

Facility Name & ID Number Gilman Healthcare Center

0049981 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,054	4,054	8
9	SNF/PED					9
10	ICF	20,545	2,020		22,565	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,545	2,020	4,054	26,619	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.67%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

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 3,289

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	260,847	21,716	12,590	295,153		295,153		295,153		1
2	Food Purchase		197,400		197,400		197,400	(2,304)	195,096		2
3	Housekeeping	121,468	19,740		141,208		141,208		141,208		3
4	Laundry	42,613	9,031	18	51,662		51,662		51,662		4
5	Heat and Other Utilities			93,524	93,524		93,524	402	93,926		5
6	Maintenance	43,588		45,712	89,300		89,300	714	90,014		6
7	Other (specify):* Waste Removal			17,032	17,032		17,032		17,032		7
8	TOTAL General Services	468,516	247,887	168,876	885,279		885,279	(1,188)	884,091		8
	B. Health Care and Programs										
9	Medical Director			11,055	11,055		11,055		11,055		9
10	Nursing and Medical Records	1,593,498	225,319	25,370	1,844,187		1,844,187	46,143	1,890,330		10
10a	Therapy	120,008	135	48,239	168,382		168,382		168,382		10a
11	Activities	94,789		3,663	98,452		98,452		98,452		11
12	Social Services	44,691		1,653	46,344		46,344		46,344		12
13	CNA Training										13
14	Program Transportation	36,682		10,709	47,391		47,391		47,391		14
15	Other (specify):* Mgmt Co Benefits Alloc							8,581	8,581		15
16	TOTAL Health Care and Programs	1,889,668	225,454	100,689	2,215,811		2,215,811	54,724	2,270,535		16
	C. General Administration										
17	Administrative	121,682		287,217	408,899		408,899	(222,275)	186,624		17
18	Directors Fees										18
19	Professional Services			98,118	98,118		98,118	(17,386)	80,732		19
20	Dues, Fees, Subscriptions & Promotions			30,596	30,596		30,596	(3,737)	26,859		20
21	Clerical & General Office Expenses	100,417	26,663	103,485	230,565		230,565	71,745	302,310		21
22	Employee Benefits & Payroll Taxes			438,008	438,008		438,008		438,008		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,671	2,671		2,671	112	2,783		24
25	Other Admin. Staff Transportation			47,713	47,713		47,713	(6,195)	41,518		25
26	Insurance-Prop.Liab.Malpractice			104,941	104,941		104,941		104,941		26
27	Other (specify):* Mgmt Co Benefits Alloc							22,143	22,143		27
28	TOTAL General Administration	222,099	26,663	1,112,749	1,361,511		1,361,511	(155,593)	1,205,918		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,580,283	500,004	1,382,314	4,462,601		4,462,601	(102,057)	4,360,544		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number

Gilman Healthcare Center

#0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							164,927	164,927			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,130	52,130		52,130	109,453	161,583			32
33	Real Estate Taxes			66,000	66,000		66,000		66,000			33
34	Rent-Facility & Grounds			185,553	185,553		185,553	(177,599)	7,954			34
35	Rent-Equipment & Vehicles			69,948	69,948		69,948	902	70,850			35
36	Other (specify):*											36
37	TOTAL Ownership			373,631	373,631		373,631	97,683	471,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		184,926	544,284	729,210		729,210		729,210			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,755	195,755		195,755		195,755			42
43	Other (specify):* Disallowed Costs	47,570	8,543	151,072	207,185		207,185	(207,185)				43
44	TOTAL Special Cost Centers	47,570	193,469	891,111	1,132,150		1,132,150	(207,185)	924,965			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,627,853	693,473	2,647,056	5,968,382		5,968,382	(211,559)	5,756,823			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,817)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	164,927	30		9
10	Interest and Other Investment Income	(1,100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,038)	20		17
18	Fines and Penalties	(12,021)	43		18
19	Entertainment				19
20	Contributions	(13,500)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,731)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,315)	43		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 See Page 5A	(116,678)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,273)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(134,286)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (134,286)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (211,559)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Comissions	\$ (2,304)	2	1
2	Marketing Salary	(47,570)	43	2
3	Marketing Expense	(40,962)	43	3
4	Miscellaneous Income Offset	(175)	21	4
5	Offset Vendor Credits	(19,196)	19	5
6	Disallow Late Fee	(34)	25	6
7	Expense Repairs under \$2,500	662	6	7
8	Disallow Marketing Travel	(7,099)	25	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(116,678)		49

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	19 Professional Fees	\$	Gilman Realty, LLC	100.00%	\$ 473	\$	473	1
2	V	32 Interest		Gilman Realty, LLC	100.00%	110,553		110,553	2
3	V	34 Rent-Facility & Grounds	185,553	Gilman Realty, LLC	100.00%			(185,553)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 185,553			\$ 111,026	\$ *	(74,527)	14

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

SEE ACCOUNTANTS' PREPARATION 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 Heat and Other Utilities	\$	Premier Healthcare Management, LLC	100.00%	\$ 402	\$	402	15
16	V	6 Maintenance		Premier Healthcare Management, LLC	100.00%	52		52	16
17	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	51,324		51,324	17
18	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0			18
19	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	8,581		8,581	19
20	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0			20
21	V	17 Administrative	287,217	Premier Healthcare Management, LLC	100.00%	52,162		(235,055)	21
22	V	17 Administrative		Premier Healthcare Management, LLC	100.00%	12,780		12,780	22
23	V	17 Administrative		Premier Healthcare Management, LLC	100.00%	0			23
24	V	19 Professional Services		Premier Healthcare Management, LLC	100.00%	3,068		3,068	24
25	V	20 Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	301		301	25
26	V	21 Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	71,920		71,920	26
27	V	24 Travel and Seminar		Premier Healthcare Management, LLC	100.00%	112		112	27
28	V	25 Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	938		938	28
29	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	20,006		20,006	29
30	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	2,137		2,137	30
31	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0			31
32	V	34 Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	7,954		7,954	32
33	V	35 Equipment Rental		Premier Healthcare Management, LLC	100.00%	902		902	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 287,217			\$ 232,639	\$ *	(54,578)	39

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

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

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 Nursing and Medical Records	\$ 9,400	Premier Healthcare Supplies, LLC	100.00%	\$ 4,219	\$ (5,181)
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		\$ 9,400			\$ 4,219	\$ * (5,181)

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Joseph & Ayelet Knopf	4.69%	Champaign Urbana Nursing & Rehab	Champaign	Premier Healthcare	Skokie	Management Co.	1
2	Yisroel & Naomi Lopin	4.69%	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Esther Schayer	3.12%	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Harry Schayer	3.12%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5	Fred Brody	3.13%	Gardenview Manor	Danville	Gilman Realty LLC	Gilman	Lessor	5
6	Joseph Abramchik	3.13%	Norridge Gardens	Norridge	REX Therapeutics	Skokie	Therapy	6
7	Orsheve Enterprises	3.12%	Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN				7
8	Barak Baver	37.50%	Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9	David Cheplowitz	37.50%	Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10			Premier Healthcare of Connerville, LLC	Connerville, IN				10
11								11
12								12
13								13
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29								29
30								30

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 Cheplowitz	Shareholder	Administrative	37.50%	See Att Sch 7A	2.48	6%	Alloc Salary	\$ 10,927	17-7	1	
2	Barak Bayer	Shareholder	Administrative	37.50%	See Att Sch 7A	2.48	6%	Alloc Salary	10,927	17-7	2	
3	Sara Bayer	Relative	Clerical	0	See Att Sch 7A	2.48	6%	Alloc Salary	2,743	21-7	3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 24,597		13	

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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, LLC
 Street Address 8170 N. McCormick Blvd. Suite 137
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 674-2800
 Fax Number (847) 674-4133

1	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	Heat and Other Utilities	Census Days	428,856	12	\$ 6,472	\$ 26,619	\$ 402	1
2	6	Maintenance	Census Days	428,856	12	843	26,619	52	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	26,619	51,324	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	26,619	0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203	26,619	8,581	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047	26,619	0	6
7	17	Administrative	Census Days	428,856	12	840,373	26,619	52,162	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	26,619	12,780	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	26,619	0	9
10	19	Professional Services	Census Days	428,856	12	49,430	26,619	3,068	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850	26,619	301	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	26,619	71,920	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803	26,619	112	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107	26,619	938	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307	26,619	20,006	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702	26,619	2,137	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332	26,619	0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146	26,619	7,954	18
19	35	Equipment Rental	Census Days	428,856	12	14,538	26,619	902	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,843,091	\$ 3,042,080	\$ 232,639	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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

1	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	Nursing and Medical Records	Revenue	12	\$ 65,860	\$	10,340	\$ 4,219	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				\$ 65,860	\$		\$ 4,219	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	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			
	A. Directly Facility Related																	
	Long-Term																	
1	Bank Leumi		X	Mortgage		7/12/2016	1,875,000	1,768,750	7/12/2021	variable	110,553	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Bank Leumi		X	Line of Credit		8/1/2016		825,032	8/1/2017	variable	51,202	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,875,000	\$ 2,593,782			\$ 161,755	9						
	B. Non-Facility Related*																	
10												10						
11										Other Interest Expense	928	11						
12										Offset Interest Income	(1,100)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (172)	14						
15	TOTALS (line 9+line14)						\$ 1,875,000	\$ 2,593,782			\$ 161,583	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # 36

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 report.			\$	66,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2016	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$	(66,000)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	132,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	66,000	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2012	50,627	8	FOR BHF USE ONLY	
	2013	51,696	9	13	FROM R. E. TAX STATEMENT FOR 2016 \$
	2014	52,226	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2015	52,709	11	15	LESS REFUND FROM LINE 6 \$
	2016	53,794	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
Accrual based on prior year tax bill.					

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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: _____ 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' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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	\$	39	\$ 87,463	\$ 87,463	\$ 787,167	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2008	6,406		20	320	320	4,769	9
10	Various		2009	162,098		20	8,105	8,105	111,329	10
11	Various		2010	530,005		20	26,500	26,500	283,280	11
12	Various		2011	29,825		20	1,491	1,491	9,655	12
13	Weber Plumbing- Replacement Temp System		2013	2,871		20	144	144	659	13
14	Digital Genset Controller		2013	3,870		20	194	194	888	14
15	Weber Plumbing - Consensing Unit		2013	5,927		20	296	296	1,358	15
16	Alternative Energy Solutions - Transfer Switch		2013	3,121		20	156	156	702	16
17	Weber Plumbing - Condensing Unit		2013	2,945		20	147	147	662	17
18	Replace 3" Cross Main In West Hall		2013	3,950		20	198	198	972	18
19	Carpeting - Resident Rooms 2, 18, 19, 25, 26 & Closets		2013	13,858		20	693	693	6,797	19
20	Fire Alarm System Repairs		2013	29,595		20	1,480	1,480	6,906	20
21	Mcdaniel Fire System		2013	5,000		20	250	250	1,063	21
22	Driveway Work		2014	4,131		20	207	207	482	22
23	Carpet-Resident Rooms & Activity Room		2014	31,687		20	1,584	1,584	5,016	23
24	New Compressor For Ne Hall & State Control Water Heater		2014	2,574		20	129	129	451	24
25	Cove Wall Tiling		2015	30,850		20	1,543	1,543	4,629	25
26	Replace Main Entry Door		2015	4,689		20	234	234	702	26
27	Carpeting - 15 East Side Resident Rooms		2015	30,400		20	1,520	1,520	4,560	27
28	Walk In Freezer Compressor		2015	3,730		20	187	187	561	28
29	Replace Water Heater		2016	7,400		20	370	370	555	29
30	Replace Carpeting in Rooms 32, 33, 43 & 44		2016	9,106		20	455	455	683	30
31	Install Electric Panel for Generator & Emergency Power Circuits		2016	2,804		20	140	140	210	31
32	Replace 3 Twin Casement and 2 Single Casement Windows		2017	4,988		20	125	125	125	32
33	2 80 Gallon Water Heaters		2017	2,765		20	69	69	69	33
34	Install New Water Heater in SW Hallway		2017	8,003		20	200	200	200	34
35	Install New Condensing Unit & Evaporator Coil in Walk-In Fridge		2017	5,081		20	127	127	127	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

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	Allocated from Premier Healthcare Management, LLC	2013	1,546	20	77	77	324	46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 4,360,292	\$	\$ 134,404	\$ 134,404	\$ 1,234,901	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 303,578	\$	\$ 30,358	\$ 30,358	10	\$ 178,261	71
72	Current Year Purchases	3,308		165	165		165	72
73	Fully Depreciated Assets	16,890					16,890	73
74								74
75	TOTALS	\$ 323,776	\$	\$ 30,523	\$ 30,523		\$ 195,316	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		SUV	2008	\$ 18,595	\$	\$	\$	5	\$ 18,595	76
77		2009 Ford Eldorado Bus	2009	55,257				5	55,257	77
78										78
79										79
80	TOTALS			\$ 73,852	\$	\$	\$		\$ 73,852	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,757,920	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,927	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 164,927	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,504,069	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Management Co.				7,954			5
6								6
7	TOTAL				\$ 7,954			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 47,915 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2016 Starcraft bus	1,826.00	\$ 22,033	17
18					18
19	Allocated from Management Co.			902	19
20					20
21	TOTAL		\$ 1,826.00	\$ 22,935	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Gilman Healthcare Center
IDPH License ID Number: 0049981
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	46,115
Copier	1,800
Total - Line 16	47,915

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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(3)	hrs	\$		\$ 154,681	\$		\$ 154,681	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			47,217			47,217	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 39(3)	hrs			333,512	135		333,647	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				172,543		172,543	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 Attached Scheule 16A</u>					8,874	12,383		21,257	13
14	TOTAL			\$		\$ 544,284	\$ 185,061		\$ 729,345	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Gilman Healthcare Center
IDPH License ID Number: 0049981
Fiscal Year End: 12/31/2017

Schedule 16A

**XIV. Special Services
Line 13 Other Services**

Description	Schedule V	
	Line & Column	Reference
Description	Reference	Amount
Lab & Xray	39(3)	6,037
Equipment Rental	39(3)	1,185
Outside MD Service-MCA	39(3)	1,652
Medical Supplies - MCA	39(2)	12,383
Total - Line 13		21,257

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (74,150)	\$ (74,150)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>925,770</u>)	711,619	711,619	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,514	21,514	6
7	Other Prepaid Expenses	5,000	5,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 663,983	\$ 663,983	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		3,411,067	14
15	Leasehold Improvements, at Historical Cost	970,537	949,225	15
16	Equipment, at Historical Cost	524,220	397,628	16
17	Accumulated Depreciation (book methods)	(929,235)	(1,504,069)	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>Loan Fees</u>		67,869	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 565,522	\$ 3,321,720	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,229,505	\$ 3,985,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,861,068	\$ 1,861,068	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	630	630	28
29	Short-Term Notes Payable	825,032	825,032	29
30	Accrued Salaries Payable	214,444	214,444	30
31	Accrued Taxes Payable (excluding real estate taxes)	627,911	627,911	31
32	Accrued Real Estate Taxes(Sch.IX-B)		132,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	642,393	642,393	36
37	<u>Due to Related Parties</u>	1,674,539	3,216,640	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,846,017	\$ 7,520,118	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,768,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposit</u>	1,344	1,344	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,344	\$ 1,770,094	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,847,361	\$ 9,290,212	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,617,856)	\$ (5,304,509)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,229,505	\$ 3,985,703	48

Facility Name: Gilman Healthcare Center
IDPH License ID Number: 0049981
Fiscal Year End: 12/31/2017

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	52,402	52,402
Accrued Expenses	122,484	122,484
Accrued Bed Tax	28,726	28,726
Payroll Withholdings	431,507	431,507
Due to HFS	7,274	7,274
Total - Line 36	642,393	642,393

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,256,596)	1
2	Restatements (describe):		2
3	Post closing adjustments -Depreciation Expense	(158,792)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,415,388)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(202,468)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (202,468)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,617,856)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center# 0049981Report Period Beginning: 1/1/2017Ending: 12/31/2017**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,036,228	1
2	Discounts and Allowances for all Levels	407,510	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,443,738	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,433	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 295,433	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,304	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	(80)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,048	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,272	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,100	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,100	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	175	28
28a	<u>Vendor Credits</u>	19,196	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,371	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,765,914	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	885,279	31
32	Health Care	2,215,811	32
33	General Administration	1,361,511	33
B. Capital Expense			
34	Ownership	373,631	34
C. Ancillary Expense			
35	Special Cost Centers	936,395	35
36	Provider Participation Fee	195,755	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,968,382	40
41	Income before Income Taxes (line 30 minus line 40)**	(202,468)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (202,468)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,135,477	44
45	Private Pay - Net Inpatient Revenue	429,153	45
46	Medicare - Net Inpatient Revenue	1,879,108	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,443,738	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,601	1,628	\$ 58,445	\$ 35.90	1
2	Assistant Director of Nursing	587	676	21,559	31.89	2
3	Registered Nurses	7,973	8,234	272,925	33.15	3
4	Licensed Practical Nurses	14,983	15,855	455,151	28.71	4
5	CNAs & Orderlies	50,444	52,890	699,634	13.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,268	4,611	120,008	26.03	8
9	Activity Director					9
10	Activity Assistants	5,204	5,664	94,789	16.74	10
11	Social Service Workers	2,290	2,401	44,691	18.61	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,080	27,614	13.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,640	21,369	233,233	10.91	15
16	Dishwashers					16
17	Maintenance Workers	1,849	2,097	43,588	20.79	17
18	Housekeepers	10,359	10,789	121,468	11.26	18
19	Laundry	3,443	3,743	42,613	11.38	19
20	Administrator	3,040	3,168	121,682	38.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,649	6,052	100,417	16.59	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	616	648	10,819	16.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	7,648	7,829	159,217	20.34	33
34	TOTAL (lines 1 - 33)	141,498	149,734	\$ 2,627,853 *	\$ 17.55	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	Monthly	\$ 12,475	L1, C3	35
36	Medical Director	Monthly	11,055	L9, C3	36
37	Medical Records Consultant	Monthly	1,151	L10, C3	37
38	Nurse Consultant	Monthly	13,138	L10, C3	38
39	Pharmacist Consultant	Monthly	9,891	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,653	L12, C3	45
46	Other(specify) <u>Rehab Mgmt</u>	Monthly	24,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 73,363		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	45	1,190	L10, C3	52
53	TOTAL (lines 50 - 52)	45	\$ 1,190		53

SEE ACCOUNTANTS' PREPARATION REPORT

Gilman Healthcare Center

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,504	2,608	74,965	28.74
Transportation	3,112	3,149	36,682	11.65
Marketing	2,032	2,072	47,570	22.96
TOTAL	<u>7,648</u>	<u>7,829</u>	<u>159,217</u>	

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	
Adam Zanger	Administrator	0	\$ 51,100	Workers' Compensation Insurance	\$ 100,202	IDPH License Fee	\$ 1,990	
Cheryl Vittorio	Administrator	0	4,800	Unemployment Compensation Insurance	48,288	Advertising: Employee Recruitment	11,604	
Janelle Ditta	Administrator	0	65,782	FICA Taxes	196,580	Health Care Worker Background Check (Indicate # of checks performed <u>32</u>)	1,263	
				Employee Health Insurance	62,019	Patient Background Checks <u>153</u>	2,093	
				Employee Meals		Dues & Subscriptions	4,810	
				Illinois Municipal Retirement Fund (IMRF)*	845	Licenses & Permits	900	
				Other Employee Benefits	15,893	IL Council on LTC	3,898	
				Physical Exams	399			
				Pension Contributions	13,782			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 121,682			Allocated from Management Co.	301	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 287,217			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 287,217	TOTAL (agree to Schedule V, line 22, col.8)		\$ 438,008	TOTAL (agree to Sch. V, line 20, col. 8)	
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
See Attached	Legal		\$ 17,582				Out-of-State Travel	\$
Richard Peelo & Associates, Inc	Accounting		2,100					
CohnReznick LLP	Accounting		10,355				In-State Travel	
Personel Planners	Unemployment Consult		719					
Sharon Lofgren	Medicare Billing		3,600				Seminar Expense	2,671
Ability Network	Medicare Billing		2,162				Allocated from Management Co.	112
ADP	Data Processing		946					
Change Healthcare	Data Processing		495				Entertainment Expense	()
eSolutions INC	Data Processing		2,962				(agree to Sch. V, line 24, col. 8)	
Matrixcare	Data Processing		21,172				TOTAL	\$ 2,783
HDSI	Data Processing		2,301					
See Attached Schedule 21A			33,724					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 98,118	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name: Gilman Healthcare Center
IDPH License ID Number: 0049981
Fiscal Year End: 12/31/2017

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Singer Networks	Data Processing	3,441
Paycor	Payroll Processing	14,460
Terrill Consulting Services, Inc.	Billing Consultant	8,530
M & M Financial	Accounting/Tax	5,420
IIT/Sourcetech	Computer Services	1,370
CT Lien Solutions	Risk Management	503
Total		33,724

Facility Name & ID Number Gilman Healthcare Center# 0049981

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 3,898 IL Council on LTC
- (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? _____
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,317 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. \$ 195,755
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT