center</u></p> <p>Address: <u>1390 South Cresent Street</u> <u>Gilman</u> <u>60938</u> <small>Number City Zip Code</small></p> <p>County: <u>Iroquois</u></p> <p>Telephone Number: <u>(815) 265-7208</u> Fax # <u>(815) 265-7415</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/01/08</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>4,289</u>	<u>4,289</u>	8
9	SNF/PED					9
10	ICF	<u>18,459</u>	<u>4,546</u>		<u>23,005</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,459</u>	<u>4,546</u>	<u>4,289</u>	<u>27,294</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.53%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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 06/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 3,955

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	235,180	17,784	6,174	259,138		259,138		259,138		1
2	Food Purchase		151,303		151,303	(15,148)	136,156	(252)	135,903		2
3	Housekeeping	138,870	18,705		157,575		157,575		157,575		3
4	Laundry	19,816	12,154		31,970		31,970		31,970		4
5	Heat and Other Utilities			106,286	106,286		106,286	(3,372)	102,914		5
6	Maintenance	42,092		45,758	87,850		87,850	38,160	126,010		6
7	Other (specify):*										7
8	TOTAL General Services	435,958	199,946	158,218	794,122	(15,148)	778,975	34,536	813,510		8
	B. Health Care and Programs										
9	Medical Director			3,200	3,200		3,200		3,200		9
10	Nursing and Medical Records	1,524,808	66,482	17,194	1,608,484		1,608,484	(4,883)	1,603,601		10
10a	Therapy		2,590	4,000	6,590		6,590		6,590		10a
11	Activities	81,242	3,592		84,834		84,834		84,834		11
12	Social Services	42,232		1,425	43,657		43,657		43,657		12
13	CNA Training										13
14	Program Transportation	42,030		31,409	73,439		73,439		73,439		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,690,312	72,664	57,228	1,820,204		1,820,204	(4,883)	1,815,321		16
	C. General Administration										
17	Administrative	99,602		265,818	365,420		365,420	(139,057)	226,363		17
18	Directors Fees										18
19	Professional Services			83,459	83,459		83,459	(14,301)	69,158		19
20	Dues, Fees, Subscriptions & Promotions			29,014	29,014		29,014	(6,401)	22,613		20
21	Clerical & General Office Expenses	32,285	19,771	123,206	175,262		175,262	(110,882)	64,380		21
22	Employee Benefits & Payroll Taxes			435,950	435,950	15,148	451,098		451,098		22
23	Inservice Training & Education										23
24	Travel and Seminar			315	315		315		315		24
25	Other Admin. Staff Transportation			6,418	6,418		6,418		6,418		25
26	Insurance-Prop.Liab.Malpractice			53,811	53,811		53,811		53,811		26
27	Other (specify):*							11,403	11,403		27
28	TOTAL General Administration	131,887	19,771	997,991	1,149,649	15,148	1,164,797	(259,238)	905,558		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,258,157	292,381	1,213,437	3,763,975		3,763,975	(229,585)	3,534,390		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Gilman Healthcare Center

#0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			106,453	106,453		106,453	62,889	169,342			30
31	Amortization of Pre-Op. & Org.			9,058	9,058		9,058	(0)	9,058			31
32	Interest			42,603	42,603		42,603	260,176	302,779			32
33	Real Estate Taxes			52,800	52,800		52,800		52,800			33
34	Rent-Facility & Grounds			362,600	362,600		362,600	(362,600)				34
35	Rent-Equipment & Vehicles			22,493	22,493		22,493		22,493			35
36	Other (specify):*											36
37	TOTAL Ownership			596,007	596,007		596,007	(39,535)	556,472			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,320	583,232	774,552		774,552		774,552			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*		4,826	13,759	18,585		18,585	(18,585)	0			43
44	TOTAL Special Cost Centers		196,146	651,194	847,340		847,340	(18,585)	828,755			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,258,157	488,527	2,460,638	5,207,322		5,207,322	(287,705)	4,919,617			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Gilman Healthcare Center**

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,372)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	62,889	30		9
10	Interest and Other Investment Income	(1,353)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(252)	02		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	(20,246)	21		18
19	Entertainment				19
20	Contributions	(6,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,000)	21		24
25	Fund Raising, Advertising and Promotional	(335)	20		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	(96,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,395)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(180,310)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (180,310)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (287,705)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Supplies	\$ (4,826)	43	1
2	Marketing - Advertising & Promotions	(13,759)	43	2
3	Theft & Damage Loss	(500)	21	3
4	Bank Charges	(48,136)	21	4
5	Additional R&M	38,160	06	5
6	Non-Allowable Legal	(13,223)	19	6
7	Building Co. - Bank Charges	(45)	21	7
8	Building Co. - Legal & Professional Fees	(10,864)	19	8
9	Building Co. - Amortization	(5,552)	31	9
10	Building Co. - Penalties & Settlements	(2,333)	21	10
11	Non-Allowable Interest	(34,504)	32	11
12	Non-Allowable Data Processing	(1,079)	19	12
13	Chamber of Commerce Dues	(66)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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36				36
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(96,726)		49

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
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77			28
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79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(252)											(252)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,372)											(3,372)	5
6	Maintenance	38,160											38,160	6
7	Other (specify):*													7
8	TOTAL General Services	34,536											34,536	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(4,883)								(4,883)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs				(4,883)								(4,883)	16
	C. General Administration													
17	Administrative			(139,057)									(139,057)	17
18	Directors Fees													18
19	Professional Services	(25,165)	10,864										(14,301)	19
20	Fees, Subscriptions & Promotions	(6,401)											(6,401)	20
21	Clerical & General Office Expenses	(113,260)	2,378										(110,882)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			11,403									11,403	27
28	TOTAL General Administration	(144,826)	13,242	(127,654)									(259,238)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(110,290)	13,242	(127,654)	(4,883)								(229,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	62,889											62,889	30
31	Amortization of Pre-Op. & Org.	(5,552)	5,552										(0)	31
32	Interest	(35,857)	296,033										260,176	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(362,600)										(362,600)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	21,480	(61,015)										(39,535)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(18,585)											(18,585)	43
44	TOTAL Special Cost Centers	(18,585)											(18,585)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(107,395)	(47,773)	(127,654)	(4,883)								(287,705)	45

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Received - Real Estate	\$ 362,600	Gilman Realty, LLC	100.00%	\$	(362,600)	1
2	V	21 Bank Charges		Gilman Realty, LLC	100.00%	45	45	2
3	V	32 Interest	21,774	Gilman Realty, LLC	100.00%	317,807	296,033	3
4	V	19 Legal and Professional Fees		Gilman Realty, LLC	100.00%	10,864	10,864	4
5	V	31 Amortization		Gilman Realty, LLC	100.00%	5,552	5,552	5
6	V	21 Penalties and Settlement		Gilman Realty, LLC	100.00%	2,333	2,333	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 384,374			\$ 336,601	\$ * (47,773)	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	17 MGMT FEE - DAVID CHEPLOWITZ	\$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	\$ 51,308	\$ 51,308 15
16	V	17 MGMT FEE - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	75,453	75,453 16
17	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	11,403	11,403 17
18	V						
19	V						
20	V						
21	V	17 MANAGEMENT FEES	265,818	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(265,818) 21
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 265,818			\$ 138,164	\$ * (127,654) 39

* 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	10 MEDICAL SUPPLIES	\$	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	\$ 6,347	\$ 6,347
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V	10 MEDICAL SUPPLIES	11,230	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%		(11,230)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 11,230			\$ 6,347	\$ * (4,883)

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

* 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		\$			\$	\$	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		\$			\$	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARAK BAVER	37.500%	COURTYARD HEALTHCARE CENTER,LLC	BERWYN	GILMAN REALTY, LLC	GILMAN	BUILDING CO.	1
2	DAVID CHEPLOWITZ	37.500%			PREMIER HEALTHCARE MANA	CHICAGO	MANAGEMENT CO.	2
3	ESTHER SCHAYER	3.120%			PREMIER HEALTHCARE SUPPI	CHICAGO	MEDICAL SUPPLY	3
4	FRED BRODY	3.130%						4
5	HARRY SCHAYER	3.120%						5
6	JOSEPH & AYELET KNOFF	4.690%						6
7	JOSEPH ABRAMCHIK	3.130%						7
8	ORSHEVE ENTERPRISES, LLC	3.120%						8
9	YISROEL & NAOMI LOPIN	4.690%						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Gilman Healthcare Center

#

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	David Clepowitz	Shareholder	Administrative	37.50	See Attached	5	12.50%	Sal/Mgmt Fee	\$ 81,448	17-1, 17-3	1
2	Barak Bayer	Shareholder	Administrative	37.50	See Attached	15.09	37.73%	Mgmt. Fee	75,453	17-3	2
3											3
4											4
5											5
6											6
7											7
8	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										8
9	By The Illinois Department of HFS.										9
10											10
11											11
12											12
13								TOTAL	\$ 156,901		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 PREMIER HEALTHCARE MANAGEMENT, L
 Street Address 2824 W. COYLE
 City / State / Zip Code CHICAGO, IL 60645
 Phone Number (773) 575-2222
 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	17	MGMT FEE - DAVID CHEPLO	PATIENT DAYS	72,347	2	\$ 136,000	\$ 27,294	\$ 51,308	1
2	17	MGMT FEE - BARAK BAVER	PATIENT DAYS	72,347	2	200,000	27,294	75,453	2
3	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	72,347	2	30,226	27,294	11,403	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					\$ 366,226	\$	\$ 138,164	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization PREMIER HEALTHCARE SUPPLIES, LLC
 Street Address 2824 W. COYLE
 City / State / Zip Code CHICAGO, IL 60645
 Phone Number (773) 575-2222
 Fax Number ()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	REVENUE	27,800	2	\$ 15,711	\$ 11,230	\$ 6,347	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					\$ 15,711	\$	\$ 6,347	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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		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	The Private Bank		X	Construction Loan	\$9,259.00	7/2009	\$ 500,000	\$ 286,767	7/14		\$ 22,609	1								
2	The Private Bank		X	Mortgage				3,366,000		6.50%	221,829	2								
3	The Private Bank		X	Loan				2,634,000		6.50%	61,475	3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6	The Private Bank		X	Line of Credit			1,250,000	610,486	7/14/11	Prime+3.25	16,749	6								
7	Wells Fargo		X	Note Payable - Auto	\$344.41	7/8/2008	18,596	9,374	7/7/14	9.9500	1,103	7								
8	See Supplemental Schedule						44,000	20,000			2,142	8								
9	TOTAL Facility Related				\$9,603.41		\$ 1,812,596	\$ 6,926,627			\$ 325,907	9								
	B. Non-Facility Related*																			
10	Interest Income		X								(1,353)	10								
11	Bldg Co. - Interest Income		X								(21,774)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (23,127)	14								
15	TOTALS (line 9+line14)						\$ 1,812,596	\$ 6,926,627			\$ 302,779	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6		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						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	Private Bank	X	Note Payable - Auto (VAN)		11/30/09	\$ 44,000	\$ 20,000	07/01/13	8.00%	\$ 2,142	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2010 report.		\$	52,778		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.)		\$	51,023		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,755)		3																			
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	54,555		4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	52,800		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2006	_____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2010</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2007	48,717	9																					
	2008	49,453	10																					
	2009	51,198	11																					
	2010	51,023	12																					

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gilman Healthcare Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0049981

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

Table with 4 columns: (A) Tax Index Number, (B) Property Description, (C) Total Tax, (D) Tax Applicable to Nursing Home. Row 1: 11-C-23-07-226-004, Long Term Care Property, \$ 51,023.42, \$ 51,023.42. TOTALS: \$ 51,023.42, \$ 51,023.42.

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gilman Healthcare Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0049981

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 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,655 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 98,794 2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 9,058 4. Dates Incurred: _____

Nature of Costs: Construction Loan, Working Capital Loan
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	99			1976	\$ 3,411,067	\$	39	\$ 87,463	\$ 87,463	\$ 262,389
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69					106,453		(106,453)	69
70		\$ 3,411,067	\$ 106,453		\$ 87,463	\$ (18,990)	\$ 262,389	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,411,067	\$ 106,453		\$ 87,463	\$ (18,990)	\$ 262,389	1
2	United Pipe And Supplies	2008	6,406		20	534	534	1,779	2
3	Drywall	2009	4,111		20	206	206	600	3
4	Ac Coil	2009	3,282		20	274	274	707	4
5	Patio	2009	19,155		20	1,411	1,411	3,704	5
6	Roof	2009	81,944		20	8,194	8,194	19,803	6
7	Windows	2009	24,742		20	2,474	2,474	5,979	7
8	Dining Room Addition	2009	3,729		20	186	186	396	8
9	Sidewalk	2009	2,840		20	189	189	410	9
10	Prairie Bros Construction, Inc	2009	7,539		20	377	377	801	10
11	Rgb Architectural Group, Inc.	2009	8,398		20	420	420	892	11
12	Weber Plumbing & Heating Co.	2009	2,691		20	135	135	280	12
13	Diversified Service - Floors	2009	3,667		20	183	183	428	13
14	Rgb Architectural Group - Dining & Therapy Room Remodel Arc	2010	29,805		20	1,490	1,490	2,980	14
15	B1 Accelerator On Fire Sprinkler	2010	2,980		20	149	149	261	15
16	Paving Parking Lot	2010	38,500		20	2,567	2,567	4,278	16
17	Crane Concrete	2010	6,115		20	408	408	645	17
18	Cabinetry	2010	16,969		20	3,394	3,394	5,939	18
19	Dining Room Cabinetry	2010	37,599		20	8,760	8,760	14,599	19
20	Demo Walls, Frame New Walls	2010	29,679		20	1,484	1,484	2,350	20
21	Masonry, Interior Glass Block Wall	2010	9,036		20	452	452	715	21
22	Plumbing Work	2010	15,400		20	770	770	1,219	22
23	Hvac	2010	6,200		20	310	310	491	23
24	Vinyl Flooring & Wallcoverings In Therapy Room	2010	37,097		20	7,419	7,419	11,747	24
25	Stove Outlet, Counter Top Recps And Tele.	2010	7,799		20	1,560	1,560	2,470	25
26	Redo Fire Coking For Barrier Wall	2010	2,500		20	125	125	229	26
27	United Pipe And Supply Limp	2010	2,831		20	142	142	189	27
28	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	109,367		20	5,468	5,468	10,025	28
29	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	153,486		20	7,674	7,674	13,430	29
30	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	24,642		20	1,232	1,232	2,054	30
31	Fe Moran - Wall Project	2011	2,975		20	149	149	149	31
32	2 Hour Firewall	2011	26,850		20	559	559	559	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	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	TOTAL (lines 1 thru 33)	\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	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	TOTAL (lines 1 thru 33)	\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	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	TOTAL (lines 1 thru 33)	\$ 4,139,401	\$ 106,453		\$ 146,157	\$ 39,704	\$ 372,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12H & 12I lines 1 thru 33)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	\$ 58,256	\$	\$ 11,295	\$ 11,295	10	\$ 20,913	71
72	Current Year Purchases	10,339		470	470	10	470	72
73	Fully Depreciated Assets	2,367				10	2,367	73
74								74
75	TOTALS	\$ 70,961	\$	\$ 11,765	\$ 11,765		\$ 23,750	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		SUV	2008	\$ 18,596	\$	\$ 2,365	\$ 2,365	5	\$ 15,047	76
77		2009 Ford Eldorado Bus	2009	55,257		9,054	9,054	5	22,058	77
78										78
79										79
80	TOTALS			\$ 73,852	\$	\$ 11,420	\$ 11,420		\$ 37,105	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)	\$ 4,284,214	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,453	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,342	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 62,889	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 433,355	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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: \$ 4,798 Description: See Attached Schedule

(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	Facility	Ford Bus	\$	\$ 10,392	17
18	Facility	2011 Nissan Murano		7,303	18
19					19
20					20
21	TOTAL		\$	\$ 17,695	21

10. Effective dates of current rental agreement:

Beginning 06/01/2008

Ending 05/31/2013

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

Fiscal Year Ending Annual Rent

12. /2012 \$ _____

13. /2013 \$ _____

14. /2014 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	215,425	\$		\$	215,425	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				119,314				119,314	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				248,493				248,493	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					136,809			136,809	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): <u>See Supplemental</u>							54,511			54,511	13
14	TOTAL			\$		\$	583,232	\$	191,320	\$	774,552	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning: 01/01/11

Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 500	\$ 90,505	1
2	Cash-Patient Deposits	6,208	6,208	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,783,946	1,783,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,079	56,079	6
7	Other Prepaid Expenses	2,500	2,500	7
8	Accounts Receivable (owners or related parties)	39,536	580,608	8
9	Other(specify): <u>See Attached Schedule</u>	25,818	25,818	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,914,587	\$ 2,545,664	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,884,000	12
13	Land			13
14	Buildings, at Historical Cost		3,411,067	14
15	Leasehold Improvements, at Historical Cost	759,688	759,688	15
16	Equipment, at Historical Cost	193,017	193,017	16
17	Accumulated Depreciation (book methods)	(205,651)	(333,201)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	16,241	47,140	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 763,295	\$ 5,961,711	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,677,882	\$ 8,507,375	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 614,301	\$ 631,785	26
27	Officer's Accounts Payable	9,106	9,106	27
28	Accounts Payable-Patient Deposits	6,936	6,936	28
29	Short-Term Notes Payable	610,486	610,486	29
30	Accrued Salaries Payable	86,664	86,664	30
31	Accrued Taxes Payable (excluding real estate taxes)	114,268	114,268	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,555	32
33	Accrued Interest Payable	4,572	4,572	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	508,705	508,705	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,955,038	\$ 2,027,077	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	316,141	2,950,141	39
40	Mortgage Payable		3,366,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 316,141	\$ 6,316,141	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,271,179	\$ 8,343,218	46
47	TOTAL EQUITY(page 18, line 24)	\$ 406,703	\$ 164,157	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,677,882	\$ 8,507,375	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 295,328	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 295,331	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	111,372	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)	\$ 111,372	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)	\$ 406,703	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981Report Period Beginning: 01/01/11Ending: 12/31/11

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,488,651	1
2	Discounts and Allowances for all Levels	(721,456)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,767,195	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,427,006	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,427,006	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	122,928	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)	\$ 122,928	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,353	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,353	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	212	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 212	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,318,694	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	794,122	31
32	Health Care	1,820,204	32
33	General Administration	1,149,649	33
B. Capital Expense			
34	Ownership	596,007	34
C. Ancillary Expense			
35	Special Cost Centers	793,137	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,207,322	40
41	Income before Income Taxes (line 30 minus line 40)**	111,372	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 111,372	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Gilman Healthcare Center**

0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,592	1,600	\$ 70,067	\$ 43.79	1
2	Assistant Director of Nursing	2,032	2,080	49,014	23.56	2
3	Registered Nurses	10,885	11,436	292,895	25.61	3
4	Licensed Practical Nurses	22,523	24,252	492,442	20.31	4
5	CNAs & Orderlies	52,165	56,307	613,664	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	2,250	42,040	18.68	9
10	Activity Assistants	3,715	3,914	39,202	10.02	10
11	Social Service Workers	2,160	2,264	42,232	18.65	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	33,191	15.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,809	21,696	201,989	9.31	15
16	Dishwashers					16
17	Maintenance Workers	2,183	2,407	42,092	17.49	17
18	Housekeepers	11,610	12,826	138,870	10.83	18
19	Laundry	1,697	1,891	19,816	10.48	19
20	Administrator	1,744	1,832	99,602	54.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,898	2,014	32,285	16.03	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	674	690	6,726	9.75	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,902	4,028	42,030	10.43	33
34	TOTAL (lines 1 - 33)	142,591	153,567	\$ 2,258,157 *	\$ 14.70	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	72	\$ 6,174	01-03	35
36	Medical Director	Monthly	3,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	290	11,369	10-03	38
39	Pharmacist Consultant	Monthly	5,825	10-03	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	32	1,425	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	Monthly	4,000	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 31,993		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Sheryl Light 1/01 - 6/03	Administrative	0.00%	\$ 44,738	Workers' Compensation Insurance	\$ 82,259	IDPH License Fee	\$		
David Cheplowitz 6/04 - 9/11	Administrative	37.50%	30,140	Unemployment Compensation Insurance	56,090	Advertising: Employee Recruitment	3,071		
Pamella Britt 9/12 - 12/31	Administrator	0.00%	24,724	FICA Taxes	172,357	Health Care Worker Background Check			
				Employee Health Insurance	109,595	(Indicate # of checks performed <u>55</u>)	1,866		
				Employee Meals	15,148	Patient Background Checks <u>58</u>	1,740		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	2,532		
				Pension Contributions	12,615	Dues and Subscriptions	13,404		
				Employee Physical Exam	21				
				Employee Benefits - Other	3,013				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,602	TOTAL (agree to Schedule V, line 22, col.8)		\$ 22,612			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
Premier Healthcare Management, LLC			\$ 265,818				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 265,818	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services							Description		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount		
Frost, Ruttenberg & Rothblatt	Accounting		\$ 14,204			\$	Out-of-State Travel \$		
See Attached	Legal		22,389						
AccuMed Services	MDS/CarePlan Software		3,780						
Alpha Data	Payroll Service		2,560				In-State Travel		
Emdeon Business Services	REV System		1,293						
HDSI	A/R Accounting Services		5,471						
Singer Networks	Data Processing		7,219						
IVAN's	Medicare Billing		655				Seminar Expense 315		
Paycor	Payroll Processing		2,404						
Non-Allowable	Data Processing		1,079						
Personnel Planners	Unemployment Consult.		1,644				Entertainment Expense ()		
See Supplemental Schedule			20,760				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 83,458	TOTAL			\$	TOTAL 315	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/11

Ending:

12/31/11**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCTC - \$12,434
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,878 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. _____
- (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. \$ 54,203
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. \$ 15,148 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ None
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT