FOR BHF USE

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0049981

Facility Name: Gilman Healthcare Center

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

County: Iroquois

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,095	2,095	8
9	SNF/PED					9
10	ICF	19,060	1,036		20,096	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,060	1,036	2,095	22,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.24%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 1,973

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	257,406	32,715	12,886	303,007		303,007		303,007			1
2	Food Purchase		140,695		140,695		140,695	(37)	140,658			2
3	Housekeeping	187,444	43,023	77,775	308,242		308,242		308,242			3
4	Laundry		16,664		16,664		16,664		16,664			4
5	Heat and Other Utilities			93,960	93,960		93,960	521	94,481			5
6	Maintenance	50,808		46,664	97,472		97,472	238	97,710			6
7	Other (specify):* Waste Removal			15,838	15,838		15,838		15,838			7
8	TOTAL General Services	495,658	233,097	247,123	975,878		975,878	722	976,600			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,525,140	183,846	148,182	1,857,168		1,857,168	32,659	1,889,827			10
10a	Therapy	32,776	(306)	20,518	52,988		52,988	(14,932)	38,056			10a
11	Activities	110,205		10,781	120,986		120,986		120,986			11
12	Social Services	127,281		70	127,351		127,351		127,351			12
13	CNA Training											13
14	Program Transportation			8,744	8,744		8,744		8,744			14
15	Other (specify):* Mgmt Co Benefits Alloc							6,804	6,804			15
16	TOTAL Health Care and Programs	1,795,402	183,540	212,295	2,191,237		2,191,237	24,531	2,215,768			16
	C. General Administration											
17	Administrative	106,307		247,615	353,922		353,922	(212,162)	141,760			17
18	Directors Fees											18
19	Professional Services			262,107	262,107		262,107	(16,058)	246,049			19
20	Dues, Fees, Subscriptions & Promotions			39,898	39,898		39,898	3,765	43,663			20
21	Clerical & General Office Expenses	143,355	20,645	25,373	189,373		189,373	73,121	262,494			21
22	Employee Benefits & Payroll Taxes			1,278,323	1,278,323		1,278,323	(862,008)	416,315			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,502	1,502		1,502	112	1,614			24
25	Other Admin. Staff Transportation			16,865	16,865		16,865	(1,128)	15,737			25
26	Insurance-Prop.Liab.Malpractice			59,588	59,588		59,588	1,020	60,608			26
27	Other (specify):* Mgmt Co Benefits Alloc							21,393	21,393			27
28	TOTAL General Administration	249,662	20,645	1,931,271	2,201,578		2,201,578	(991,945)	1,209,633			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,540,722	437,282	2,390,689	5,368,693		5,368,693	(966,692)	4,402,001			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: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			87,311	87,311		87,311	97,400	184,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,018	78,018		78,018	145,497	223,515			32
33	Real Estate Taxes			69,000	69,000		69,000		69,000			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(170,308)	9,692			34
35	Rent-Equipment & Vehicles			48,559	48,559		48,559	996	49,555			35
36	Other (specify):* Loan Fees			8,333	8,333		8,333		8,333			36
37	**TOTAL Ownership**			471,221	471,221		471,221	73,585	544,806			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,971	369,849	393,820		393,820	(53,903)	339,917			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,400	187,400		187,400		187,400			42
43	Other (specify):* Disallowed Costs	41,334	7,074	97,961	146,369		146,369	(146,369)				43
44	**TOTAL Special Cost Centers**	41,334	31,045	655,210	727,589		727,589	(200,272)	527,317			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,582,056	468,327	3,517,120	6,567,503		6,567,503	(1,093,379)	5,474,124			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(7,025)	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	(29,009)	30		9
10	Interest and Other Investment Income	(190)	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	(23,053)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(70)	20		17
18	Fines and Penalties	(676)	43		18
19	Entertainment				19
20	Contributions	(3,450)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23,902)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,285)	43		24
25	Fund Raising, Advertising and Promotional	(19,599)	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	(903,818)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,085,077)		$	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)	(8,302)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,302)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,093,379)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Gilman Healthcare Center

ID# 0049981

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Comissions	$ (37)	2	1
2	Marketing Salary	(41,334)	43	2
3	Expense Repairs under $2,500	236	6	3
4	Expense Equipment under $2,500	1,828	21	4
5	Offset Miscellaneous Income Against Expense	(365)	21	5
6	Disallow Marketing Travel Exp	(2,138)	25	6
7	Disallow Prior Year FICA Taxes	(862,008)	22	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(903,818)		49

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation		Gilman Realty, LLC	100.00%	$ 126,336	$ 126,336	1
2	V	32	Interest		Gilman Realty, LLC	100.00%	164,951	164,951	2
3	V	34	Rent-Facility & Grounds	180,000	Gilman Realty, LLC	100.00%		(180,000)	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			$ 180,000			$ 291,287	$ * 111,287	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 521	$ 521	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	2	2	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	32,659	32,659	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	6,804	6,804	18
19	V	17	Administrative	247,615	Premier Healthcare Management, LLC	100.00%	35,453	(212,162)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	5,022	5,022	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	137	137	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	71,304	71,304	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	112	112	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	822	822	24
25	V	26	Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	100.00%	52	52	25
26	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	21,393	21,393	26
27	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	9,692	9,692	27
28	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	996	996	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			$ 247,615			$ 184,969	$ * (62,646)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	Therapy	$ 14,932	REX Therapeutics	100.00%	$	$ (14,932)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	2,822	2,822	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	3,698	3,698	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	354	354	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	188	188	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	968	968	20
21	V	30	Depreciation		REX Therapeutics	100.00%	73	73	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	3,789	3,789	22
23	V	39	Therapy Management Wages		REX Therapeutics	100.00%	7,368	7,368	23
24	V								24
25	V								25
26	V								26
27	V	39	Therapy Wages	193,408	REX Therapeutics	100.00%	119,501	(73,907)	27
28	V	39	Contract Therapy		REX Therapeutics	100.00%	0		28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	12,636	12,636	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			$ 208,340			$ 151,397	$ * (56,943)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Winfield Woods Healthcare Center	Winfield	Management, LLC			2
3	Esther Schayer	3.12	Pershing Gardens Healthcare Center	Stickney	Premier Healthcare	Skokie	Medical Supply	3
4	Harry Schayer	3.12	Norridge Gardens	Norridge	Supplies, LLC			4
5	Fred Brody	3.13	Gardenview Manor	Danville	Gilman Realty LLC	Gilman	Lessor	5
6	Joseph Abramchik	3.13	Premier Healthcare of New Harmony, LLC	New Harmony, IN	REX Therapeutics	Skokie	Therapy	6
7	Orsheve Enterprises	3.12						7
8	Barak Baver	75.00						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Sara Baver	Relative	Clerical	0.00	See Att Sch 7A	3.06	7.65	Alloc Salary	$ 3,387	21-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,387		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: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Operating Revenues	64,636,666	8	$ 6,803	$	4,952,343	$ 521	1
2	6	Maintenance	Operating Revenues	64,636,666	8	20		4,952,343	2	2
3	10	Nursing and Medical Records	Operating Revenues	64,636,666	8	426,253	426,253	4,952,343	32,659	3
4	15	Emp Benefit Alloc-Healthcare	Operating Revenues	64,636,666	8	88,802		4,952,343	6,804	4
5	17	Administrative	Operating Revenues	64,636,666	8	462,726	462,726	4,952,343	35,453	5
6	19	Professional Services	Operating Revenues	64,636,666	8	65,562		4,952,343	5,022	6
7	20	Dues, Fees, Subs & Promo	Operating Revenues	64,636,666	8	1,782		4,952,343	137	7
8	21	Clerical & Gen Office Expenses	Operating Revenues	64,636,666	8	930,635	877,535	4,952,343	71,304	8
9	24	Travel and Seminar	Operating Revenues	64,636,666	8	1,464		4,952,343	112	9
10	25	Other Admin. Staff Trans	Operating Revenues	64,636,666	8	10,729		4,952,343	822	10
11	26	Insurance-Prop.Liab.Malpractice	Operating Revenues	64,636,666	8	675		4,952,343	52	11
12	27	Emp Benefit Alloc-Gen Admin	Operating Revenues	64,636,666	8	279,218		4,952,343	21,393	12
13	34	Rent-Facility & Grounds	Operating Revenues	64,636,666	8	126,494		4,952,343	9,692	13
14	35	Equipment Rental	Operating Revenues	64,636,666	8	12,997		4,952,343	996	14
15								4,952,343		15
16	17	Professional Services	Direct Allocation	60,000	1	60,000			0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,474,160	$ 1,766,514		$ 184,969	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Therapy Revenue	8,309,425	12	$ 112,512	$	208,385	$ 2,822	1
2	20	Fees and Subscriptions	Therapy Revenue	8,309,425	12	147,440		208,385	3,698	2
3	21	Clerical & General Office Exp	Therapy Revenue	8,309,425	12	14,128		208,385	354	3
4	25	Other Admin Staff Transp	Therapy Revenue	8,309,425	12	7,522		208,385	188	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	8,309,425	12	38,581		208,385	968	5
6	30	Depreciation	Therapy Revenue	8,309,425	12	2,921		208,385	73	6
7	32	Interest Expense	Therapy Revenue	8,309,425	12	151,084		208,385	3,789	7
8	39	Therapy Management Wages	Therapy Revenue	8,309,425	12	293,802	293,802	208,385	7,368	8
9										9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	5,717,814	12	5,424,012	5,424,012	119,501	119,501	12
13	39	Contract Therapy	Direct Allocation	206,555	3	206,555				13
14	39	Allocated Employee Benefits	Total Wages	5,717,814	12	569,187		126,869	12,636	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,967,744	$ 5,717,814		$ 151,397	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X	Mortgage		7/12/2016	1,875,000	1,796,130	7/12/2021	variable	$ 164,951	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit		8/1/2016		764,100	8/1/2017	variable	51,723	6
7	TCF		X	Bus			65,390	43,779	8/28/19	variable	3,242	7
8												8
9	TOTAL Facility Related						$ 1,940,390	$ 2,604,009			$ 219,916	9
	B. Non-Facility Related*											
10								Other Interest			23,053	10
11								Offset Interest Income			(190)	11
12								Allocated from REX			3,789	12
13								Disallow Related Party Interest			(23,053)	13
14	TOTAL Non-Facility Related						$	$			$ 3,599	14
15	TOTALS (line 9+line14)						$ 1,940,390	$ 2,604,009			$ 223,515	15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 248,349	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.)	See Below	$ 247,209	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,140)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,140	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.		$ 69,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	52,709	8
	2016	53,794	9
	2017	53,631	10
	2018	52,280	11
	2019	52,177	12

Accrual based on prior year tax bill.

Payments Made:		
	2019	52,177
	Prior Yrs	195,032
		247,209

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gilman Healthcare Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0049981

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	Long Term Care Property	$ 52,177.44	$ 52,177.44
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,177.44	$ 52,177.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2009	1976	$ 3,411,067	$	39	$ 87,463	$ 87,463	$ 1,049,556	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	6,406		20	320	320	5,729	9
10	Various			2009	162,098		20	8,105	8,105	135,644	10
11	Various			2010	530,005		20	26,500	26,500	362,780	11
12	Various			2011	29,825		20	1,491	1,491	14,127	12
13	Weber Plumbing- Replacement Temp System			2013	2,871		20	144	144	1,091	13
14	Digital Genset Controller			2013	3,870		20	194	194	1,470	14
15	Weber Plumbing - Consensing Unit			2013	5,927		20	296	296	2,246	15
16	Alternative Energy Solutions - Transfer Switch			2013	3,121		20	156	156	1,170	16
17	Weber Plumbing - Condensing Unit			2013	2,945		20	147	147	1,103	17
18	Replace 3" Cross Main In West Hall			2013	3,950		20	198	198	1,566	18
19	Carpeting - Resident Rooms 2, 18, 19, 25, 26 & Closets			2013	13,858		20	693	693	8,876	19
20	Fire Alarm System Repairs			2013	29,595		20	1,480	1,480	11,346	20
21	Mcdaniel Fire System			2013	5,000		20	250	250	1,813	21
22	Driveway Work			2014	4,131		20	207	207	1,103	22
23	Carpet-Resident Rooms & Activity Room			2014	31,687		20	1,584	1,584	9,768	23
24	New Compressor For Ne Hall & State Control Water Heater			2014	2,574		20	129	129	838	24
25	Cove Wall Tiling			2015	30,850		20	1,543	1,543	9,258	25
26	Replace Main Entry Door			2015	4,689		20	234	234	1,404	26
27	Carpeting - 15 East Side Resident Rooms			2015	30,400		20	1,520	1,520	9,120	27
28	Walk In Freezer Compressor			2015	3,730		20	187	187	1,122	28
29	Replace Water Heater			2016	7,400		20	370	370	1,665	29
30	Replace Carpeting in Rooms 32, 33, 43 & 44			2016	9,106		20	455	455	2,048	30
31	Install Electric Panel for Generator & Emergency Power Circuits			2016	2,804		20	140	140	630	31
32	Replace 3 Twin Casement and 2 Single Casement Windows			2017	4,988		20	249	249	872	32
33	2 80 Gallon Water Heaters			2017	2,765		20	138	138	483	33
34	Install New Water Heater in SW Hallway			2017	8,003		20	400	400	1,400	34
35	Install New Condensing Unit & Evaporator Coil in Walk-In Fridge			2017	5,081		20	254	254	889	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 395	37
38	Replace Vinyl Flooring - Room 36 and 42	2019	3,766		20	188	188	282	38
39	Install A/C-East Hallway	2019	2,975		20	149	149	223	39
40	Alarm Annunciator Panel Repair	2019	4,458		20	223	223	334	40
41	Water Heater	2020	9,700		20	243	243	243	41
42	Install Outlets and Connect Emergency Generator	2020	11,500		20	288	288	288	42
43									43
44									44
45									45
46	Allocated from Premier Healthcare Management, LLC	2013	1,907		20	95	95	590	46
47									47
48	Allocated from REX Therapeutics					73	73		48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58	Financial Statement Depreciation Expense			55,050			(55,050)		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)		$ 4,396,218	$ 55,050		$ 136,264	$ 81,214	$ 1,641,472	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: 1/1/2020 Ending: 12/31/2020

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	$ 316,446	$ 18,808	$ 31,645	$ 12,837	10 yrs	$ 271,927	71
72	Current Year Purchases	18,471	2,771	1,847	(924)	10 yrs	1,847	72
73	Fully Depreciated Assets	16,890					16,890	73
74								74
75	TOTALS	$ 351,807	$ 21,579	$ 33,492	$ 11,913		$ 290,664	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	10,682	14,955	4,273	5	29,910	78
79										79
80	TOTALS			$ 148,626	$ 10,682	$ 14,955	$ 4,273		$ 103,762	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)	$ 4,896,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,311	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,711	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 97,400	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,035,898	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	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				9,692			5
6								6
7	TOTAL				$ 9,692 **			7

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

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 48,559 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					18
19	Allocated from Management Co			996	19
20					20
21	TOTAL		$	$ 996	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: **12/31/2020**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	42,737
Office Equipment	5,822
Total - Line 16	**48,559**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)(7)	703	hrs	$ 29,791		$ 40,558	$	703	$ 70,349	1
2	Licensed Speech and Language Development Therapist	39(3)(7)	742	hrs	31,427		42,785		742	74,212	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(3)(7)	1376	hrs	58,283		79,349		1,376	137,632	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				23,613		23,613	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Therapy Manager-Allo	39(7)	53		7,368				53	7,368	12
13	Other (specify): Medical Supplies						19,336	358		19,694	13
14	TOTAL				$ 126,869		$ 182,028	$ 23,971	2,874	$ 332,868	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: **12/31/2020**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	17,085
Outside MD Service-MCA	39(3)	2,251
Medical Supplies - MCA	39(2)	358
Total - Line 13		**19,694**

STATE OF ILLINOIS

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 129,067	$ 129,067	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 139,647)	386,459	386,459	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,073	16,073	6
7	Other Prepaid Expenses	193,004	193,004	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 724,603	$ 724,603	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	1,010,038	985,151	15
16	Equipment, at Historical Cost	637,823	500,433	16
17	Accumulated Depreciation (book methods)	(1,439,052)	(2,035,898)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Fees	32,850	66,496	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 241,659	$ 2,927,249	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 966,262	$ 3,651,852	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 777,304	$ 777,304	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	807,879	807,879	29
30	Accrued Salaries Payable	238,702	238,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,671,904	1,671,904	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70,140	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	440,966	440,966	36
37	Due to Related Parties	2,474,299	4,012,539	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,411,054	$ 8,019,434	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,796,130	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,796,130	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,411,054	$ 9,815,564	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,444,792)	$ (6,163,712)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 966,262	$ 3,651,852	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/2020**

Schedule 17A

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

Description	Operating	After Consolidation
Due to BCBS	46,106	46,106
Due to HFS	4,964	4,964
Accrued Expenses	76,639	76,639
Accrued Bed Tax	6,865	6,865
Payroll Withholdings	1,275	1,275
Due to Medicare	305,117	305,117
Total - Line 36	**440,966**	**440,966**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,297,341)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,297,341)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(147,451)	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)**	$ (147,451)	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)**	$ (5,444,792)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,404,888	1
2	Discounts and Allowances for all Levels	298,245	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,703,133	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,085	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,085	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	999,511	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	37	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	(1)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	89	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 999,636	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	190	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 190	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	365	28
28a	PY Vendor Credits	467,643	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 468,008	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,420,052	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	975,878	31
32	Health Care	2,191,237	32
33	General Administration	2,201,578	33
	B. Capital Expense		
34	Ownership	471,221	34
	C. Ancillary Expense		
35	Special Cost Centers	540,189	35
36	Provider Participation Fee	187,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,567,503	40
41	**Income before Income Taxes (line 30 minus line 40)****	(147,451)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (147,451)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,906,010	44
45	Private Pay - Net Inpatient Revenue	353,834	45
46	Medicare - Net Inpatient Revenue	1,087,807	46
47	Other-(specify) Insurance	48,438	47
48	Other-(specify) Hospice	307,044	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,703,133	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: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,616	2,728	$ 85,099	$ 31.19	1
2	Assistant Director of Nursing	1,108	1,188	34,435	28.99	2
3	Registered Nurses	5,049	5,491	206,793	37.66	3
4	Licensed Practical Nurses	13,436	14,689	479,850	32.67	4
5	CNAs & Orderlies	34,156	37,123	618,220	16.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,324	1,488	32,776	22.03	8
9	Activity Director					9
10	Activity Assistants	5,532	6,389	110,205	17.25	10
11	Social Service Workers	3,500	3,944	93,195	23.63	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,200	38,440	17.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,613	19,096	218,966	11.47	15
16	Dishwashers					16
17	Maintenance Workers	2,181	2,409	50,808	21.09	17
18	Housekeepers	16,089	16,878	187,444	11.11	18
19	Laundry					19
20	Administrator	2,080	2,160	106,307	49.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,169	6,733	143,355	21.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,071	1,103	13,452	12.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	7,684	8,084	162,711	20.13	33
34	TOTAL (lines 1 - 33)	121,552	131,703	$ 2,582,056 *	$ 19.61	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,886	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	192	18,142	L10, C3	38
39	Pharmacist Consultant	Monthly	5,146	L10, C3	39
40	Physical Therapy Consultant	Monthly		L39, C7	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	1	70	L12,C3	45
46	Other(specify) Rehab Mgmt	Monthly		L10A, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	193	$ 60,244		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	191	$ 13,894	L10, C3	50
51	Licensed Practical Nurses	1,364	80,701	L10, C3	51
52	Certified Nurse Assistants/Aides	871	30,299	L10, C3	52
53	TOTAL (lines 50 - 52)	2,426	$ 124,894		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Gilman Healthcare Center

Period Beginning **1/1/2020**
Period End **12/31/2020**

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		3,691	3,952	87,291	22.09
Transportation		2,457	2,596	34,086	13.13
Marketing		1,536	1,536	41,334	26.91
	TOTAL	7,684	8,084	162,711	

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Ditta	Administrator	0	$ 106,307
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,307

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 247,615
TOTAL (agree to Schedule V, line 17, col. 3)	$ 247,615
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 89,094
CohnReznick LLP	Accounting	16,700
Plante & Moran, PLLC	Accounting	112
Richard Peelo & Associates, Inc	Accounting	2,800
Wipfli LLP	Accounting	8,208
Dyatech, LLC	Benefits Administration	812
GCHMO, Inc	Managed Care Contracting Serv	16,200
Ability Network	Computer Services	4,711
M&M Financial	Financial Consultant	750
Bill.Com	Bill Payment Processing	2,945
See Attached Schedule 21A		119,775
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 262,107

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,646
Unemployment Compensation Insurance	11,849
FICA Taxes	189,596
Employee Health Insurance	72,608
Employee Meals	1,128
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	21,564
Other Employee Benefits	10,924
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,315

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	23,701
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,247
Patient Background Checks 7	70
Dues & Subscriptions	12,590
Licenses & Permits	300
Allocated from Management Co.	137
Allocated from REX Therapeutics	3,698
Less: Public Relations Expense	(70)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,663

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,502
Allocated from Management Co.	112
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,614

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Gilman Healthcare Center**
IDPH License ID Number: **0049981**
Fiscal Year End: **12/31/2020**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Personel Planners	Unemployment Consult	360
Resolute Healthcare Solutions	Healthcare Billing	21,206
Sharon Lofgren	Medicare Billing	3,600
Terrill Consulting Services, Inc.	Billing Consultant	21,582
InPath Security, LLC	Data Processing	16,842
Change Healthcare	Data Processing	703
eSolutions INC	Data Processing	9,975
HDSI	Data Processing	1,913
Matrixcare	Data Processing	26,247
Experian Health	Revenue Cycle Management	144
Paycor	Payroll Processing	15,328
Sedgwick CMS	Claims Management	700
TaxSaver Plan	Benefits Administration	175
Collaborative Healthcare Urgency Grou	Healthcare Emergency Preparedness	1,000
Total		**119,775**

Facility Name & ID Number Gilman Healthcare Center # 0049981 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **29,593** 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. $ **187,400**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,128** 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% Line 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 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.