



Facility Name & ID Number Gilman Healthcare Center

# 0049981 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>8,686</u>	<u>8,686</u>	8
9	SNF/PED					9
10	ICF	<u>10,610</u>	<u>3,512</u>		<u>14,122</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,610</u>	<u>3,512</u>	<u>8,686</u>	<u>22,808</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.12%

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

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 99 and days of care provided 4,276

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	239,118	19,872	6,198	265,188		265,188		265,188		1
2	Food Purchase		127,167		127,167	(14,965)	112,202	(196)	112,006		2
3	Housekeeping	110,607	18,164		128,771		128,771		128,771		3
4	Laundry	21,945	14,107		36,052		36,052		36,052		4
5	Heat and Other Utilities			92,238	92,238		92,238	(3,858)	88,380		5
6	Maintenance	41,090		64,485	105,575		105,575	21,652	127,227		6
7	Other (specify):*							300	300		7
8	<b>TOTAL General Services</b>	<b>412,760</b>	<b>179,310</b>	<b>162,921</b>	<b>754,991</b>	<b>(14,965)</b>	<b>740,026</b>	<b>17,898</b>	<b>757,924</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,405,842	125,363	8,807	1,540,012		1,540,012	11,912	1,551,924		10
10a	Therapy		1,861	24,000	25,861		25,861		25,861		10a
11	Activities	88,163	3,416		91,579		91,579		91,579		11
12	Social Services	34,118		3,003	37,121		37,121		37,121		12
13	CNA Training										13
14	Program Transportation	41,049		34,569	75,618		75,618		75,618		14
15	Other (specify):*							1,383	1,383		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,569,172</b>	<b>130,640</b>	<b>77,579</b>	<b>1,777,391</b>		<b>1,777,391</b>	<b>13,295</b>	<b>1,790,686</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	54,656		128,943	183,599		183,599	(97,049)	86,550		17
18	Directors Fees										18
19	Professional Services			54,859	54,859		54,859	(1,766)	53,093		19
20	Dues, Fees, Subscriptions & Promotions			26,637	26,637		26,637	(11,448)	15,189		20
21	Clerical & General Office Expenses	30,486	21,365	130,492	182,343		182,343	(81,817)	100,526		21
22	Employee Benefits & Payroll Taxes			441,347	441,347	14,965	456,312		456,312		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,325	5,325		5,325		5,325		24
25	Other Admin. Staff Transportation			13,677	13,677		13,677	321	13,998		25
26	Insurance-Prop.Liab.Malpractice			73,572	73,572		73,572	299	73,871		26
27	Other (specify):*							8,010	8,010		27
28	<b>TOTAL General Administration</b>	<b>85,142</b>	<b>21,365</b>	<b>874,852</b>	<b>981,359</b>	<b>14,965</b>	<b>996,324</b>	<b>(183,450)</b>	<b>812,874</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,067,074</b>	<b>331,315</b>	<b>1,115,352</b>	<b>3,513,741</b>		<b>3,513,741</b>	<b>(152,257)</b>	<b>3,361,484</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Gilman Healthcare Center

#0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			127,399	127,399		127,399	46,858	174,257			30
31	Amortization of Pre-Op. & Org.			5,128	5,128		5,128		5,128			31
32	Interest			61,115	61,115		61,115	289,356	350,471			32
33	Real Estate Taxes			52,000	52,000		52,000	(4,892)	47,108			33
34	Rent-Facility & Grounds			374,200	374,200		374,200	(370,103)	4,097			34
35	Rent-Equipment & Vehicles			11,897	11,897		11,897		11,897			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			631,739	631,739		631,739	(38,781)	592,958			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,408	524,622	706,030		706,030		706,030			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,692	166,692		166,692		166,692			42
43	Other (specify):*	24,664	8,154	11,239	44,057		44,057	(44,056)	1			43
44	<b>TOTAL Special Cost Centers</b>	24,664	189,562	702,553	916,779		916,779	(44,056)	872,723			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,091,738	520,877	2,449,644	5,062,259		5,062,259	(235,094)	4,827,165			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning: 01/01/13

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(4,175)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(46,564)	30		9
10	Interest and Other Investment Income	(911)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(196)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,313)	21		18
19	Entertainment				19
20	Contributions	(11,800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,377)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (209,336)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(25,758)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (25,758)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (235,094)</b>		<b>37</b>

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

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

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

<b>BHF USE ONLY</b>					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Supplies	\$ (8,154)	43	1
2	Marketing - Advertising & Promotions	(11,239)	43	2
3	Non Allowable Interest	(17,287)	32	3
4	Bank Charges	(14,496)	21	4
5	Additional R&M	19,441	06	5
6	Non-Allowable Legal	(3,679)	19	6
7	Building Co. - Bank Charges	(35)	21	7
8	Building Co. -Amortization	(7,546)	31	8
9	Marketing Salaries	(24,664)	43	9
10	Additional Computer Expense	16,488	21	10
11	Prior Period Expense	(34,203)	21	11
12	Organization Fees	(2,004)	21	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	<b>Total</b>	(87,377)	49

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(196)											(196)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,175)		317									(3,858)	5
6	Maintenance	19,441		2,211									21,652	6
7	Other (specify):*			300									300	7
8	<b>TOTAL General Services</b>	<b>15,070</b>		<b>2,828</b>									<b>17,898</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			15,608	(3,696)								11,912	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,383									1,383	15
16	<b>TOTAL Health Care and Programs</b>			<b>16,991</b>	<b>(3,696)</b>								<b>13,295</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(97,049)									(97,049)	17
18	Directors Fees													18
19	Professional Services	(3,679)		1,913									(1,766)	19
20	Fees, Subscriptions & Promotions	(11,800)		352									(11,448)	20
21	Clerical & General Office Expenses	(92,563)	35	10,711									(81,817)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			321									321	25
26	Insurance-Prop.Liab.Malpractice			299									299	26
27	Other (specify):*			8,010									8,010	27
28	<b>TOTAL General Administration</b>	<b>(108,042)</b>	<b>35</b>	<b>(75,443)</b>									<b>(183,450)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(92,972)</b>	<b>35</b>	<b>(55,624)</b>	<b>(3,696)</b>								<b>(152,257)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(46,564)	87,517	5,905									46,858	30
31	Amortization of Pre-Op. & Org.	(7,546)	7,546											31
32	Interest	(18,198)	306,176	1,378									289,356	32
33	Real Estate Taxes		(4,892)										(4,892)	33
34	Rent-Facility & Grounds		(373,500)	3,397									(370,103)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(72,308)</b>	<b>22,847</b>	<b>10,680</b>									<b>(38,781)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(44,056)											(44,056)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(44,056)</b>											<b>(44,056)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(209,336)</b>	<b>22,882</b>	<b>(44,944)</b>	<b>(3,696)</b>								<b>(235,094)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 373,500	Gilman Realty	100.00%	\$	\$(373,500)	1
2	V	32 Interest	6,016	Gilman Realty	100.00%	312,192	306,176	2
3	V	21 Bank Charges		Gilman Realty	100.00%	35	35	3
4	V	33 Real Estate Tax	52,000	Gilman Realty	100.00%	47,108	(4,892)	4
5	V	31 Amortization		Gilman Realty	100.00%	7,546	7,546	5
6	V	30 Depreciation		Gilman Realty	100.00%	87,517	87,517	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 431,516			\$ 454,398	\$ * 22,882	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	\$ 317	\$	317	15
16	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	2,211		2,211	16
17	V	7 EMPLOYEE BEN. GEN SERVICES.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	300		300	17
18	V	10 NURSING SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	15,608		15,608	18
19	V	15 EMPLOYEE BEN. HEALTH CARE.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,383		1,383	19
20	V	17 NON-OWNER ADMIN. COMP.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	16,570		16,570	20
21	V	17 SALARY - DAVID CHEPLOWITZ		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	7,662		7,662	21
22	V	17 SALARY - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	7,662		7,662	22
23	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,913		1,913	23
24	V	20 LICENSES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	352		352	24
25	V	21 OFFICE EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	10,711		10,711	25
26	V	25 TRAVEL		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	321		321	26
27	V	26 GENERAL INSURANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	299		299	27
28	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	8,010		8,010	28
29	V	30 DEPRECIATION		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	5,905		5,905	29
30	V	32 INTEREST		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,378		1,378	30
31	V	34 RENT		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	3,397		3,397	31
32	V								32
33	V	21 CLERICAL SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%				33
34	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%				34
35	V								35
36	V	17 MANAGEMENT FEES	128,943	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%			(128,943)	36
37	V								37
38	V								38
39	Total		\$ 128,943			\$ 83,999	\$ *	(44,944)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 MEDICAL SUPPLIES	\$ 6,774	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	\$ 3,078	\$ (3,696)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,774			\$ 3,078	\$ * (3,696)

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 01/01/13 Ending: 12/31/13

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cleplowitz	Shareholder	Administrative	37.5%	See Attached	3	7.50%	Mgmt. Fee	\$ 7,662	17-7	1
2	Barak Baver	Shareholder	Administrative	37.5%	See Attached	3	7.50%	Mgmt. Fee	7,662	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,324		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PREMIER HEALTHCARE MANAGEMENT, L  
 Street Address 8170 N. MCCORMICK BLVD. SUITE 137  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-2800  
 Fax Number ( 847) 674-4133

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	277,021	7	\$ 3,854	\$ 22,808	\$ 317	1
2	6	REPAIRS AND MAINTENANC	PATIENT DAYS	277,021	7	26,859	23,471	2,211	2
3	7	EMPLOYEE BEN. GEN SERVI	PATIENT DAYS	277,021	7	3,639	22,808	300	3
4	10	NURSING SALARY	PATIENT DAYS	277,021	7	189,576	189,576	15,608	4
5	15	EMPLOYEE BEN. HEALTH C	PATIENT DAYS	277,021	7	16,798	22,808	1,383	5
6	17	NON-OWNER ADMIN. COM	PATIENT DAYS	277,021	7	201,257	201,257	16,570	6
7	17	SALARY - DAVID CHEPLOW	PATIENT DAYS	277,021	7	93,056	93,056	7,662	7
8	17	SALARY - BARAK BAVER	PATIENT DAYS	277,021	7	93,056	93,056	7,662	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	277,021	7	23,241	22,808	1,913	9
10	20	LICENSES	PATIENT DAYS	277,021	7	4,280	22,808	352	10
11	21	OFFICE EXPENSE	PATIENT DAYS	277,021	7	130,092	93,182	10,711	11
12	25	TRAVEL	PATIENT DAYS	277,021	7	3,902	22,808	321	12
13	26	GENERAL INSURANCE	PATIENT DAYS	277,021	7	3,629	22,808	299	13
14	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	277,021	7	97,291	22,808	8,010	14
15	30	DEPRECIATION	PATIENT DAYS	277,021	7	71,719	22,808	5,905	15
16	32	INTEREST	PATIENT DAYS	277,021	7	16,742	22,808	1,378	16
17	34	RENT	PATIENT DAYS	277,021	7	41,262	22,808	3,397	17
18						-			18
19	21	CLERICAL SALARY	PATIENT DAYS	40	3	40,024	40,024	-	19
20	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	40	3	10,859	-	-	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,071,136	\$ 733,622	\$ 83,999	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	REVENUE	68,271	7	\$ 31,014	\$ 6,774	\$ 3,078	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					\$ 31,014	\$	\$ 3,078	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number

Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
6												6					
7	<b>TOTAL Long-Term</b>											7					
	<b>Working Capital</b>																
8	<b>Other</b>						\$	\$			\$ 15,059	8					
9												9					
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Working Capital</b>										15,059	14					
	<b>B. Non-Facility Related*</b>																
15	<b>Allocated from Premier Healthcare Management</b>						\$	\$			\$ 1,378	15					
16												16					
17												17					
18												18					
19												19					
20	<b>TOTAL Non-Facility Related</b>										1,378	20					

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<b>3,519</b>		<b>1</b>
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.)		\$	<b>50,627</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>47,108</b>		<b>3</b>
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>47,108</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>49,453</u>	8	<b>FOR BHF USE ONLY</b>	
	2009	<u>51,198</u>	9	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2012 \$ <b>13</b>
	2010	<u>51,023</u>	10	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2011	<u>51,099</u>	11	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2012	<u>50,627</u>	12	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>Beginning Accrual Adj</b>					

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gilman Healthcare Center COUNTY Iroquois  
 FACILITY IDPH LICENSE NUMBER 0049981  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-C-23-07-226-004</u>	<u>Long Term Care Property</u>	\$ <u>50,626.90</u>	\$ <u>50,626.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>50,626.90</u></u>	\$ <u><u>50,626.90</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Gilman Healthcare Center

# 0049981 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

None

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

1. Total Amount Incurred: 98,794 2. Number of Years Over Which it is Being Amortized: Various  
 3. Current Period Amortization: 5,128 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		2009	1976	\$ 3,411,067	\$ 87,517	39	\$ 87,463	\$ (54)	\$ 437,315	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2008		6,406		20	534	534	2,847	9
10	Various		2009		162,098		20	13,915	13,915	61,479	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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		2,049	1,122		20	(1,102)	20	68
69			127,399			(127,399)		69
70		\$ 3,581,620	\$ 216,038		\$ 101,932	\$ (114,106)	\$ 501,661	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,581,620	\$ 216,038		\$ 101,932	\$ (114,106)	\$ 501,661	1
2	Rgb Architectural Group - Dining & Therapy Room Remodel Arc	2010	29,805		20	1,490	1,490	5,961	2
3	B1 Accelerator On Fire Sprinkler	2010	2,980		20	149	149	559	3
4	Paving Parking Lot	2010	38,500		20	2,567	2,567	9,411	4
5	Crane Concrete	2010	6,115		20	408	408	1,461	5
6	Cabinetry	2010	16,969		20	3,394	3,394	12,727	6
7	Dining Room Cabinetry	2010	37,599		20	7,520	7,520	27,573	7
8	Demo Walls, Frame New Walls	2010	29,679		20	1,484	1,484	5,317	8
9	Masonry, Interior Glass Block Wall	2010	9,036		20	452	452	1,619	9
10	Plumbing Work	2010	15,400		20	770	770	2,759	10
11	Hvac	2010	6,200		20	310	310	1,111	11
12	Vinyl Flooring & Wallcoverings In Therapy Room	2010	37,097		20	7,419	7,419	26,586	12
13	Stove Outlet, Counter Top Recps And Tele.	2010	7,799		20	1,560	1,560	5,589	13
14	Redo Fire Coking For Barrier Wall	2010	2,500		20	125	125	479	14
15	United Pipe And Supply Limp	2010	2,831		20	142	142	472	15
16	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	109,367		20	5,468	5,468	20,962	16
17	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	153,486		20	7,674	7,674	28,779	17
18	Dining Room - Walls, Flooring, Ceiling, Electrical	2010	24,642		20	1,232	1,232	4,518	18
19	Fe Moran - Wall Project	2011	2,975		20	149	149	446	19
20	2 Hour Firewall	2011	26,850		20	1,343	1,343	3,244	20
21	Weber Plumbing- Replacement Temp System	2013	2,871		20	84	84	84	21
22	Digital Genset Controller	2013	3,870		20	113	113	113	22
23	Weber Plumbing - Consensing Unit	2013	5,927		20	173	173	173	23
24	Alternative Energy Solutions - Transfer Switch	2013	3,121		20	78	78	78	24
25	Weber Plumbing - Condensing Unit	2013	2,945		20	74	74	74	25
26	Replace 3" Cross Main In West Hall	2013	3,950		20	181	181	181	26
27	Mcdaniel Fire System Sprinklers	2013	5,000		20	63	63	63	27
28	Fire Alarm System Repairs	2013	29,595		20	1,045	1,045	1,045	28
29	Carpeting: Resident Room #S-18,19,2,26,25 And Closets	2013	13,858		20	413	413	413	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,212,587	\$ 216,038		\$ 147,810	\$ (68,228)	\$ 663,457	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0049981**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,212,587	\$ 216,038		\$ 147,810	\$ (68,228)	\$ 663,457	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,212,587	\$ 216,038		\$ 147,810	\$ (68,228)	\$ 663,457	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0049981**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>4,212,587</b>	\$ <b>216,038</b>		\$ <b>147,810</b>	\$ <b>(68,228)</b>	\$ <b>663,457</b>	1
2									2
3									3
4									4
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6									6
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>4,212,587</b>	\$ <b>216,038</b>		\$ <b>147,810</b>	\$ <b>(68,228)</b>	\$ <b>663,457</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0049981**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>4,212,587</b>	\$ <b>216,038</b>		\$ <b>147,810</b>	\$ <b>(68,228)</b>	\$ <b>663,457</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>4,212,587</b>	\$ <b>216,038</b>		\$ <b>147,810</b>	\$ <b>(68,228)</b>	\$ <b>663,457</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0049981**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

# **0049981**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**XI. OWNERSHIP COSTS (continued)**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<b>Allocated from Premier Healthcare Management</b>	2013	2,049	1,122	20	20	(1,102)	20	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$	\$		\$	\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 2,049	\$ 1,122		\$ 20	\$ (1,102)	\$ 20	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 89,693	\$ 365	\$ 16,307	\$ 15,942	10	\$ 53,098	71
72	Current Year Purchases	27,257	4,418	1,938	(2,480)	10	1,938	72
73	Fully Depreciated Assets	2,367				10	2,367	73
74								74
75	<b>TOTALS</b>	\$ 119,317	\$ 4,783	\$ 18,245	\$ 13,462		\$ 57,403	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		SUV	2008	\$ 18,596	\$	\$ 1,471	\$ 1,471	5	\$ 18,596	76
77		2009 Ford Eldorado Bus	2009	55,257		6,732	6,732	5	35,904	77
78										78
79										79
80	<b>TOTALS</b>			\$ 73,852	\$	\$ 8,203	\$ 8,203		\$ 54,499	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)	\$ 4,405,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,821	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,257	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (46,564)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 775,359	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	SPRIKLER CO -	\$ 2,500	92
93	LEASEHOLD IMPROVEMENT	2,375	93
94	LEASEHOLD IMPROVEMENT	3,725	94
95		\$ 8,600	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	Storage				700			5
6	Allocated from Premier Healthcare Management				3,397			6
7	TOTAL				\$ 4,097			7

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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 3,483 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford Bus	\$ 829.00	\$ 8,414	17
18					18
19					19
20					20
21	TOTAL		\$ 829.00	\$ 8,414	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' COMPILATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 242,698	\$		\$ 242,698	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			51,046			51,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			229,606			229,606	4
5	Physician Care	39 - 03	visits			1,272			1,272	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				130,740		130,740	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						50,668		50,668	13
14	<b>TOTAL</b>			\$		\$ 524,622	\$ 181,408	\$	\$ 706,030	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 500	\$ 2,037,908	1
2	Cash-Patient Deposits	40,210	40,210	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,252,627	2,252,627	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,515	54,515	6
7	Other Prepaid Expenses	2,500	2,500	7
8	Accounts Receivable (owners or related parties)	46,350	46,350	8
9	Other(specify): <u>See Attached Schedule</u>	89,849	89,849	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,486,551	\$ 4,523,959	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	843,283	4,254,350	15
16	Equipment, at Historical Cost	283,406	283,406	16
17	Accumulated Depreciation (book methods)	(450,644)	(840,631)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	297,494	305,744	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 973,539	\$ 4,002,869	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,460,090	\$ 8,526,828	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 760,614	\$ 816,303	26
27	Officer's Accounts Payable	9,106	9,106	27
28	Accounts Payable-Patient Deposits	2,424	2,424	28
29	Short-Term Notes Payable	1,508,333	1,508,333	29
30	Accrued Salaries Payable	100,613	100,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	85,262	85,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,343	2,343	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	128,255	128,255	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,596,950	\$ 2,652,639	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		6,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	694,918	139,000	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 694,918	\$ 6,139,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,291,868	\$ 8,791,639	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 168,222	\$ (264,811)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,460,090	\$ 8,526,828	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>447,874</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Office Expenses/Rounding</b>	<b>(9,116)</b>	<b>3</b>
<b>4</b>	<b>Bank Charges</b>	<b>(1,258)</b>	<b>4</b>
<b>5</b>	<b>Amortization</b>	<b>5,128</b>	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>442,628</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(274,406)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(274,406)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>168,222</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,966,566	1
2	Discounts and Allowances for all Levels	582,982	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,549,548</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	206,685	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 206,685</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	30,587	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 30,587</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	911	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 911</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	122	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 122</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,787,853</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	754,991	31
32	Health Care	1,777,391	32
33	General Administration	981,359	33
<b>B. Capital Expense</b>			
34	Ownership	631,739	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	750,087	35
36	Provider Participation Fee	166,692	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,062,259</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(274,406)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (274,406)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,577,010	44
45	Private Pay - Net Inpatient Revenue	644,096	45
46	Medicare - Net Inpatient Revenue	2,079,582	46
47	Other-(specify) <u>Insurance</u>	248,860	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 4,549,548</b>	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' COMPILATION REPORT**

Facility Name & ID Number Gilman Healthcare Center

# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,924	3,207	\$ 82,140	\$ 25.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,129	7,288	271,820	37.30	3
4	Licensed Practical Nurses	20,288	21,491	455,717	21.21	4
5	CNAs & Orderlies	46,300	48,828	584,915	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,712	6,152	88,163	14.33	10
11	Social Service Workers	2,160	2,274	34,118	15.00	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,160	35,336	16.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,568	20,985	203,782	9.71	15
16	Dishwashers					16
17	Maintenance Workers	1,927	2,255	41,090	18.22	17
18	Housekeepers	10,481	11,360	110,607	9.74	18
19	Laundry	1,748	1,946	21,945	11.28	19
20	Administrator	2,080	2,080	54,656	26.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,050	2,210	30,486	13.79	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	1,089	1,152	11,250	9.77	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,242	4,370	65,713	15.04	33
34	TOTAL (lines 1 - 33)	129,738	137,758	\$ 2,091,738 *	\$ 15.18	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	72	\$ 6,198	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	538	10-03	38
39	Pharmacist Consultant	Monthly	8,269	10-03	39
40	Physical Therapy Consultant	Monthly	24,000	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,003	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	\$ 49,208		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lonnie Nichols	Administrator	0	\$ 14,113	Workers' Compensation Insurance	\$ 95,715	IDPH License Fee	\$ 1,990	
Shmuel Sussman	Administrator	0	5,365	Unemployment Compensation Insurance	85,568	Advertising: Employee Recruitment	3,618	
Janice Tabor-Ulrich	Administrator	0	11,976	FICA Taxes	157,466	Health Care Worker Background Check	586	
Jason Young	Administrator	0	23,202	Employee Health Insurance	90,416	(Indicate # of checks performed <u>58</u> )		
				Employee Meals	14,965	Patient Background Checks <u>150</u>	1,500	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	1,893	
				Pension Contributions	11,834	Dues & Subscriptions	5,250	
				Employee Benefits - Other	348	Allocated from Premier Healthcare Manager	352	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 54,656					
B. Administrative - Other								
Description			Amount					
Premier Healthcare Management- Management Fees			\$ 128,943					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 128,943					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ability Network	Medicare Billing		\$ 183				Out-of-State Travel	\$
Paycor	Paycor		3,460					
Singer Networks	Data Processing		4,476				In-State Travel	
Various	Legal		7,887					
Personnel Planners	Unemployment Consult.		2,050				Seminar Expense	5,325
ITT Source Tech	Data Processing		1,255					
MDI Achieve	Data Processing		3,874					
Richard Peelo & Associates	Medicare Consulting		4,400				Entertainment Expense	( )
Sharon Lofgren	Medicare Billing		3,600				(agree to Sch. V,	
AccuMed Services	MDS/CarePlan Software		4,065				line 24, col. 8)	
Emdeon Business Services	REV System		1,750				TOTAL	\$ 5,325
See Supplemental Schedule			17,859					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,859					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,133 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. \$ 166,692  
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' COMPILATION 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. \$ 14,965 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ None
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.