

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0049981

Facility Name: Gilman Healthcare Center

Address: 1390 S Crescent St Gilman 60938
Number City Zip Code

County: Iroquois

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

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date) _____
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,627	545	2,172	8
9	SNF/PED									9
10	ICF	5,928	6,927	3,539		842			17,236	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,928	6,927	3,539		842	1,627	545	19,408	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 53.71%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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 certified beds 99

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

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	293,908	37,151	18,360	349,419		349,419		349,419			1
2	Food Purchase		185,990		185,990		185,990		185,990			2
3	Housekeeping	249,652	35,217		284,869		284,869		284,869			3
4	Laundry		7,547		7,547		7,547		7,547			4
5	Heat and Other Utilities			138,673	138,673		138,673	741	139,414			5
6	Maintenance	57,977	6,932	29,637	94,546		94,546	1,646	96,192			6
7	Other (specify):* Waste Disposal			18,944	18,944		18,944		18,944			7
8	TOTAL General Services	601,537	272,837	205,614	1,079,988		1,079,988	2,387	1,082,375			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,095,427	116,812	163,957	2,376,196		2,376,196	34,155	2,410,351			10
10a	Therapy	79,242		24,650	103,892		103,892	(24,650)	79,242			10a
11	Activities	162,260		1,075	163,335		163,335		163,335			11
12	Social Services	57,983			57,983		57,983		57,983			12
13	CNA Training											13
14	Program Transportation	12,476		7,030	19,506		19,506		19,506			14
15	Other (specify):* Mgmt Co Benefits Alloc							19,226	19,226			15
16	TOTAL Health Care and Programs	2,407,388	116,812	220,712	2,744,912		2,744,912	28,731	2,773,643			16
	C. General Administration											
17	Administrative	108,970		302,075	411,045		411,045	(246,690)	164,355			17
18	Directors Fees											18
19	Professional Services			224,134	224,134		224,134	(13,898)	210,236			19
20	Dues, Fees, Subscriptions & Promotions			118,175	118,175		118,175	2,021	120,196			20
21	Clerical & General Office Expenses	204,538	14,287	157,272	376,097		376,097	78,707	454,804			21
22	Employee Benefits & Payroll Taxes			377,965	377,965		377,965		377,965			22
23	Inservice Training & Education											23
24	Travel and Seminar			752	752		752	1,177	1,929			24
25	Other Admin. Staff Transportation			19,119	19,119		19,119	(4,581)	14,538			25
26	Insurance-Prop.Liab.Malpractice			92,943	92,943		92,943	10,548	103,491			26
27	Other (specify):* Mgmt Co Benefits Alloc							43,043	43,043			27
28	TOTAL General Administration	313,508	14,287	1,292,435	1,620,230		1,620,230	(129,673)	1,490,557			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,322,433	403,936	1,718,761	5,445,130		5,445,130	(98,555)	5,346,575			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.

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			58,079	58,079		58,079	89,528	147,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			197,070	197,070		197,070	13,381	210,451			32
33	Real Estate Taxes			18,544	18,544		18,544		18,544			33
34	Rent-Facility & Grounds			162,000	162,000		162,000	(154,556)	7,444			34
35	Rent-Equipment & Vehicles			50,973	50,973		50,973	2,984	53,957			35
36	Other (specify):*											36
37	TOTAL Ownership			486,666	486,666		486,666	(48,663)	438,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,608	308,848	365,456		365,456	(34,484)	330,972			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			314,249	314,249		314,249		314,249			42
43	Other (specify):* Disallowed Costs	46,013	2,311	401,992	450,316		450,316	(450,316)				43
44	TOTAL Special Cost Centers	46,013	58,919	1,025,089	1,130,021		1,130,021	(484,800)	645,221			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,368,446	462,855	3,230,516	7,061,817		7,061,817	(632,018)	6,429,799			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,984)	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	(38,651)	30		9
10	Interest and Other Investment Income	(48)	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	(1,419)	17		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(648)	20		17
18	Fines and Penalties	(124,072)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(24,871)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,623)	43		24
25	Fund Raising, Advertising and Promotional	(2,324)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(229,261)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (519,901)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(112,117)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (112,117)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (632,018)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Disallow Marketing Supplies	(2,311)	43	3
4	Disallow Marketing Salaries	(46,013)	43	4
5	Miscellaneous Income Offset	(1,327)	21	5
6	Disallow Prior Year Expense Adjustments	(166,769)	43	6
7	Disallow Late Fees	(123)	43	7
8	Disallow Laboratory Expense	(10,097)	43	8
9	Disallow Marketing Travel Exp	(4,594)	25	9
10	Expense Equipment/Repairs under \$2,500	1,973	21	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	(229,261)		49

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		

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	30	Depreciation		Gilman Realty, LLC	100.00%	\$ 126,336	\$ 126,336	1
2	V	34	Rent-Facility & Grounds	162,000	Gilman Realty, LLC	100.00%		(162,000)	2
3	V								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			\$ 162,000			\$ 126,336	\$ * (35,664)	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	Utilities	\$	Premier Healthcare Management, LLC	0.00%	\$ 741	\$ 741	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	0.00%	1,646	1,646	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	0.00%	39,215	39,215	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	0.00%	10,296	10,296	18
19	V	17	Administrative	302,075	Premier Healthcare Management, LLC	0.00%	56,804	(245,271)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	0.00%	4,323	4,323	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	0.00%	688	688	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	0.00%	96,944	96,944	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	0.00%	136	136	23
24	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	0.00%	791	791	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	0.00%	38,892	38,892	25
26	V	30	Depreciation		Premier Healthcare Management, LLC	0.00%	1,700	1,700	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	0.00%	7,147	7,147	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	0.00%	2,984	2,984	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 302,075			\$ 262,307	\$ * (39,768)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		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	10A	Therapy	\$24,650	REX Therapeutics	0.00%	\$	\$(24,650)	15
16	V	19	Professional Services		REX Therapeutics	0.00%	6,336	6,336	16
17	V	20	Fees and Subscriptions		REX Therapeutics	0.00%	1,804	1,804	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	0.00%	5,602	5,602	18
19	V	24	Travel and Seminar		REX Therapeutics	0.00%	1,041	1,041	19
20	V	25	Other Admin Staff Transp		REX Therapeutics	0.00%	13	13	20
21	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	0.00%	1,095	1,095	21
22	V	30	Depreciation		REX Therapeutics	0.00%	143	143	22
23	V	32	Interest Expense		REX Therapeutics	0.00%	13,429	13,429	23
24	V	34	Rent-Facility & Grounds		REX Therapeutics	0.00%	297	297	24
25	V	39	Therapy Management Wages		REX Therapeutics	0.00%	16,664	16,664	25
26	V	39	Therapy Consultant	271,338	REX Therapeutics	0.00%	29	(271,309)	26
27	V								27
28	V	39	Therapy Wages		REX Therapeutics	0.00%	193,158	193,158	28
29	V	39	Allocated Employee Benefits		REX Therapeutics	0.00%	27,003	27,003	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$295,988			\$266,614	\$ *(29,374)	39

* 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.

☒ X

 YES

☐ NO

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

1		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	\$ 37,038	Staffing Solutions Partners, LLC	0.00%	\$ 31,978	\$ (5,060)	15
16	V	15	Emp Benefit Alloc-Healthcare		Staffing Solutions Partners, LLC	0.00%	8,930	8,930	16
17	V	19	Professional Services		Staffing Solutions Partners, LLC	0.00%	314	314	17
18	V	20	Fees and Subscriptions		Staffing Solutions Partners, LLC	0.00%	177	177	18
19	V	21	Clerical & General Office Exp		Staffing Solutions Partners, LLC	0.00%	1,069	1,069	19
20	V	26	Insurance-Prop.Liab.Malp		Staffing Solutions Partners, LLC	0.00%	8,662	8,662	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 37,038			\$ 51,130	\$ * 14,092	39

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	21	Clerical & General Office Exp	\$ 78,000	Healthcare Solutions Group	81.26%	\$ 52,446	\$ (25,554)	15
16	V	27	Emp Benefit Alloc-Gen Admin		Healthcare Solutions Group	81.26%	4,151	4,151	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 78,000			\$ 56,597	\$ * (21,403)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			AHVA Care of Winfield	Winfield, IL	Premier Healthcare	Skokie, IL	Management Co.	1
2			AHVA Care of Stickney	Stickney, IL	Management, LLC			2
3			Norridge Gardens	Norridge, IL	Premier Healthcare	Skokie, IL	Medical Supply	3
4			Premier Healthcare of New Harmony, LLC	New Harmony, IN	Supplies, LLC			4
5			Avondale Estates of Elgin	Elgin, IL	Gilman Realty LLC	Gilman	Lessor	5
6					REX Therapeutics	Skokie	Therapy	6
7					Healthcare Solutions			7
8					Group	Skokie	Billing Services	8
9					Staffing Solutions			9
10					Partners	Skokie	Staffing Services	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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	Barak Bayer	Owner	Administrative	84.38	See Att Sch 7A	3.15	7.88	Alloc Salary	\$ 18,130	17-7	1
2	Sara Bayer	Relative	Clerical	0.00	See Att Sch 7A	0.12	8.00	Alloc Salary	\$ 404	21-7	2
3	Chana Bayer	Relative	Administrative	0.00	See Att Sch 7A	2.70	13.50	Alloc Salary	4,084	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	\$ 22,618		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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Weighted Operating Rev	78,891,476	8	\$ 9,406	\$	6,218,782	\$ 741	1
2	6	Maintenance	Weighted Operating Rev	78,891,476	8	20,881		6,218,782	1,646	2
3	10	Nursing and Medical Records	Weighted Operating Rev	78,891,476	8	497,470	497,470	6,218,782	39,215	3
4	15	Emp Benefit Alloc-Healthcare	Weighted Operating Rev	78,891,476	8	130,621		6,218,782	10,296	4
5	17	Administrative	Weighted Operating Rev	78,891,476	8	720,615	720,615	6,218,782	56,804	5
6	19	Professional Services	Weighted Operating Rev	78,891,476	8	54,836		6,218,782	4,323	6
7	20	Dues, Fees, Subs & Promo	Weighted Operating Rev	78,891,476	8	8,732		6,218,782	688	7
8	21	Clerical & Gen Office Expenses	Weighted Operating Rev	78,891,476	8	1,229,838	1,158,439	6,218,782	96,944	8
9	24	Travel and Seminar	Weighted Operating Rev	78,891,476	8	1,720		6,218,782	136	9
10	26	Insurance-Prop.Liab.Malpractice	Weighted Operating Rev	78,891,476	8	10,039		6,218,782	791	10
11	27	Emp Benefit Alloc-Gen Admin	Weighted Operating Rev	78,891,476	8	493,383		6,218,782	38,892	11
12	30	Depreciation	Weighted Operating Rev	78,891,476	8	21,569		6,218,782	1,700	12
13	34	Rent-Facility & Grounds	Weighted Operating Rev	78,891,476	8	90,656		6,218,782	7,147	13
14	35	Equipment Rental	Weighted Operating Rev	78,891,476	8	37,860		6,218,782	2,984	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,327,626	\$ 2,376,524		\$ 262,307	25

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

(847) 674-4133

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Staffing Solutions Partners, LLC
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 674-2800
Fax Number (847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing and Medical Records	Direct Allocation	61,663	2	\$ 61,663	\$ 61,663	31,978	\$ 31,978	1
2	15	Emp Benefit Alloc-Healthcare	Total Charges	74,724	2	18,016		37,038	8,930	2
3	19	Professional Services	Total Charges	74,724	2	633		37,038	314	3
4	20	Fees and Subscriptions	Total Charges	74,724	2	358		37,038	177	4
5	21	Clerical & General Office Exp	Total Charges	74,724	2	2,157		37,038	1,069	5
6	26	Insurance-Prop.Liab.Malp	Total Charges	74,724	2	17,476		37,038	8,662	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					\$ 100,303	\$ 61,663		\$ 51,130	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Healthcare Solutions Group
Street Address 7836 Frontage Rd
City / State / Zip Code Skokie, IL 60077
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	21	Clerical & General Office Exp	Total Charges	577,500	5	\$ 388,302	\$ 385,894	78,000	\$ 52,446	1
2	27	Emp Benefit Alloc-Gen Admin	Total Charges	577,500	5	30,734		78,000	4,151	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					\$ 419,036	\$ 385,894		\$ 56,597	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	TCF		X	Bus			65,390	1,446	8/28/19	variable		6							
7							Allocated Working Capital Loan Costs/ Interest				197,070	7							
8												8							
9	TOTAL Facility Related						\$ 65,390	\$ 1,446				\$ 197,070	9						
	B. Non-Facility Related*																		
10								Allocated from REX/Staffing Solutions				13,429	10						
11								Offset Interest Income			(48)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$ 13,381	14						
15	TOTALS (line 9+line14)						\$ 65,390	\$ 1,446				\$ 210,451	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME	<u>Gilman Healthcare Center</u>	COUNTY	<u>Iroquois</u>
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CONTACT PERSON REGARDING THIS REPORT Larry Templin

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:34,655
- B. General Construction Type:ExteriorBrickFrameNumber of Stories1
- C. Does the Operating Entity?

(a) Own the Facility

X(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. List the bed capacity for the building if it differs from the licensed total.
- G. Have you properly capitalized all major repairs and equipment purchases?
- H. Are you presently operating under a sale and leaseback arrangement?

N/A
- I. Are you presently operating under a sublease agreement?

No
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YESXNO
- If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
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:

1/1/2025

Ending:

12/31/2025

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	\$ 1,486,871	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	6,406		20			6,406	9
10	Various			2009	162,098		20			162,098	10
11	Various			2010	530,005		20	26,500	26,500	495,280	11
12	Various			2011	29,825		20	1,491	1,491	21,582	12
13	Weber Plumbing- Replacement Temp System			2013	2,871		20	144	144	1,811	13
14	Digital Genset Controller			2013	3,870		20	194	194	2,440	14
15	Weber Plumbing - Consensing Unit			2013	5,927		20	296	296	3,726	15
16	Alternative Energy Solutions - Transfer Switch			2013	3,121		20	156	156	1,950	16
17	Weber Plumbing - Condensing Unit			2013	2,945		20	147	147	1,838	17
18	Replace 3" Cross Main In West Hall			2013	3,950		20	198	198	2,556	18
19	Carpeting - Resident Rooms 2, 18, 19, 25, 26 & Closets			2013	13,858		20	693	693	12,341	19
20	Fire Alarm System Repairs			2013	29,595		20	1,480	1,480	18,746	20
21	Mcdaniel Fire System			2013	5,000		20	250	250	3,063	21
22	Driveway Work			2014	4,131		20	207	207	2,138	22
23	Carpet-Resident Rooms & Activity Room			2014	31,687		20	1,584	1,584	17,688	23
24	New Compressor For Ne Hall & State Control Water Heater			2014	2,574		20	129	129	1,483	24
25	Cove Wall Tiling			2015	30,850		20	1,543	1,543	16,973	25
26	Replace Main Entry Door			2015	4,689		20	234	234	2,574	26
27	Carpeting - 15 East Side Resident Rooms			2015	30,400		20	1,520	1,520	16,720	27
28	Walk In Freezer Compressor			2015	3,730		20	187	187	2,057	28
29	Replace Water Heater			2016	7,400		20	370	370	3,515	29
30	Replace Carpeting in Rooms 32, 33, 43 & 44			2016	9,106		20	455	455	4,323	30
31	Install Electric Panel for Generator & Emergency Power Circuits			2016	2,804		20	140	140	1,330	31
32	Replace 3 Twin Casement and 2 Single Casement Windows			2017	4,988		20	249	249	2,117	32
33	2 80 Gallon Water Heaters			2017	2,765		20	138	138	1,173	33
34	Install New Water Heater in SW Hallway			2017	8,003		20	400	400	3,400	34
35	Install New Condensing Unit & Evaporator Coil in Walk-In Fridge			2017	5,081		20	254	254	2,159	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

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Repair Broken Water Line - East Wing	2018	\$ 3,166	\$	20	\$ 158	\$ 158	\$ 1,185	37
38	Replace Vinyl Flooring - Room 36 and 42	2019	3,766		20	188	188	1,222	38
39	Install A/C-East Hallway	2019	2,975		20	149	149	968	39
40	Alarm Annunciator Panel Repair	2019	4,458		20	223	223	1,449	40
41	Water Heater	2020	9,700		20	485	485	2,668	41
42	Install Outlets and Connect Emergency Generator	2020	11,500		20	575	575	3,163	42
43	Roof Repair-Replace Shingles/Install Ice Protector	2021	6,641		20	332	332	1,494	43
44	New Windows-Therapy Room	2021	14,655		20	733	733	3,298	44
45	Install New Water Heater	2022	11,858		20	593	593	2,075	45
46	Strip & Wax Tile Floors - 4500 Sq Ft	2022	3,931		20	197	197	689	46
47	Install New Sprinkler System - North Corridor	2023	135,426		20	6,771	6,771	16,928	47
48	Install New Air Handler/Condensing Unit	2023	5,750		20	288	288	720	48
49	Replace Kitchen Air Conditioner	2023	10,250		20	513	513	1,282	49
50	New Air Handler in Southwest Hallway	2023	4,770		20	239	239	597	50
51	Install New Alarm Doors at 4 Exit Doors/Installed New Anunciato	2024	2,530		20	127	127	190	51
52	Sprinkler Panel Upgrades-Added 2 New Modules	2024	3,895		20	195	195	292	52
53	New 3 Ton Air Handler	2024	6,350		20	318	318	477	53
54	Replace Condensing Unit	2024	4,900		20	245	245	368	54
55	Repair Dry Sprinkler Leak in Attic	2024	4,622		20	231	231	347	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)		\$ 4,609,889	\$		\$ 138,982	\$ 138,982	\$ 2,337,770	70

SEE ACCOUNTANTS' PREPARATION 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	Totals from Page 12A, Carried Forward		\$ 4,609,889	\$		\$ 138,982	\$ 138,982	\$ 2,337,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	Allocated from Premier Healthcare Management LLC.	2023	3,268		20	163	163	408	13
14	Allocated from Premier Healthcare Management LLC.	2024	1,262		20	63	63	95	14
15									15
16									16
17	Financial Statement Depreciation			58,079			(58,079)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,614,419	\$ 58,079		\$ 139,208	\$ 81,129	\$ 2,338,273	34

SEE ACCOUNTANTS' PREPARATION 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	\$ 68,410	\$	\$ 6,559	\$ 6,559	10 yrs	\$ 25,146	71
72	Current Year Purchases	4,456		223	223	10 yrs	223	72
73	Fully Depreciated Assets	314,881					314,881	73
74	Premier Healthcare Mgmt LLC/REX Therapeutics			1,617	1,617			74
75	TOTALS	\$ 387,747	\$	\$ 8,399	\$ 8,399		\$ 340,250	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	Facility	SUV	2008	\$ 18,595	\$	\$	\$	5	\$ 18,595	76
77	Facility	2009 Ford Eldorado Bus	2009	55,257				5	55,257	77
78	Resident	2016 Ford Starcraft	2019	74,774				5	74,774	78
79										79
80	TOTALS			\$ 148,626	\$	\$	\$		\$ 148,626	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)	\$ 5,150,792	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,079	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,607	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 89,528	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,827,149	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Management Co.				7,147			5
6	Allocated from REX Therapeutics				297			6
7	TOTAL				\$7,444			7

**

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

N/A

9. Option to Buy:
- ☐ YES☐ NO
- Terms: N/A
- *

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: \$52,465
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	Allocated from Management Co			1,492	18
19					19
20					20
21	TOTAL		\$	\$1,492	21

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

Facility Name:

Gilman Healthcare Center

IDPH License ID Number:

0049981

Fiscal Year End:

12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment	23,807
Office Equipment	21,310
Timeclock	1,317
Dietary Equipment	4,539
Allocated from Premier Mgmt	1,492
Total - Line 16	52,465

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

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

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(7)	2373	hrs	\$ 109,930		\$	\$	2,373	\$ 109,930	1
2	Licensed Speech and Language Development Therapist	39(7)	269	hrs	12,478				269	12,478	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(2), (7)	1528	hrs	70,750			366	1,528	71,116	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				56,242		56,242	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Therapy Mgr-Allocated</u>	39(7)	218		16,664				218	16,664	12
13	Other (specify): <u>Allocated Empl Benefit</u>	39(7)			27,003					27,003	13
14	TOTAL				\$ 236,825		\$	\$ 56,608	4,388	\$ 293,433	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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 63,113	\$ 63,153	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	535,520	535,520	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,723	39,723	6
7	Other Prepaid Expenses	28,946	28,776	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch 17A	202,552	202,552	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 869,854	\$ 869,724	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	1,180,918	1,203,352	15
16	Equipment, at Historical Cost	743,905	536,373	16
17	Accumulated Depreciation (book methods)	(1,726,364)	(2,827,149)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Att Sch 17A	384,161	(122,688)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 582,620	\$ 2,200,955	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,452,474	\$ 3,070,679	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,080,066	\$ 1,098,804	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,446	1,446	29
30	Accrued Salaries Payable	233,312	233,312	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	1,500,562	1,500,562	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,544	38,544	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Att Sch 17A	1,667,963	1,092,613	36
37	Due to Related Parties	4,291,870	5,698,035	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,813,763	\$ 9,663,316	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Long Term Lease Liability	299,054	299,054	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 299,054	\$ 299,054	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,112,817	\$ 9,962,370	46
47	TOTAL EQUITY (page 18, line 24)	\$ (7,660,343)	\$ (6,891,691)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,452,474	\$ 3,070,679	48

Facility Name:

Gilman Healthcare Center

IDPH License ID Number:

0049981

Fiscal Year End:

12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
Interest Receivable	192,391	192,391
Employee Loan Advance	231	231
Due From Others	9,930	9,930
Total - Line 9	202,552	202,552

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Security Deposits	12,774	12,774
Escrow-Insurance	32,850	32,850
Accum Amort-Loan Costs		(506,849)
Right of Use Asset	338,537	338,537
Total - Line 23	384,161	(122,688)

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued Expenses	1,503,408	928,058
Payroll Withholdings	106,303	106,303
Due to Others	18,769	18,769
Short Term Lease Liability	39,483	39,483
Total - Line 36	1,667,963	1,092,613

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,818,681)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,818,681)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(841,662)	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)	\$ (841,662)	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)	\$ (7,660,343)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center

0049981

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,001,723	1
2	Discounts and Allowances for all Levels	(63,207)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,938,516	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	100,311	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 100,311	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,118	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	574	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,692	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,327	28
28a	CAN Initiative/QI Incentive	177,261	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 178,588	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,220,155	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,079,988	31
32	Health Care	2,744,912	32
33	General Administration	1,620,230	33
	B. Capital Expense		
34	Ownership	486,666	34
	C. Ancillary Expense		
35	Special Cost Centers	815,772	35
36	Provider Participation Fee	314,249	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,061,817	40
41	Income before Income Taxes (line 30 minus line 40)**	(841,662)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (841,662)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,554,531.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,819,337.00	45
46	MMAI-Medicaid is the Primary Payer	929,498.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	279,252.00	48
49	Medicare Part A	1,062,434.00	49
50	Other-(specify) Insurance	64,825.00	50
51	Other-(specify) Managed Medicare A	228,639.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,938,516	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,741	1,925	\$ 96,580	\$ 50.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,264	9,710	512,246	52.75	3
4	Licensed Practical Nurses	9,199	10,129	438,574	43.30	4
5	CNAs & Orderlies	31,341	33,628	986,427	29.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,552	1,840	56,392	30.65	8
9	Activity Director	2,058	2,157	50,044	23.20	9
10	Activity Assistants	6,099	6,315	112,216	17.77	10
11	Social Service Workers	1,850	1,983	57,983	29.24	11
12	Dietician					12
13	Food Service Supervisor	1,937	2,165	47,626	22.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,293	14,093	246,282	17.48	15
16	Dishwashers					16
17	Maintenance Workers	1,768	2,057	57,977	28.19	17
18	Housekeepers	13,059	14,315	249,652	17.44	18
19	Laundry					19
20	Administrator	1,676	1,920	108,970	56.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,704	1,924	77,534	40.30	23
24	Clerical	6,129	6,711	127,004	18.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Pg 20A</u>	4,076	4,276	142,939	33.43	33
34	TOTAL (lines 1 - 33)	106,746	115,148	\$ 3,368,446 *	\$ 29.25	34

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	336	\$ 18,360	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,122	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Rehab Consultant</u>	Monthly	24,650	L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	336	\$ 71,132		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	706	\$ 53,332	L10, C3	50
51	Licensed Practical Nurses	470	27,362	L10, C3	51
52	Certified Nurse Assistants/Aides	2,213	79,028	L10, C3	52
53	TOTAL (lines 50 - 52)	3,389	\$ 159,722		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Gilman Healthcare Center

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS/Care Plan Coordinator	1,420	1,420	61,600	43.38
Restorative Nurse	511	527	22,850	43.36
Transportation	772	828	12,476	15.07
Marketing	1,373	1,501	46,013	30.65
TOTAL	4,076	4,276	142,939	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount
Janelle Ditta	Administrator	0	\$ 108,970	Workers' Compensation Insurance		\$ 35,028	IDPH License Fee		\$ 1,658
				Unemployment Compensation Insurance		19,152	Advertising: Employee Recruitment		96,569
				FICA Taxes		252,513	Health Care Worker Background Check		
				Employee Health Insurance		49,683	(Indicate # of checks performed 24)		1,067
				Employee Meals		3,965	Patient Background Checks		275 2,815
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Pension Contributions		12,738	Providence		6,000
				Other Employee Benefits		4,886	Licenses & Permits		1,401
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Dues & Subscriptions		8,665
							Allocated from Mgmt Co./REX/SS		2,669
B. Administrative - Other							Less: Public Relations Expense		(648)
Description			Amount				PAC and Lobbying payments		()
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 302,075				All non-allowable advertising		()
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 120,196
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 377,965			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 302,075	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description		Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount						Out-of-State Travel	\$
See Attached	Legal	\$ 32,175							
Templin Healthcare Accounting	Accounting	6,636							
Roth & Company LLP	Accounting	20,000						In-State Travel	
Ability Network Inc./Wellsky	Data Processing	14,439							
Change Healthcare	Data Processing	741							
Claimex	Billing Consultant	964							
Collaborative Healthcare Urgency Gr	Healthcare Emergency Prepared	1,321						Seminar Expense	752
Dyatech, LLC	Benefits Consultant	675							
eSolutions, Inc	Data Processing	4,639						Allocated from Mgmt Co./REX/Staffing Solutions	1,177
Experian Health Inc.	Revenue Cycle Management	160						Entertainment Expense	()
								(agree to Sch. V, line 24, col. 8)	
See Attached Schedule 21A		142,384		TOTAL		\$		TOTAL	\$ 1,929
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 224,134						

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Facility Name:

Gilman Healthcare Center

IDPH License ID Number:

0049981

Fiscal Year End:

12/31/2025

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
GCHMO, Inc	Managed Care Contracting Services	20,717
IPR Tech Group	Data Processing	15,360
Matrixcare	Data Processing	6,651
Pax8	Data Processing	5,910
Paycom/Paycor	Payroll Processing	15,474
Personnel Planners	Unemployment Consultants	720
PointClickCare Technologies Inc	Accounting Software/Data Processing	52,577
Sage Intacct, Inc	Data Processing	8,834
SNF Metrics LLC	Data Processing	6,945
Wellsky	Data Processing	9,196
Total		142,384

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 33,833

Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 314,249

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 3,965

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A
- (12)

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% Line 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A

No
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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.