		FOR BHF USE					

LL1

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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0049981

Facility Name: Gilman Healthcare Center

Address: 1390 S Cresent St (Number) Gilman (City) 60938 (Zip Code)

County: Iroquois

Telephone Number: (815) 265-7208 **Fax #** (815) 265-7415

HFS ID Number:

Date of Initial License for Current Owners: 6/1/2008

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,706	3,706	8
9	SNF/PED					9
10	ICF	17,826	3,249		21,075	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,826	3,249	3,706	24,781	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.39%

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 3,619

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	247,152	20,064	7,928	275,144		275,144		275,144			1
2	Food Purchase		182,914		182,914		182,914	(2,381)	180,533			2
3	Housekeeping	79,105	16,899		96,004		96,004		96,004			3
4	Laundry	57,378	9,340	895	67,613		67,613		67,613			4
5	Heat and Other Utilities			91,471	91,471		91,471	265	91,736			5
6	Maintenance	49,798		32,615	82,413		82,413	95	82,508			6
7	Other (specify):* Waste Removal			18,342	18,342		18,342		18,342			7
8	TOTAL General Services	433,433	229,217	151,251	813,901		813,901	(2,021)	811,880			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,551,931	179,857	8,896	1,740,684		1,740,684	36,274	1,776,958			10
10a	Therapy	125,631	21	38,676	164,328		164,328		164,328			10a
11	Activities	95,485		2,147	97,632		97,632		97,632			11
12	Social Services	45,942		3,615	49,557		49,557		49,557			12
13	CNA Training											13
14	Program Transportation	34,079		29,074	63,153		63,153		63,153			14
15	Other (specify):*							6,879	6,879			15
16	TOTAL Health Care and Programs	1,853,068	179,878	91,408	2,124,354		2,124,354	43,153	2,167,507			16
	C. General Administration											
17	Administrative	148,636		151,448	300,084		300,084	(102,675)	197,409			17
18	Directors Fees											18
19	Professional Services			118,750	118,750		118,750	(1,249)	117,501			19
20	Dues, Fees, Subscriptions & Promotions			42,473	42,473		42,473	(2,269)	40,204			20
21	Clerical & General Office Expenses	96,919	29,112	69,400	195,431		195,431	61,166	256,597			21
22	Employee Benefits & Payroll Taxes			440,313	440,313		440,313		440,313			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,454	13,454		13,454	310	13,764			24
25	Other Admin. Staff Transportation			25,373	25,373		25,373	451	25,824			25
26	Insurance-Prop.Liab.Malpractice			94,066	94,066		94,066		94,066			26
27	Other (specify):*							17,118	17,118			27
28	TOTAL General Administration	245,555	29,112	955,277	1,229,944		1,229,944	(27,148)	1,202,796			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,532,056	438,207	1,197,936	4,168,199		4,168,199	13,984	4,182,183			29

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

SEE ACCOUNTANTS' PREPARATION 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: 1/1/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,000	60,000		60,000	119,469	179,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,849	30,849		30,849	134,038	164,887			32
33	Real Estate Taxes			66,000	66,000		66,000		66,000			33
34	Rent-Facility & Grounds			186,156	186,156		186,156	(176,876)	9,280			34
35	Rent-Equipment & Vehicles			21,481	21,481		21,481		21,481			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,486	364,486		364,486	76,631	441,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,435	556,869	712,304		712,304		712,304			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,844	184,844		184,844		184,844			42
43	Other (specify):* Nonallowable Exp	47,435	7,848	138,559	193,842		193,842	(193,842)				43
44	**TOTAL Special Cost Centers**	47,435	163,283	880,272	1,090,990		1,090,990	(193,842)	897,148			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,579,491	601,490	2,442,694	5,623,675		5,623,675	(103,227)	5,520,448			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,002)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	119,469	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(339)	20		17
18	Fines and Penalties	(21,801)	43		18
19	Entertainment				19
20	Contributions	(27,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,422)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	43		24
25	Fund Raising, Advertising and Promotional	(119)	43		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 See Page 5A	(97,374)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,160)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,067)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,067)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (103,227)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (2,381)	2	1
2	Marketing Salary	(37,435)	43	2
3	Marketing Expense	(54,985)	43	3
4	PAC Dues	(2,573)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(97,374)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gilman Healthcare Center **#** 0049981 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,381)	0	0	0	0	0	0	0	0	0	0	(2,381)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	265	0	0	0	0	0	0	0	0	265	5
6	Maintenance	0	0	95	0	0	0	0	0	0	0	0	95	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,381)	0	360	0	0	0	0	0	0	0	0	(2,021)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	42,064	(5,790)	0	0	0	0	0	0	0	36,274	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	6,879	0	0	0	0	0	0	0	0	6,879	15
16	**TOTAL Health Care and Programs**	0	0	48,943	(5,790)	0	0	0	0	0	0	0	43,153	16
	C. General Administration													
17	Administrative	0	0	(102,675)	0	0	0	0	0	0	0	0	(102,675)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,422)	0	5,173	0	0	0	0	0	0	0	0	(1,249)	19
20	Fees, Subscriptions & Promotions	(2,912)	0	643	0	0	0	0	0	0	0	0	(2,269)	20
21	Clerical & General Office Expenses	0	308	60,858	0	0	0	0	0	0	0	0	61,166	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	310	0	0	0	0	0	0	0	0	310	24
25	Other Admin. Staff Transportation	0	0	451	0	0	0	0	0	0	0	0	451	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	17,118	0	0	0	0	0	0	0	0	17,118	27
28	**TOTAL General Administration**	(9,334)	308	(18,122)	0	0	0	0	0	0	0	0	(27,148)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,715)	308	31,181	(5,790)	0	0	0	0	0	0	0	13,984	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gilman Healthcare Center # 0049981 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	119,469	0	0	0	0	0	0	0	0	0	0	119,469	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72)	134,110	0	0	0	0	0	0	0	0	0	134,038	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(186,156)	9,280	0	0	0	0	0	0	0	0	(176,876)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	119,397	(52,046)	9,280	0	0	0	0	0	0	0	0	76,631	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(183,842)	0	(10,000)	0	0	0	0	0	0	0	0	(193,842)	43
44	**TOTAL Special Cost Centers**	(183,842)	0	(10,000)	0	0	0	0	0	0	0	0	(193,842)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(76,160)	(51,738)	30,461	(5,790)	0	0	0	0	0	0	0	(103,227)	45

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 Page 6 Supplemental		See Page 6 Supplemental		See Page 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical & Gen Office Expenses	$	Gilman Realty, LLC	100.00%	$ 308	$ 308	1
2	V	32	Interest		Gilman Realty, LLC	100.00%	134,110	134,110	2
3	V	34	Rent-Facility & Grounds	186,156	Gilman Realty, LLC	100.00%		(186,156)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 186,156			$ 134,418	$ * (51,738)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 265	$ 265	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	95	95	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	42,064	42,064	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	6,879	6,879	18
19	V	17	Administrative	151,448	Premier Healthcare Management, LLC	100.00%	48,773	(102,675)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	5,173	5,173	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	643	643	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	60,858	60,858	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	310	310	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	451	451	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	17,118	17,118	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	9,280	9,280	26
27	V	43	Marketing Consultant	10,000	Premier Healthcare Management, LLC	100.00%		(10,000)	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			$ 161,448			$ 191,909	$ * 30,461	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 9,129	Premier Healthcare Supplies, LLC	100.00%	$ 3,339	$ (5,790)	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			$ 9,129			$ 3,339	$ * (5,790)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Joseph & Ayelet Knopf	4.69%	Champaign Urbana Nursing & Rehab	Champaign	Premier Healthcare	Skokie	Management Co.	1
2	Yisroel & Naomi Lopin	4.69%	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Esther Schayer	3.12%	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Harry Schayer	3.12%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Fred Brody	3.13%	Gardenview Manor	Danville	Gilman Realty LLC	Gilman	Lessor	5
6	Joseph Abramchik	3.13%	Norridge Gardens	Norridge	REX Therapeutics	Skokie	Therapy	6
7	Orsheve Enterprises	3.12%	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN				7
8	Barak Baver	37.50%	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	David Cheplowitz	37.50%	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10			Premier Healthcare of Connersville, LLC	Connersville, IN				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' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cheplowitz	Shareholder	Administrative	37.50%	See Att Sch 7A	2.84	7%	Alloc Salary	$ 11,078	17-7	1
2	Barak Baver	Shareholder	Administrative	37.50%	See Att Sch 7A	2.84	7%	Alloc Salary	11,078	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	2.84	7%	Alloc Salary	3,139	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 25,295		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' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Census Days	348,950	11	$ 3,732	$	24,781	$ 265	1
2	6	Maintenance	Census Days	348,950	11	1,338		24,781	95	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	24,781	42,064	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		24,781	6,879	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	24,781	48,773	5
6	19	Professional Services	Census Days	348,950	11	72,849		24,781	5,173	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		24,781	643	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	24,781	60,858	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		24,781	310	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		24,781	451	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		24,781	17,118	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		24,781	9,280	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					$ 2,702,363	$ 2,066,407		$ 191,909	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: Premier Healthcare Supplies, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing and Medical Records	Revenue	111,222	11	$ 40,679	$	9,129	$ 3,339	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					$ 40,679	$		$ 3,339	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$			$ 99,104	1
2	Bank Leumi		X	Mortgage		7/12/2016	1,875,000	1,843,750	7/12/2021	variable	35,006	2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Note Payable							5,320	6
7	Bank Leumi		X	Line of Credit		8/1/2016		825,032	8/1/2017	variable	15,593	7
8												8
9	TOTAL Facility Related						$ 1,875,000	$ 2,668,782			$ 155,023	9
	B. Non-Facility Related*											
10	Allocated from Management Co.											10
11								Loan Cost Amortization			9,936	11
12								Offset Interest Income			(72)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,864	14
15	TOTALS (line 9+line14)						$ 1,875,000	$ 2,668,782			$ 164,887	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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' PREPARATION 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: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,709	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.)		$ 52,709	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,000	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.		$ 66,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	51,099	8
	2012	50,627	9
	2013	51,696	10
	2014	52,226	11
	2015	52,709	12

Accrual based on prior year tax bill.

Note: Beg accrual adjusted to reflect adj beg balance

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gilman Healthcare Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0049981

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	Long Term Care Property	$ 52,708.88	$ 52,708.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,708.88	$ 52,708.88

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

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] 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: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2009	1976	$ 3,411,067	$	39	$ 87,463	$ 87,463	$ 699,704	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	6,406		20	534	534	4,449	9
10	Various			2009	162,098		20	13,915	13,915	103,224	10
11	Various			2010	530,005		20	29,367	29,367	256,780	11
12	Various			2011	29,825		20	1,491	1,491	8,164	12
13	Weber Plumbing- Replacement Temp System			2013	2,871		20	144	144	515	13
14	Digital Genset Controller			2013	3,870		20	194	194	694	14
15	Weber Plumbing - Consensing Unit			2013	5,927		20	296	296	1,062	15
16	Alternative Energy Solutions - Transfer Switch			2013	3,121		20	156	156	546	16
17	Weber Plumbing - Condensing Unit			2013	2,945		20	147	147	515	17
18	Replace 3" Cross Main In West Hall			2013	3,950		20	198	198	774	18
19	Carpeting - Resident Rooms 2, 18, 19, 25, 26 & Closets			2013	13,858		20	1,980	1,980	6,104	19
20	Fire Alarm System Repairs			2013	29,595		20	1,480	1,480	5,426	20
21	Mcdaniel Fire System			2013	5,000		20	250	250	813	21
22	Driveway Work			2014	4,131		20	118	118	275	22
23	Carpet-Resident Rooms & Activity Room			2014	31,687		20	1,584	1,584	3,432	23
24	New Compressor For Ne Hall & State Control Water Heater			2014	2,574		20	129	129	322	24
25	Cove Wall Tiling			2015	30,850		20	1,543	1,543	3,086	25
26	Replace Main Entry Door			2015	4,689		20	234	234	468	26
27	Carpeting - 15 East Side Resident Rooms			2015	30,400		20	1,520	1,520	3,040	27
28	Walk In Freezer Compressor			2015	3,730		20	187	187	374	28
29	Replace Water Heater			2016	7,400		20	185	185	185	29
30	Replace Carpeting in Rooms 32, 33, 43 & 44			2016	9,106		20	228	228	228	30
31	Install Electric Panel for Generator & Emergency Power Circuits			2016	2,804		20	70	70	70	31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	Allocated from Premier Healthcare Management, LLC	2013	1,767		20	88	88	282	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									69
70	TOTAL (lines 4 thru 69)		$ 4,339,676	$		$ 143,501	$ 143,501	$ 1,100,532	70

SEE ACCOUNTANTS' PREPARATION 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: 1/1/16 Ending: 12/31/16

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	$ 297,991	$	$ 29,799	$ 29,799	10	$ 147,624	71
72	Current Year Purchases	5,587		279	279	10	279	72
73	Fully Depreciated Assets	16,890				10	16,890	73
74								74
75	TOTALS	$ 320,468	$	$ 30,078	$ 30,078		$ 164,793	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	$ 18,595	$	$	$	5	$ 18,595	76
77		2009 Ford Eldorado Bus	2009	55,257		5,890	5,890	5	55,257	77
78										78
79										79
80	TOTALS			$ 73,852	$	$ 5,890	$ 5,890		$ 73,852	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)	$ 4,733,996	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,469	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 179,469	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,339,177	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Allocated from Management Co.				9,280			5
6								6
7	TOTAL				$ 9,280 **			7

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

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 6,480 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	Facility	Ford Bus	829.00	6,484	18
19	Facility	2016 Staracraft bus	1,826.00	8,517	19
20					20
21	TOTAL		$ 2,655.00	$ 15,001	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	4,680
Copier	1,800
Total - Line 16	**6,480**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

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

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$		$ 183,367	$		$ 183,367	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			30,728			30,728	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			320,963			320,963	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				155,162		155,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached Scheule 16A					21,811	273		22,084	13
14	TOTAL			$		$ 556,869	$ 155,435		$ 712,304	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' PREPARATION REPORT

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/16**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	9,357
Outside MD Service-MCA	39(3)	12,454
Medical Supplies - MCA	39(2)	273
Total - Line 13		**22,084**

STATE OF ILLINOIS

Facility Name & ID Number Gilman Healthcare Center **#** 0049981 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,112	$ 3,112	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,195,644)	647,757	647,757	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,925	4,925	6
7	Other Prepaid Expenses	5,000	5,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 660,794	$ 660,794	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		3,411,067	14
15	Leasehold Improvements, at Historical Cost	970,537	928,609	15
16	Equipment, at Historical Cost	499,413	394,320	16
17	Accumulated Depreciation (book methods)	(770,443)	(1,339,177)	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): Loan Fees		163,475	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 699,507	$ 3,558,294	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,360,301	$ 4,219,088	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,224,334	$ 1,224,334	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	630	630	28
29	Short-Term Notes Payable	825,032	825,032	29
30	Accrued Salaries Payable	193,880	193,880	30
31	Accrued Taxes Payable (excluding real estate taxes)	678,026	678,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	2,675,252	4,282,880	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,597,154	$ 7,270,782	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,843,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposit	19,743	19,743	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,743	$ 1,863,493	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,616,897	$ 9,134,275	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,256,596)	$ (4,915,187)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,360,301	$ 4,219,088	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	54,242	54,242
Accrued Expenses	76,084	76,084
Accrued Bed Tax	27,323	27,323
Payroll Withholdings	493,606	493,606
Due to Related Parties	1,986,209	3,593,837
Due to HFS	37,788	37,788
Total - Line 36	**2,675,252**	**4,282,880**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (554,928)	1
2	Restatements (describe): Bad Debt Expense		2
3	**Prior Period Adjustments - Bad Debt Expense**	(2,855,947)	3
4	**Prior Period Adjustments - Other Expenses**	(372,819)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,783,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(472,902)	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)**	$ (472,902)	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)**	$ (4,256,596)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,458,062	1
2	Discounts and Allowances for all Levels	398,301	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,856,363	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,077	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 283,077	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	2,381	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	23	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,857	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,261	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,150,773	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	813,901	31
32	Health Care	2,124,354	32
33	General Administration	1,229,944	33
	B. Capital Expense		
34	Ownership	364,486	34
	C. Ancillary Expense		
35	Special Cost Centers	906,146	35
36	Provider Participation Fee	184,844	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,623,675	40
41	**Income before Income Taxes (line 30 minus line 40)****	(472,902)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (472,902)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,445,067	44
45	Private Pay - Net Inpatient Revenue	662,474	45
46	Medicare - Net Inpatient Revenue	1,723,962	46
47	Other-(specify) Insurance	24,860	47
48	Other-(specify) Veterans		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,856,363	49

* **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.**

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	2,051	$ 78,410	$ 38.23	1
2	Assistant Director of Nursing	607	695	19,677	28.31	2
3	Registered Nurses	7,536	7,731	248,442	32.14	3
4	Licensed Practical Nurses	16,265	16,995	456,867	26.88	4
5	CNAs & Orderlies	48,483	50,570	684,450	13.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,124	4,526	125,631	27.76	8
9	Activity Director	2,066	2,114	46,505	22.00	9
10	Activity Assistants	3,920	4,169	48,980	11.75	10
11	Social Service Workers	2,192	2,108	45,942	21.79	11
12	Dietician					12
13	Food Service Supervisor	966	1,014	27,594	27.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,507	20,872	219,558	10.52	15
16	Dishwashers					16
17	Maintenance Workers	2,427	2,663	49,798	18.70	17
18	Housekeepers	6,396	6,893	79,105	11.48	18
19	Laundry	5,117	5,449	57,378	10.53	19
20	Administrator	3,388	3,468	148,636	42.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,237	3,409	96,919	28.43	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	947	963	9,359	9.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	6,148	6,354	136,240	21.44	33
34	TOTAL (lines 1 - 33)	135,337	142,044	$ 2,579,491 *	$ 18.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	179	$ 8,754	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,955	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,941	L10, C3	39
40	Physical Therapy Consultant	Monthly	2,000	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	52	3,296	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	28,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	231	$ 59,946		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

Gilman Healthcare Center

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		1,792	1,792	54,726	30.54
Transportation		2,433	2,615	34,079	13.03
Marketing		1,923	1,947	47,435	24.36
	TOTAL	6,148	6,354	136,240	

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adam Zanger	Administrator	0	$ 4,000
Kim Colbrook	Administrator	0	47,394
Marcos Perez, II	Administrator	0	47,385
Janelle Ditta	Asst. Admin.	0	49,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,636

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 151,448
TOTAL (agree to Schedule V, line 17, col. 3)	$ 151,448
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 11,108
Personel Planners	Unemployment Consult	$ 535
Sharon Lofgren	Medicare Billing	3,600
Ability Network	Medicare Billing	6,703
ADP	Data Processing	11,661
Change Healthcare	Data Processing	679
eSolutions INC	Data Processing	2,620
HDSI	A/R Accounting Services	4,543
Matrixcare	Data Processing	25,251
Richard Peelo	Accounting	4,200
Frost/Marcum LLP	Accounting	8,340
See Attached Schedule 21A		39,510
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 118,750

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,785
Unemployment Compensation Insurance	80,850
FICA Taxes	192,293
Employee Health Insurance	81,571
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	15,508
Other Emloyee Benefits	6,306
TOTAL (agree to Schedule V, line 22, col.8)	$ 440,313

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	28,610
Health Care Worker Background Check	
(Indicate # of checks performed 24)	2,413
Patient Background Checks 158	2,790
Dues & Subscriptions	75
Licenses & Permits	450
IL Council on LTC	5,223
Allocated from Management Co.	643
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,204

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,454
Allocated from Management Co.	310
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,764

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/16**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Singer Networks	Data Processing	5,881
Quickbooks	Accounting Software	897
Terrill Consulting Services, Inc.	Billing Consultant	14,926
Perfect Staffing Solutions	Staffing Agency	12,750
M & M Financial	Accounting/Tax	5,000
IIT/Sourcetech	Computer Services	56
Total		**39,510**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **5,223 IL Council on LTC**

(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. $ **18,229** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **184,844**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** 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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees