

Facility Name & ID Number All American Nursing Home

0026294 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	96	Intermediate (ICF)	96	35,040	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	159			159	8
9	SNF/PED					9
10	ICF	48,251	1		48,252	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,410	1		48,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.11%

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/08/1981

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/08/1981 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	289,420	48,459	9,226	347,105		347,105	12,328	359,433		1
2	Food Purchase		219,036		219,036	(6,928)	212,108	(0)	212,108		2
3	Housekeeping	216,387	42,665		259,052		259,052		259,052		3
4	Laundry	43,059	15,356		58,415		58,415		58,415		4
5	Heat and Other Utilities			148,479	148,479		148,479	(2,342)	146,137		5
6	Maintenance	172,000	65,178	148,504	385,682		385,682	(82,817)	302,865		6
7	Other (specify):*							1,738	1,738		7
8	TOTAL General Services	720,866	390,694	306,209	1,417,769	(6,928)	1,410,841	(71,093)	1,339,748		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,607,893	43,399	13,390	1,664,682		1,664,682		1,664,682		10
10a	Therapy	26,151		948	27,099		27,099		27,099		10a
11	Activities	65,318	2,608	472	68,398		68,398		68,398		11
12	Social Services	141,779		7,917	149,696		149,696		149,696		12
13	CNA Training										13
14	Program Transportation			729	729		729		729		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,841,141	46,007	38,456	1,925,604		1,925,604		1,925,604		16
	C. General Administration										
17	Administrative	116,735		372,000	488,735		488,735	(264,738)	223,997		17
18	Directors Fees										18
19	Professional Services			73,161	73,161	(402)	72,759	3,323	76,082		19
20	Dues, Fees, Subscriptions & Promotions			32,096	32,096		32,096	(9,935)	22,161		20
21	Clerical & General Office Expenses	79,121	49,010	42,548	170,679		170,679	57,712	228,391		21
22	Employee Benefits & Payroll Taxes			520,160	520,160	6,928	527,088		527,088		22
23	Inservice Training & Education										23
24	Travel and Seminar			960	960		960	154	1,114		24
25	Other Admin. Staff Transportation			3,216	3,216		3,216	3,958	7,174		25
26	Insurance-Prop.Liab.Malpractice			142,695	142,695		142,695	2,392	145,087		26
27	Other (specify):*							51,563	51,563		27
28	TOTAL General Administration	195,856	49,010	1,186,836	1,431,702	6,526	1,438,228	(155,572)	1,282,656		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,757,863	485,711	1,531,501	4,775,075	(402)	4,774,673	(226,665)	4,548,008		29

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

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 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	
	D. Ownership											
30	Depreciation			269,402	269,402		269,402	(172,021)	97,381			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,352	13,352		13,352	1,861	15,213			32
33	Real Estate Taxes			169,291	169,291	402	169,693	5,199	174,892			33
34	Rent-Facility & Grounds			652,000	652,000		652,000	(652,000)				34
35	Rent-Equipment & Vehicles			7,651	7,651		7,651	10,703	18,354			35
36	Other (specify):*											36
37	TOTAL Ownership			1,111,696	1,111,696	402	1,112,098	(806,258)	305,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			372,724	372,724		372,724		372,724			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			372,724	372,724		372,724		372,724			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,757,863	485,711	3,015,921	6,259,495		6,259,495	(1,032,922)	5,226,573			45

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,005)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(175,436)	30		9
10	Interest and Other Investment Income	(510)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(0)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(491)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,312)	20		28
29	Other-Attach Schedule	(113,188)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (297,941)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(734,981)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (734,981)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,032,922)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Misc. Income	\$ (550)	21	1
2	Replacement Inc. Tax	(1,699)	21	2
3	Building Co. - Accounting Fees	(1,025)	19	3
4	Building Co. - ILL. RT	(10,620)	21	4
5	Additional R&M	3,183	06	5
6	Capitalized R&M	(93,142)	06	6
7	PAC Dues	(5,132)	20	7
8	Collections	(1,420)	21	8
9	Non Allowable Legal	(1,566)	19	9
10	Penalty	(1,216)	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		(113,188)	49

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ID# 0026294

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number All American Nursing Home# 0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				12,328								12,328	1
2	Food Purchase	(0)											(0)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,005)		1,663									(2,342)	5
6	Maintenance	(89,959)		1,524	5,618								(82,817)	6
7	Other (specify):*				1,738								1,738	7
8	TOTAL General Services	(93,964)		3,187	19,684								(71,093)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(340,562)	75,824								(264,738)	17
18	Directors Fees													18
19	Professional Services	(2,591)	1,025	4,397		492							3,323	19
20	Fees, Subscriptions & Promotions	(9,935)											(9,935)	20
21	Clerical & General Office Expenses	(15,505)	10,620	62,597									57,712	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			154									154	24
25	Other Admin. Staff Transportation			3,958									3,958	25
26	Insurance-Prop.Liab.Malpractice			1,929		463							2,392	26
27	Other (specify):*			46,875	4,688								51,563	27
28	TOTAL General Administration	(28,032)	11,645	(220,652)	80,512	955							(155,572)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(121,996)	11,645	(217,465)	100,196	955							(226,665)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(175,436)		818		2,597							(172,021)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(510)		71		2,300							1,861	32
33	Real Estate Taxes					5,199							5,199	33
34	Rent-Facility & Grounds		(652,000)	15,640		(15,640)							(652,000)	34
35	Rent-Equipment & Vehicles			10,703									10,703	35
36	Other (specify):*													36
37	TOTAL Ownership	(175,946)	(652,000)	27,232		(5,544)							(806,258)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(297,941)	(640,355)	(190,233)	100,196	(4,589)							(1,032,922)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 652,000	Zikainim Building Partnership	100.00%	\$	\$ (652,000)	1
2	V	19 Accounting Fees		Zikainim Building Partnership	100.00%	1,025	1,025	2
3	V	21 ILL. RT		Zikainim Building Partnership	100.00%	10,620	10,620	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		\$ 652,000			\$ 11,645	\$ * (640,355)	14

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

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	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,663	\$	1,663	15
16	V	6 REPAIRS AND MAINT.				1,524		1,524	16
17	V	17 ADMIN. SALARY				31,438		31,438	17
18	V	19 PROFESSIONAL FEES				4,397		4,397	18
19	V	21 CLERICAL & GENERAL				62,597		62,597	19
20	V	24 SEMINARS				154		154	20
21	V	25 ADMIN. STAFF TRAVEL				3,958		3,958	21
22	V	26 INSURANCE				1,929		1,929	22
23	V	27 EMPLOYEE BENEFITS				46,875		46,875	23
24	V	30 DEPRECIATION				818		818	24
25	V	32 INTEREST EXPENSE				71		71	25
26	V	34 BUILDING RENT				15,640		15,640	26
27	V	35 EQUIPMENT RENTAL				10,703		10,703	27
28	V								28
29	V	17 MANAGEMENT FEES	372,000					(372,000)	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		\$ 372,000			\$ 181,767	\$ *	(190,233)	39

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

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	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 3,106	\$	3,106	15
16	V	1 DIET. COMP - D. WENGROW				9,222		9,222	16
17	V	6 MAINT. COMP. - NON-OWNER				5,618		5,618	17
18	V	7 EMP. BEN. - S. WEBSTER				303		303	18
19	V	7 EMP. BEN. - D. WENGROW				798		798	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				637		637	20
21	V	17 ADMIN. COMP - H. WENGROW				61,538		61,538	21
22	V	17 ADMIN. COMP - J. WEBSTER				14,286		14,286	22
23	V	27 EMP. BEN. - H. WENGROW				3,801		3,801	23
24	V	27 EMP. BEN. - J. WEBSTER				887		887	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		\$			\$ 100,196	\$ *	100,196	39

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

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	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	310	\$	310	15
16	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		463		463	16
17	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,597		2,597	17
18	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,300		2,300	18
19	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		182		182	19
20	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		5,199		5,199	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	34 RENT	15,640	DOUBLE YOU REALTY, LLC				(15,640)	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		\$ 15,640			\$ 11,051	\$ *	(4,589)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jeffrey Webster	50.000%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ZIKAINIM PARTNERSHIP	LINCOLNWOOD	BUILDING CO.	1
2	Howard Wengrow	50.000%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3			ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKK	3
4			HICKORY NURSING PAVILION, INC.	HICKORY HILLS				4
5			RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	\$ 14,286	17-07	1
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	20	30.77%	Alloc. Salary	61,538	17-07	2
3	Sara Webster	Relative	Dietary		See Attached	1.54	30.74%	Alloc. Salary	3,106	01-07	3
4	Deborah Wengrow	Relative	Dietary		See Attached	1.54	30.74%	Alloc. Salary	9,222	01-07	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	\$ 88,152		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 All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	228,440	6	\$ 7,848	\$ 48,411	\$ 1,663	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	228,440	6	7,190	48,411	1,524	2
3	17	ADMIN. SALARY	PATIENT DAYS	228,440	6	148,350	148,350	31,438	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	228,440	6	20,750	48,411	4,397	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	228,440	6	295,380	246,964	62,597	5
6	24	SEMINARS	PATIENT DAYS	228,440	6	728	48,411	154	6
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	228,440	6	18,679	48,411	3,958	7
8	26	INSURANCE	PATIENT DAYS	228,440	6	9,103	48,411	1,929	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	228,440	6	221,191	48,411	46,875	9
10	30	DEPRECIATION	PATIENT DAYS	228,440	6	3,858	48,411	818	10
11	32	INTEREST	PATIENT DAYS	228,440	6	336	48,411	71	11
12	34	BUILDING RENT	PATIENT DAYS	228,440	6	73,800	48,411	15,640	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	228,440	6	50,504	48,411	10,703	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					\$ 857,717	\$ 395,314	\$ 181,767	25

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization STAYCARE MANAGEMENT, LTD.
 Street Address 3737 W ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	2	3,106	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	2	9,222	2
3	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	6	26,510	26,510	8	5,618	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	984		2	303	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,597		2	798	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,006		8	637	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	200,000	200,000	20	61,538	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	200,000	200,000	5	14,286	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,355		20	3,801	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,413		5	887	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					\$ 497,969	\$ 466,614		\$ 100,196	25

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization DOUBLE YOU REALTY, LLC
 Street Address 3737 W. ARTHUR AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 679-2121
 Fax Number (847) 679-2122

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	228,440	6	1,465	48,411	310	1
2	26	INSURANCE	PATIENT DAYS	228,440	6	2,186	48,411	463	2
3	30	DEPRECIATION	PATIENT DAYS	228,440	6	12,255	48,411	2,597	3
4	32	INTEREST EXPENSE	PATIENT DAYS	228,440	6	10,851	48,411	2,300	4
5	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	228,440	6	857	48,411	182	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	228,440	6	24,531	48,411	5,199	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					\$ 52,145	\$	\$ 11,051	25

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Allocated from Double You Realty		X	Mortgage			\$	\$			\$ 2,300					
2																
3																
4																
5																
Working Capital																
6	MB Financial		X	Line of Credit				930,000			13,352					
7	Allocated from Staycare		X								71					
8																
9	TOTAL Facility Related						\$	\$ 930,000			\$ 15,723					
B. Non-Facility Related*																
10	Interest Income		X								(510)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$ (510)					
15	TOTALS (line 9+line14)						\$	\$ 930,000			\$ 15,213					

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.)

** 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

All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>169,031</u>	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.)		\$	<u>171,860</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,829</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>171,661</u>	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.)		\$	<u>402</u>	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 \$ <u>186</u> For <u>2003</u> 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.		\$	<u>174,892</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>146,999</u>	8	FOR BHF USE ONLY	
	2010	<u>154,270</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>153,581</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>164,108</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>166,661</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>2013 Accrual - \$166,661 x 1.03 = \$171,660.83</u>					
<u>Allocated from Double You - \$5,199</u>					
<u>Allocated from Double You - Appeal Costs: \$182</u>					

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME All American Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026294

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-08-113-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>142,635.27</u>	\$ <u>142,635.27</u>
2. <u>14-08-113-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>10,421.43</u>	\$ <u>10,421.43</u>
3. <u>14-08-113-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,941.62</u>	\$ <u>6,941.62</u>
4. <u>14-08-113-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,662.47</u>	\$ <u>6,662.47</u>
5. <u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>24,595.01</u>	\$ <u>5,212.17</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>191,255.80</u></u>	\$ <u><u>171,872.96</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number All American Nursing Home

0026294 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,350 B. General Construction Type: Exterior Brick Frame Fireproof Brick Number of Stories 4

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

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

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

None

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

1. Total Amount Incurred: _____ 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	<u>Facility</u>	<u>18,750</u>	<u>1981</u>	<u>\$ 87,895</u>	<u>1</u>
2	<u>Allocatd from Double You</u>		<u>2003</u>	<u>10,596</u>	<u>2</u>
3	TOTALS	18,750		\$ 98,491	3

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	144		1969	\$ 514,131	\$		\$	\$	\$ 514,131	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1968	2,650		20			2,650	9
10	Various		1972	5,248		20			5,248	10
11	Various		1974	6,075		20			6,075	11
12	Various		1975	22,572		20			22,572	12
13	Various		1978	24,379		20			24,379	13
14	Various		1979	217,961		20			217,961	14
15	Various		1980	41,050		20			41,050	15
16	Various		1981	9,192		20			9,192	16
17	Various		1985	30,550		20			30,550	17
18	Various		1986	49,476		20			41,484	18
19	Various		1987	32,346		20	95	95	20,545	19
20	Various		1988	11,000		20			6,838	20
21	Various		1989	60,399		20			52,707	21
22	Various		1990	10,050		20			9,085	22
23	Various		1991	38,074		20			33,568	23
24	Various		1992	22,062		20			20,554	24
25	Various		1993	15,250		20			14,650	25
26	Various		1994	42,293		20	1,374	1,374	40,855	26
27	Various		1995	185,841		20	9,292	9,292	178,715	27
28	Various		1996	60,561		20	3,028	3,028	54,590	28
29	Various		1997	37,873		20	1,894	1,894	33,288	29
30	Various		1998	20,369		20	1,018	1,018	16,987	30
31	Various		1999	27,926		20	1,396	1,396	21,648	31
32	Various		2000	17,615		20	881	881	12,745	32
33	Various		2001	22,954		20	847	847	17,603	33
34	Various		2002	20,041		20			20,041	34
35	Various		2003	3,863		20	193	193	2,220	35
36	Various		2004	15,301		20	765	765	8,074	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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2005	\$ 25,109	\$	20	\$ 2,021	\$ 2,021	\$ 18,907	37
38	Various	2006	36,422		20	2,646	2,646	23,183	38
39	Various	2007	105,232		20	7,094	7,094	58,738	39
40	Various	2008	51,323		20	4,862	4,862	31,774	40
41	Various	2009	130,246		20	13,025	13,025	73,405	41
42	Various	2010	24,165		20	2,066	2,066	9,770	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		105,976	2,597		2,832	235	33,534	68
69	Financial Statement Depreciation			269,402			(269,402)		69
70	TOTAL (lines 4 thru 69)		\$ 2,045,576	\$ 271,999		\$ 55,329	\$ (216,670)	\$ 1,729,315	70

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,045,576	\$ 271,999		\$ 55,329	\$ (216,670)	\$ 1,729,315	1
2	Walk In Freezer Repairs	2011	6,379		20	1,276	1,276	4,678	2
3	Water Heater	2012	7,369		20	614	614	1,791	3
4	Countertop And Built In Cabinetry	2012	2,700		20	540	540	1,215	4
5	Sprinkler System In Elevators	2012	3,859		20	386	386	997	5
6	New Transfer Switch	2013	6,500		20	650	650	1,192	6
7	Rooftop Heat Exchanger/Compressor	2013	15,950		20	1,595	1,595	2,525	7
8	Wrought Iron Fence	2013	14,300		20	953	953	1,271	8
9	Walk-In Cooler	2013	6,218		20	1,244	1,244	2,073	9
10	Parking Lot Surfacing	2013	14,500		20	967	967	1,289	10
11	A/C Improvements And Parts	2013	8,404		20	840	840	1,261	11
12	Re-Hung And Adjust Elevator Door	2013	2,872		20	144	144	168	12
13	Cylinder	2014	11,722		20	440	440	440	13
14	Replace Elevator Hydraulic Cylinder Repair	2014	24,500		20	715	715	715	14
15	Passenger 1 Elevator Hydraulic Cylinder Repair	2014	4,089		20	175	175	175	15
16	Lobby & Corridors, Remove And Install Wallcovering	2014	17,397		20	870	870	870	16
17	Doors, Unicombo Closer Reinforcement, Power Ajust Aluminum C	2014	2,722		20	136	136	136	17
18	Install Fire Pump Annunciator	2014	2,679		20	134	134	134	18
19	Repair And Replace Burner Controls For Steam Boilers	2014	4,357		20	218	218	218	19
20	Replace Pipe In Crawlspace, Trench Tunnel & Replace Drain	2014	19,700		20	735	735	735	20
21	Piping- Replace 5 Risers	2014	4,200		20	210	210	210	21
22	Piping- Run 5 Risers, 1-Inch Copper Lines, 2 Inch Return Line	2014	6,000		20	300	300	300	22
23	Furnish/Install Pump For Steam Boilers	2014	6,900		20	345	345	345	23
24	Piping East Side/North Side Of Building	2014	25,100		20	1,255	1,255	1,255	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)		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	34

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	34

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	34

**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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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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)		\$ 2,263,991	\$ 271,999		\$ 70,069	\$ (201,930)	\$ 1,753,305	34

**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 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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

Facility Name & ID Number All American Nursing Home

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 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You Realty, LLC	2003	101,284	2,597	39	2,597		31,057	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Staycare Management	2003	4,692		20	235	235	2,477	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	TOTAL (lines 1 thru 33)		\$ 105,976	\$ 2,597		\$ 2,832	\$ 235	\$ 33,534	34

**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	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward		\$ 105,976	\$ 2,597		\$ 2,832	\$ 235	\$ 33,534	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 105,976	\$ 2,597		\$ 2,832	\$ 235	\$ 33,534	34

**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	\$ 202,967	\$	\$ 23,495	\$ 23,495	10	\$ 110,880	71
72	Current Year Purchases	20,880		1,275	1,275	10	1,275	72
73	Fully Depreciated Assets	373,471		1,046	1,046	10	373,471	73
74								74
75	TOTALS	\$ 597,318	\$	\$ 25,816	\$ 25,816		\$ 485,626	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		Allocated from Staycare	2012	\$ 7,172	\$ 818	\$ 1,496	\$ 678	5	\$ 1,688	76
77										77
78										78
79										79
80	TOTALS			\$ 7,172	\$ 818	\$ 1,496	\$ 678		\$ 1,688	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)	\$ 2,966,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 272,817	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,381	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (175,436)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,240,619	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	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								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	RX350 2014 Lexus	\$ 637.61	\$ 7,651	17
18	Allocated from Staycare			10,703	18
19					19
20					20
21	TOTAL		\$ 637.61	\$ 18,354	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.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			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		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	N/A	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): See Supplemental									13	
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 383,715	\$ 406,741	1
2	Cash-Patient Deposits	28,888	28,888	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,872,380	1,872,380	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	172,622	172,622	6
7	Other Prepaid Expenses	2,659	2,659	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	7,956	266,594	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,468,220	\$ 2,749,884	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		138,750	13
14	Buildings, at Historical Cost		1,913,250	14
15	Leasehold Improvements, at Historical Cost	958,970	958,970	15
16	Equipment, at Historical Cost	557,539	557,539	16
17	Accumulated Depreciation (book methods)	(1,244,333)	(3,157,583)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 272,176	\$ 410,926	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,740,396	\$ 3,160,810	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 329,009	\$ 329,009	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,889	28,889	28
29	Short-Term Notes Payable	930,000	930,000	29
30	Accrued Salaries Payable	172,979	172,979	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,398	2,398	31
32	Accrued Real Estate Taxes(Sch.IX-B)	171,661	171,661	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	282,583	282,583	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,917,519	\$ 1,917,519	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,917,519	\$ 1,917,519	46
47	TOTAL EQUITY(page 18, line 24)	\$ 822,877	\$ 1,243,291	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,740,396	\$ 3,160,810	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 707,334	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 707,333	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	115,544	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)	\$ 115,544	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)	\$ 822,877	24 *

* This must agree with page 17, line 47.

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	\$ 6,373,091	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,373,091	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	716	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 716	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	510	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 510	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	722	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 722	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,375,039	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,417,769	31
32	Health Care	1,925,604	32
33	General Administration	1,431,702	33
B. Capital Expense			
34	Ownership	1,111,696	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	372,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,259,495	40
41	Income before Income Taxes (line 30 minus line 40)**	115,544	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 115,544	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,372,941	44
45	Private Pay - Net Inpatient Revenue	150	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,373,091	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,211	2,453	\$ 87,769	\$ 35.78	1
2	Assistant Director of Nursing	1,720	1,984	63,024	31.77	2
3	Registered Nurses	4,444	4,510	131,118	29.07	3
4	Licensed Practical Nurses	20,002	22,128	551,634	24.93	4
5	CNAs & Orderlies	52,045	56,742	600,577	10.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,946	2,250	26,151	11.62	8
9	Activity Director	1,851	2,040	32,397	15.88	9
10	Activity Assistants	3,404	3,547	32,921	9.28	10
11	Social Service Workers	7,572	8,199	141,779	17.29	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,125	38,424	18.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,417	24,633	250,996	10.19	15
16	Dishwashers					16
17	Maintenance Workers	13,280	15,634	172,000	11.00	17
18	Housekeepers	18,866	20,957	216,387	10.33	18
19	Laundry	3,905	4,321	43,059	9.97	19
20	Administrator	1,964	2,080	86,495	41.58	20
21	Assistant Administrator	1,095	1,230	30,240	24.59	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,150	6,487	79,121	12.20	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	1,958	2,198	32,645	14.85	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,933	4,390	141,126	32.15	33
34	TOTAL (lines 1 - 33)	170,752	187,908	\$ 2,757,863 *	\$ 14.68	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 9,226	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant	Monthly	3,080	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,310	10-03	39
40	Physical Therapy Consultant	Monthly	948	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	472	11-03	44
45	Social Service Consultant	85	4,617	12-03	45
46	Other(specify)				46
47	<u>Religious Services</u>	Monthly	3,300	12-03	47
48					48
49	TOTAL (lines 35 - 48)	94	\$ 46,953		49

C. CONTRACT NURSES

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

Facility Name & ID Number All American Nursing Home

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Report Period Beginning: 01/01/14

Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Claussen	Administrator	0	\$ 86,495	Workers' Compensation Insurance	\$ 76,054	IDPH License Fee	\$ 1,990	
Ari Lebowicz	Asst. Administrator	0	30,240	Unemployment Compensation Insurance	30,148	Advertising: Employee Recruitment		
				FICA Taxes	202,994	Health Care Worker Background Check	5,190	
				Employee Health Insurance	185,825	(Indicate # of checks performed <u>519</u>)		
				Employee Meals	6,928	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licences/Permits & Fees	4,561	
				Employee Benefits	183	Dues and Subscriptions	10,420	
				Union Pensions Expense	21,408	Dues, Subscriptions Alloc from Staycare		
				401K	1,628			
				Christmas Expense	1,920			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,734	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 527,087		\$ 22,161		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Staycare - Management Fees			\$ 372,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 372,000				Seminar Expense	960
							Allocated from Staycare	154
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 23,430					
Personnel Planners	Unemployment Consulting		1,476					
MDI Achieve	Computer Services		3,850					
KBC Computer Services	Computer Services		4,756					
Staycare Management	Admissions Consulting		22,895					
See Attached	Legal		9,229					
Legat Architect	Architect Fees		7,525					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 73,161	TOTAL			Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL \$ 1,114	

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$15,552
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,462 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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
All American Nursing Home
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 372,724
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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. \$ 6,928 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 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? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.