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.

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

I. IDPH License ID Number: 0049981

Facility Name: Gilman Healthcare Center

Address: 1390 South Cresent Street (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 1/1/2018 to 12/31/2018 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: 1/1/2018 Ending: 12/31/2018

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	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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			3,404	3,404	8
9	SNF/PED					9
10	ICF	23,304	1,506		24,810	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,304	1,506	3,404	28,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.08%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 3,171

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: 12/31/18 Fiscal Year: 12/31/18

* 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: 1/1/2018 Ending: 12/31/2018

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	305,154	23,190	14,930	343,274		343,274		343,274			1
2	Food Purchase		223,820		223,820		223,820	(1,426)	222,394			2
3	Housekeeping	146,441	24,352		170,793		170,793		170,793			3
4	Laundry	44,673	10,020	20	54,713		54,713		54,713			4
5	Heat and Other Utilities			108,454	108,454		108,454	435	108,889			5
6	Maintenance	48,873		41,356	90,229		90,229	6,345	96,574			6
7	Other (specify):* Waste Removal			15,409	15,409		15,409		15,409			7
8	TOTAL General Services	545,141	281,382	180,169	1,006,692		1,006,692	5,354	1,012,046			8
	B. Health Care and Programs											
9	Medical Director			11,577	11,577		11,577		11,577			9
10	Nursing and Medical Records	1,793,238	188,162	11,445	1,992,845		1,992,845	34,941	2,027,786			10
10a	Therapy	126,407	1,152	28,874	156,433		156,433		156,433			10a
11	Activities	104,086		7,059	111,145		111,145		111,145			11
12	Social Services	82,088			82,088		82,088		82,088			12
13	CNA Training											13
14	Program Transportation			24,242	24,242		24,242		24,242			14
15	Other (specify):* Mgmt Co Benefits Alloc							7,508	7,508			15
16	TOTAL Health Care and Programs	2,105,819	189,314	83,197	2,378,330		2,378,330	42,449	2,420,779			16
	C. General Administration											
17	Administrative	92,397		284,969	377,366		377,366	(254,966)	122,400			17
18	Directors Fees											18
19	Professional Services			180,248	180,248		180,248	13,568	193,816			19
20	Dues, Fees, Subscriptions & Promotions			21,579	21,579		21,579	(3,710)	17,869			20
21	Clerical & General Office Expenses	168,843	26,777	55,099	250,719		250,719	83,045	333,764			21
22	Employee Benefits & Payroll Taxes			453,368	453,368		453,368		453,368			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,259	7,259		7,259	38	7,297			24
25	Other Admin. Staff Transportation			19,396	19,396		19,396	(3,963)	15,433			25
26	Insurance-Prop.Liab.Malpractice			114,591	114,591		114,591		114,591			26
27	Other (specify):* Mgmt Co Benefits Alloc							23,381	23,381			27
28	TOTAL General Administration	261,240	26,777	1,136,509	1,424,526		1,424,526	(142,607)	1,281,919			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,912,200	497,473	1,399,875	4,809,548		4,809,548	(94,804)	4,714,744			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: 1/1/2018 Ending: 12/31/2018

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			142,762	142,762		142,762	22,985	165,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,685	60,685		60,685	194,734	255,419			32
33	Real Estate Taxes			66,000	66,000		66,000	(18,651)	47,349			33
34	Rent-Facility & Grounds			149,349	149,349		149,349	(138,178)	11,171			34
35	Rent-Equipment & Vehicles			66,882	66,882		66,882	3,832	70,714			35
36	Other (specify):*											36
37	**TOTAL Ownership**			485,678	485,678		485,678	64,722	550,400			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,482	448,539	647,021		647,021		647,021			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,731	243,731		243,731		243,731			42
43	Other (specify):* **Disallowed Costs**	44,972	5,768	353,490	404,230		404,230	(404,230)				43
44	**TOTAL Special Cost Centers**	44,972	204,250	1,045,760	1,294,982		1,294,982	(404,230)	890,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,957,172	701,723	2,931,313	6,590,208		6,590,208	(434,312)	6,155,896			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: 1/1/2018 Ending: 12/31/2018

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	(6,728)	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	(103,351)	30		9
10	Interest and Other Investment Income	(1,223)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	43		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	(4,202)	20		17
18	Fines and Penalties	(15,723)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	1,254	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(323,082)	43		24
25	Fund Raising, Advertising and Promotional	(7,414)	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	(50,714)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (511,294)		$	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)	76,982		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,982		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (434,312)		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (1,426)	2	1
2	Marketing Salary	(44,972)	43	2
3	Marketing Expense	(12,500)	43	3
4	Prior Year Contributions Accrual Reversal	6,300	43	4
5	Disallow Marketing Travel	(4,373)	25	5
6	Expense Repairs under $2,500	6,257	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
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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**	(50,714)		49

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	19	Professional Fees	$	Gilman Realty, LLC	100.00%	$ 7,660	$ 7,660	1
2	V	20	Dues and Licenses		Gilman Realty, LLC	100.00%	100	100	2
3	V	30	Depreciation		Gilman Realty, LLC	100.00%	126,336	126,336	3
4	V	32	Interest		Gilman Realty, LLC	100.00%	195,957	195,957	4
5	V	33	Property Taxes	18,651	Gilman Realty, LLC	100.00%		(18,651)	5
6	V	34	Rent-Facility & Grounds	149,349	Gilman Realty, LLC	100.00%		(149,349)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 168,000			$ 330,053	$ * 162,053	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: 1/1/2018 Ending: 12/31/2018

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%	$ 435	$ 435	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	88	88	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	34,941	34,941	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	7,508	7,508	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	284,969	Premier Healthcare Management, LLC	100.00%	18,575	(266,394)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	11,428	11,428	22
23	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	4,654	4,654	23
24	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	392	392	24
25	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	83,045	83,045	25
26	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	38	38	26
27	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	410	410	27
28	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	20,925	20,925	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	2,456	2,456	29
30	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	11,171	11,171	30
31	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	3,832	3,832	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 284,969			$ 199,898	$ * (85,071)	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: 1/1/2018 Ending: 12/31/2018

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	0.0469	Champaign Urbana Nursing & Rehab	Champaign	Premier Healthcare	Skokie	Management Co.	1
2	Yisroel & Naomi Lopin	0.0469	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Esther Schayer	0.0312	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Harry Schayer	0.0312	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Fred Brody	0.0313	Norridge Gardens	Norridge	Gilman Realty LLC	Gilman	Lessor	5
6	Joseph Abramchik	0.0313	Gardenview Manor	Danville	REX Therapeutics	Skokie	Therapy	6
7	Orsheve Enterprises	0.0312	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN				7
8	Barak Baver	0.375	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	David Cheplowitz	0.375	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10			Premier Healthcare of Connersville, LLC	Connersville, IN				10
11			Premier Healthcare of New Harmony, LLC	New Harmony, IN				11
12								12
13								13
14								14
15								15
16								16
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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: 1/1/2018 Ending: 12/31/2018

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	0.38	See Att Sch 7A	3.17	7.93	Alloc Salary	$ 429	17-7	1
2	Barak Baver	Shareholder	Administrative	0.38	See Att Sch 7A	3.17	7.93	Alloc Salary	429	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	3.17	7.93	Alloc Salary	3,506	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	$ 4,364		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: 1/1/2018 Ending: 2/31/2018

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	355,708	12	$ 5,481	$	28,214	$ 435	1
2	6	Maintenance	Census Days	355,708	12	1,104		28,214	88	2
3	10	Nursing and Medical Records	Illinois Census Days	299,107	7	370,422	370,422	28,214	34,941	3
4	10	Nursing and Medical Records	Indiana Census Days	56,601	5	115,384	115,384		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	299,107	7	79,596		28,214	7,508	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	56,601	5	24,794			0	6
7	17	Administrative	Census Days	355,708	12	234,180	234,180	28,214	18,575	7
8	17	Administrative	Illinois Census Days	299,107	7	121,153	121,153	28,214	11,428	8
9	19	Professional Services	Census Days	355,708	12	58,680		28,214	4,654	9
10	20	Dues, Fees, Subs & Promo	Census Days	355,708	12	4,939		28,214	392	10
11	21	Clerical & Gen Office Expenses	Census Days	355,708	12	1,047,000	993,525	28,214	83,045	11
12	24	Travel and Seminar	Census Days	355,708	12	481		28,214	38	12
13	25	Other Admin. Staff Trans	Census Days	355,708	12	5,164		28,214	410	13
14	27	Emp Benefit Alloc-Gen Admin	Census Days	355,708	12	263,809		28,214	20,925	14
15	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	299,107	7	26,033		28,214	2,456	15
16	34	Rent-Facility & Grounds	Census Days	355,708	12	140,839		28,214	11,171	16
17	35	Equipment Rental	Census Days	355,708	12	48,305		28,214	3,832	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,547,364	$ 1,834,664		$ 199,898	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Bank Leumi		X	Mortgage		7/12/2016	1,875,000	1,693,748	7/12/2021	variable	195,957	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		764,100	8/1/2017	variable	59,587	6
7												7
8												8
9	TOTAL Facility Related						$ 1,875,000	$ 2,457,848			$ 255,544	9
	B. Non-Facility Related*											
10												10
11								Other Interest Expense			1,098	11
12								Offset Interest Income			(1,223)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (125)	14
15	TOTALS (line 9+line14)						$ 1,875,000	$ 2,457,848			$ 255,419	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 132,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (132,000)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 179,349	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.		$ 47,349	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	51,696	8
	2014	52,226	9
	2015	52,709	10
	2016	53,794	11
	2017	53,631	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

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

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	Long Term Care Property	$ 53,630.78	$ 53,630.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,630.78	$ 53,630.78

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

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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	$ 874,630	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	6,406		20	320	320	5,089	9
10	Various			2009	162,098		20	8,105	8,105	119,434	10
11	Various			2010	530,005		20	26,500	26,500	309,780	11
12	Various			2011	29,825		20	1,491	1,491	11,146	12
13	Weber Plumbing- Replacement Temp System			2013	2,871		20	144	144	803	13
14	Digital Genset Controller			2013	3,870		20	194	194	1,082	14
15	Weber Plumbing - Consensing Unit			2013	5,927		20	296	296	1,654	15
16	Alternative Energy Solutions - Transfer Switch			2013	3,121		20	156	156	858	16
17	Weber Plumbing - Condensing Unit			2013	2,945		20	147	147	809	17
18	Replace 3" Cross Main In West Hall			2013	3,950		20	198	198	1,170	18
19	Carpeting - Resident Rooms 2, 18, 19, 25, 26 & Closets			2013	13,858		20	693	693	7,490	19
20	Fire Alarm System Repairs			2013	29,595		20	1,480	1,480	8,386	20
21	Mcdaniel Fire System			2013	5,000		20	250	250	1,313	21
22	Driveway Work			2014	4,131		20	207	207	689	22
23	Carpet-Resident Rooms & Activity Room			2014	31,687		20	1,584	1,584	6,600	23
24	New Compressor For Ne Hall & State Control Water Heater			2014	2,574		20	129	129	580	24
25	Cove Wall Tiling			2015	30,850		20	1,543	1,543	6,172	25
26	Replace Main Entry Door			2015	4,689		20	234	234	936	26
27	Carpeting - 15 East Side Resident Rooms			2015	30,400		20	1,520	1,520	6,080	27
28	Walk In Freezer Compressor			2015	3,730		20	187	187	748	28
29	Replace Water Heater			2016	7,400		20	370	370	925	29
30	Replace Carpeting in Rooms 32, 33, 43 & 44			2016	9,106		20	455	455	1,138	30
31	Install Electric Panel for Generator & Emergency Power Circuits			2016	2,804		20	140	140	350	31
32	Replace 3 Twin Casement and 2 Single Casement Windows			2017	4,988		20	249	249	374	32
33	2 80 Gallon Water Heaters			2017	2,765		20	138	138	207	33
34	Install New Water Heater in SW Hallway			2017	8,003		20	400	400	600	34
35	Install New Condensing Unit & Evaporator Coil in Walk-In Fridge			2017	5,081		20	254	254	381	35
36											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' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Repair Brokern Water Line - East Wing	2018	$ 3,166	$	20	$ 79	$ 79	$ 79	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	2,646		20	132	132	687	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)		$ 4,364,558	$		$ 135,058	$ 135,058	$ 1,370,190	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: 1/1/2018 Ending: 12/31/2018

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	$ 306,886	$	$ 30,689	$ 30,689	10	$ 209,115	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	16,890					16,890	73
74								74
75	TOTALS	$ 323,776	$	$ 30,689	$ 30,689		$ 226,005	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	55,257	77
78										78
79										79
80	TOTALS			$ 73,852	$	$	$		$ 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)	$ 4,762,186	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)	$ 165,747	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 165,747	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,670,047	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: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				11,171			5
6								6
7	TOTAL				$ 11,171 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 54,100 Description: Nursing Equipment
(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	2016 Staracraft bus	1,826.00	$ 12,782	17
18					18
19	Allocated from Management Co.			3,832	19
20					20
21	TOTAL		$ 1,826.00	$ 16,614	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 & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	10A(3), 39(3)	hrs	$		$ 131,022	$		$ 131,022	1
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs			40,423			40,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2),(3),39(2), (3)	hrs			261,642	1,152		262,794	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				197,384		197,384	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 Sch 16A					22,326	1,098		23,424	13
14	TOTAL			$		$ 455,413	$ 199,634		$ 655,047	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: **12/31/2018**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	2,576
Outside MD Service-MCA	39(3)	19,750
Medical Supplies - MCA	39(2)	1,098
Total - Line 13		**23,424**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ (123,879)	$ (123,879)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 582,339)	728,497	728,497	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,000	4,000	6
7	Other Prepaid Expenses	218,047	115,087	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 826,665	$ 723,705	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	974,389	953,491	15
16	Equipment, at Historical Cost	529,791	397,628	16
17	Accumulated Depreciation (book methods)	(1,221,175)	(1,670,047)	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		67,294	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 283,005	$ 3,159,433	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,109,670	$ 3,883,138	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,316,850	$ 1,316,850	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	630	630	28
29	Short-Term Notes Payable	764,100	764,100	29
30	Accrued Salaries Payable	190,360	190,360	30
31	Accrued Taxes Payable (excluding real estate taxes)	996,319	996,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,349	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	79,651	79,651	36
37	Due to Related Parties	2,537,067	4,049,480	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,884,977	$ 7,576,739	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,693,748	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposit	2,039	2,039	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,039	$ 1,695,787	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,887,016	$ 9,272,526	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,777,346)	$ (5,389,388)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,109,670	$ 3,883,138	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/2018**

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	12,480	12,480
Accrued Expenses	11,325	11,325
Accrued Bed Tax	13,662	13,662
Due to Third Parties	42,184	42,184
Total - Line 36	**79,651**	**79,651**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,617,856)	1
2	Restatements (describe):		2
3	**Post closing adjustments - Bad Debt Reversals**	617,154	3
4	**Post closing adjustments - Depreciation Expense**	(149,182)	4
5	**Post closing adjustments - Misc Exp/Revenue Corrections**	10,259	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,139,625)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(637,721)	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)**	$ (637,721)	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)**	$ (4,777,346)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 5,213,059	1
2	Discounts and Allowances for all Levels	282,134	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,495,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	203,401	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 203,401	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	1,426	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	(83)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	863	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,206	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,223	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,223	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income - Prior Yr Expense Accrual Corrections**	250,464	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 250,464	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,952,487	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,006,692	31
32	Health Care	2,378,330	32
33	General Administration	1,424,526	33
	B. Capital Expense		
34	Ownership	485,678	34
	C. Ancillary Expense		
35	Special Cost Centers	1,051,251	35
36	Provider Participation Fee	243,731	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,590,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	(637,721)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (637,721)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,502,172	44
45	Private Pay - Net Inpatient Revenue	357,176	45
46	Medicare - Net Inpatient Revenue	1,614,605	46
47	Other-(specify) **Insurance**	21,240	47
48	Other-(specify) **Veterans**		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,495,193	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: 1/1/2018 Ending: 12/31/2018

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	2,087	2,127	$ 73,076	$ 34.36	1
2	Assistant Director of Nursing	3,574	3,773	108,308	28.71	2
3	Registered Nurses	10,092	10,238	384,492	37.56	3
4	Licensed Practical Nurses	12,551	13,460	396,173	29.43	4
5	CNAs & Orderlies	45,043	47,631	719,114	15.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,133	4,647	126,407	27.20	8
9	Activity Director					9
10	Activity Assistants	6,231	6,823	104,086	15.26	10
11	Social Service Workers	2,181	2,301	61,569	26.76	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,080	32,664	15.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,657	23,418	272,490	11.64	15
16	Dishwashers					16
17	Maintenance Workers	2,086	2,386	48,873	20.48	17
18	Housekeepers	12,806	13,258	146,441	11.05	18
19	Laundry	3,592	3,854	44,673	11.59	19
20	Administrator	2,040	2,080	92,397	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,419	7,707	168,843	21.91	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	1,546	1,566	17,092	10.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	5,543	5,824	160,474	27.55	33
34	TOTAL (lines 1 - 33)	144,469	153,173	$ 2,957,172 *	$ 19.31	34

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	Monthly	$ 14,370	L1, C3	35
36	Medical Director	Monthly	11,577	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,430	L10, C3	38
39	Pharmacist Consultant	Monthly	9,015	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Mgmt	Monthly	22,000	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 59,392		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

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

** See instructions.

Gilman Healthcare Center

Period Beginning **1/1/2018**
Period End **12/31/2018**

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		2,268	2,444	94,983	38.86
Transportation		1,232	1,268	20,519	16.18
Marketing		2,043	2,112	44,972	21.29
	TOTAL	5,543	5,824	160,474	

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Ditta	Administrator	0	$ 92,397
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,397

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 284,969
TOTAL (agree to Schedule V, line 17, col. 3)	$ 284,969
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 29,678
CohnReznick LLP	Accounting	24,910
David Hyams	Accounting	337
Focus	Accounting	2,085
Plante & Moran, PLLC	Accounting	1,333
rev accounting accrual	Accounting	(3,390)
Richard Peelo & Associates, Inc	Accounting	2,800
Templin Healthcare Accounting Servi	Accounting	2,650
Dyatech, LLC	Benefits Administration	475
GCHMO, Inc	Managed Care Contracting Serv	11,650
IIT/Sourcetech	Computer Services	985
See Attached Schedule 21A		106,735
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 180,248

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 133,106
Unemployment Compensation Insurance	(13,323)
FICA Taxes	216,298
Employee Health Insurance	75,663
Employee Meals	78
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	25,762
Physical Exams	45
Pension Contributions	15,739
TOTAL (agree to Schedule V, line 22, col.8)	$ 453,368

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	6,846
Health Care Worker Background Check	
(Indicate # of checks performed 99)	991
Patient Background Checks 354	3,548
Dues & Subscriptions	738
Licenses & Permits	1,660
Health Care Council of Illinois	7,796
Allocated from Building Entity	100
Allocated from Management Co.	392
Less: Public Relations Expense	(4,202)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,869

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,259
Allocated from Management Co.	38
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,297

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/2018**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
M & M Financial	Accounting/Tax	500
MGKappy Consulting Inc.	Financial Services Consultant	16,500
Personel Planners	Unemployment Consult	1,245
Resolute Healthcare Solutions	Healthcare Billing	20,947
Sharon Lofgren	Medicare Billing	3,600
Terrill Consulting Services, Inc.	Billing Consultant	6,104
Ability Network	Medicare Billing	6,405
Change Healthcare	Data Processing	1,005
eSolutions INC	Data Processing	4,284
HDSI	Data Processing	3,038
Matrixcare	Data Processing	22,788
Paycor	Payroll Processing	16,773
Quickbooks	Accounting Software	503
Sedgwick CMS	Claims Management	333
Singer Networks	Data Processing	4,144
TaxSaver Plan	Benefits Administration	66
Prior Year Accrual Corrections	Data Processing	(1,500)
Total		**106,735**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. **7,796 Health Care Council of Illinois**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,912** 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. $ **243,731**
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. $ **78** 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