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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0026294

Facility Name: All American Nursing Home

Address: 5448 N Broadway St (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 334-2224 **Fax #** (773) 334-0360

HFS ID Number:

Date of Initial License for Current Owners: 5/8/1981

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 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) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 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	48	Skilled (SNF)	48	17,568	1
2		Skilled Pediatric (SNF/PED)			2
3	96	Intermediate (ICF)	96	35,136	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	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					8
9	SNF/PED					9
10	ICF	44,696			44,696	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,696			44,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.81%

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 [X]

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 05/08/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/08/1981 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	309,250	45,167	9,574	363,991		363,991	12,328	376,319			1
2	Food Purchase		221,154		221,154	(7,565)	213,589		213,589			2
3	Housekeeping	244,373	46,209		290,582		290,582		290,582			3
4	Laundry	21,550	15,968		37,518		37,518		37,518			4
5	Heat and Other Utilities			149,888	149,888		149,888	(4,333)	145,555			5
6	Maintenance	214,905	59,816	60,281	335,002		335,002	7,108	342,110			6
7	Other (specify):*							1,647	1,647			7
8	TOTAL General Services	790,078	388,314	219,743	1,398,135	(7,565)	1,390,570	16,750	1,407,320			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	1,642,551	34,793	9,606	1,686,950		1,686,950		1,686,950			10
10a	Therapy	30,488		20,649	51,137		51,137		51,137			10a
11	Activities	80,507	2,944	1,560	85,011		85,011		85,011			11
12	Social Services	136,698		7,030	143,728		143,728		143,728			12
13	CNA Training											13
14	Program Transportation			1,088	1,088		1,088		1,088			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,890,244	37,737	55,933	1,983,914		1,983,914		1,983,914			16
	C. General Administration											
17	Administrative	124,124		425,500	549,624		549,624	(324,883)	224,741			17
18	Directors Fees											18
19	Professional Services			107,214	107,214	(46,006)	61,208	4,293	65,501			19
20	Dues, Fees, Subscriptions & Promotions			38,620	38,620		38,620	(10,392)	28,228			20
21	Clerical & General Office Expenses	45,831	52,609	26,555	124,995		124,995	80,549	205,544			21
22	Employee Benefits & Payroll Taxes			542,386	542,386	7,565	549,951		549,951			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,061	1,061		1,061	222	1,283			24
25	Other Admin. Staff Transportation			1,170	1,170		1,170	4,457	5,627			25
26	Insurance-Prop.Liab.Malpractice			141,532	141,532		141,532	2,797	144,329			26
27	Other (specify):*							53,365	53,365			27
28	TOTAL General Administration	169,955	52,609	1,284,038	1,506,602	(38,441)	1,468,161	(189,592)	1,278,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,850,277	478,660	1,559,714	4,888,651	(46,006)	4,842,645	(172,842)	4,669,803			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.

Facility Name & ID Number: All American Nursing Home #0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			50,567	50,567		50,567	50,973	101,540			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,015	6,015		6,015	(363)	5,652			32
33	Real Estate Taxes			175,659	175,659	46,006	221,665	5,388	227,053			33
34	Rent-Facility & Grounds			510,000	510,000		510,000	(510,000)				34
35	Rent-Equipment & Vehicles			7,967	7,967		7,967	5,875	13,842			35
36	Other (specify):*											36
37	**TOTAL Ownership**			750,208	750,208	46,006	796,214	(448,127)	348,087			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			351,173	351,173		351,173		351,173			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			351,173	351,173		351,173		351,173			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,850,277	478,660	2,661,095	5,990,032		5,990,032	(620,969)	5,369,063			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: 01/01/16 Ending: 12/31/16

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 Reference	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	(5,991)	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	42,732	30		9
10	Interest and Other Investment Income	(2,198)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(537)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(313)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,073)	20		28
29	Other-Attach Schedule	(18,830)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 11,790		$	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)	(632,759)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (632,759)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (620,969)		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.			$		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

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (50)	21	1
2	Building Co. - Accounting Fees	(1,325)	19	2
3	Building Co. - Annual Report	(250)	20	3
4	Building Co. - ILL. RT	(9,143)	21	4
5	PAC Dues	(6,782)	20	5
6	Non-Allowable Legal	(1,280)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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**	(18,830)		49

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				12,328								12,328	1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,991)		1,658									(4,333)	5
6	Maintenance			1,660	5,448								7,108	6
7	Other (specify):*				1,647								1,647	7
8	**TOTAL General Services**	(5,991)		3,318	19,423								16,750	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			(393,406)	68,523								(324,883)	17
18	Directors Fees													18
19	Professional Services	(2,605)	1,325	4,926		647							4,293	19
20	Fees, Subscriptions & Promotions	(10,642)	250										(10,392)	20
21	Clerical & General Office Expenses	(9,506)	9,143	80,912									80,549	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			222									222	24
25	Other Admin. Staff Transportation			4,457									4,457	25
26	Insurance-Prop.Liab.Malpractice			2,286		511							2,797	26
27	Other (specify):*			48,875	4,490								53,365	27
28	**TOTAL General Administration**	(22,753)	10,718	(251,728)	73,013	1,158							(189,592)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,744)	10,718	(248,410)	92,436	1,158							(172,842)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Nursing Home # 0026294 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	42,732		5,723		2,518							50,973	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,198)		32		1,803							(363)	32
33	Real Estate Taxes					5,388							5,388	33
34	Rent-Facility & Grounds		(510,000)	15,166		(15,166)							(510,000)	34
35	Rent-Equipment & Vehicles			5,875									5,875	35
36	Other (specify):*													36
37	**TOTAL Ownership**	40,534	(510,000)	26,796		(5,457)							(448,127)	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)**	11,790	(499,282)	(221,614)	92,436	(4,299)							(620,969)	45

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	34	Rent Income	$ 510,000	Zikainim Building Partnership	100.00%	$	$ (510,000)	1
2	V	19	Accounting Fees		Zikainim Building Partnership	100.00%	1,325	1,325	2
3	V	20	Annual Report		Zikainim Building Partnership	100.00%	250	250	3
4	V	21	ILL. RT		Zikainim Building Partnership	100.00%	9,143	9,143	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			$ 510,000			$ 10,718	$ * (499,282)	14

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 1,658	$ 1,658	15
16	V	6	REPAIRS AND MAINT.				1,660	1,660	16
17	V	17	ADMIN. SALARY				32,094	32,094	17
18	V	19	PROFESSIONAL FEES				4,926	4,926	18
19	V	21	CLERICAL & GENERAL				80,912	80,912	19
20	V	24	SEMINARS				222	222	20
21	V	25	ADMIN. STAFF TRAVEL				4,457	4,457	21
22	V	26	INSURANCE				2,286	2,286	22
23	V	27	EMPLOYEE BENEFITS				48,875	48,875	23
24	V	30	DEPRECIATION				5,723	5,723	24
25	V	32	INTEREST EXPENSE				32	32	25
26	V	34	BUILDING RENT				15,166	15,166	26
27	V	35	EQUIP. RENTAL-AUTO				5,875	5,875	27
28	V								28
29	V	17	MANAGEMENT FEES	425,500				(425,500)	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			$ 425,500			$ 203,886	$ * (221,614)	39

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	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.				5,448	5,448	17
18	V	7	EMP. BEN. - S. WEBSTER				287	287	18
19	V	7	EMP. BEN. - D. WENGROW				780	780	19
20	V	7	EMP. BEN. - MAINT. NON-OWNER				580	580	20
21	V	17	ADMIN. COMP - H. WENGROW				54,806	54,806	21
22	V	17	ADMIN. COMP - J. WEBSTER				13,717	13,717	22
23	V	27	EMP. BEN. - H. WENGROW				3,630	3,630	23
24	V	27	EMP. BEN. - J. WEBSTER				860	860	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			$			$ 92,436	$ * 92,436	39

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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			$		100.00%	$	$	15
16	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		339	339	16
17	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		511	511	17
18	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		2,518	2,518	18
19	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		1,803	1,803	19
20	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		308	308	20
21	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		5,388	5,388	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	15,166	DOUBLE YOU REALTY, LLC			(15,166)	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			$ 15,166			$ 10,867	$ * (4,299)	39

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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			$			$	$	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.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	50.00%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ZIKAINIM PARTNERSHIP	LINCOLNWOOD	BUILDING CO.	1
2	Howard Wengrow	50.00%	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, BOOKKEEI	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: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	$ 13,717	17-07	1
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	20	30.77%	Alloc. Salary	54,806	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	Ephraim Braunstein	Relative	Clerical		See Attached	8.22	20.55%	Alloc. Salary	16,003	21-07	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	$ 96,854		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: 01/01/16 Ending: 12/31/16

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 [X]

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 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

	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	UTILITIES	PATIENT DAYS	217,497	6	$ 8,067	$	44,696	$ 1,658	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	217,497	6	8,079		44,696	1,660	2
3	17	ADMIN. SALARY	PATIENT DAYS	217,497	6	156,174	156,174	44,696	32,094	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	23,970		44,696	4,926	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	217,497	6	393,729	339,385	44,696	80,912	5
6	24	SEMINARS	PATIENT DAYS	217,497	6	1,079		44,696	222	6
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	217,497	6	21,689		44,696	4,457	7
8	26	INSURANCE	PATIENT DAYS	217,497	6	11,124		44,696	2,286	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	217,497	6	237,834		44,696	48,875	9
10	30	DEPRECIATION	PATIENT DAYS	217,497	6	27,851		44,696	5,723	10
11	32	INTEREST	PATIENT DAYS	217,497	6	155		44,696	32	11
12	34	BUILDING RENT	PATIENT DAYS	217,497	6	73,800		44,696	15,166	12
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	217,497	6	28,591		44,696	5,875	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					$ 992,142	$ 495,559		$ 203,886	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	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.	AVG. HOURS WORKED	40	6	26,510	26,510	8	5,448	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	932		2	287	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,537		2	780	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,822		8	580	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	178,120	178,120	20	54,806	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	192,042	192,042	5	13,717	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	11,798		20	3,630	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,046		5	860	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					$ 466,911	$ 436,776		$ 92,436	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,650		44,696	339	2
3	26	INSURANCE	PATIENT DAYS	217,497	6	2,487		44,696	511	3
4	30	DEPRECIATION	PATIENT DAYS	217,497	6	12,254		44,696	2,518	4
5	32	INTEREST EXPENSE	PATIENT DAYS	217,497	6	8,771		44,696	1,803	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,500		44,696	308	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	217,497	6	26,220		44,696	5,388	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					$ 52,882	$		$ 10,867	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	Allocated from Double You Realty		X	Mortgage							1,803	3
4												4
5					-							5
	Working Capital											
6	MB Financial		X	Line Of Credit				920,000			6,015	6
7												7
8					-							8
9	TOTAL Facility Related						$	$ 920,000			$ 7,818	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,198)	10
11	Allocated from Staycare Management		X								32	11
12												12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (2,166)	14
15	TOTALS (line 9+line14)						$	$ 920,000			$ 5,652	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.)

** 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: 01/01/16 Ending: 12/31/16

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 174,296	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.)		$ 177,780	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,484	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 177,563	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.)		$ 46,006	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** $ 105,778 **For** 12,13,14 **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.		$ 227,053	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	153,581	8
	2012	164,108	9
	2013	166,661	10
	2014	169,219	11
	2015	172,392	12

2015 Accrual: $172,392 x 1.03 = $177,563

Allocated from Double You Realty: $5,388

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-113-017-0000	Long Term Care Property	$ 145,497.11	$ 145,497.11
2.	14-08-113-018-0000	Long Term Care Property	$ 11,388.71	$ 11,388.71
3.	14-08-113-019-0000	Long Term Care Property	$ 7,878.44	$ 7,878.44
4.	14-08-113-020-0000	Long Term Care Property	$ 7,627.32	$ 7,627.32
5.	10-35-329-014-0000	Home Office	$ 26,219.28	$ 5,388.11
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 198,610.86	$ 177,779.69

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [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 [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	18,750	1981	$ 87,895	1
2	Allocated from Double You Realty		2003	10,275	2
3	TOTALS	18,750		$ 98,170	3

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	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	20,736	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			40,855	26
27	Various			1995	185,841		20			183,532	27
28	Various			1996	60,561		20	954	954	58,572	28
29	Various			1997	37,873		20	1,892	1,892	37,075	29
30	Various			1998	20,369		20	1,018	1,018	19,024	30
31	Various			1999	27,926		20	1,396	1,396	24,441	31
32	Various			2000	17,615		20	881	881	14,506	32
33	Various			2001	22,954		20	847	847	19,297	33
34	Various			2002	20,041		20			20,041	34
35	Various			2003	3,863		20	193	193	2,606	35
36	Various			2004	15,301		20	765	765	9,604	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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Various	2005	$ 25,109	$	20	$ 490	$ 490	$ 20,985	37
38	Various	2006	36,422		20	1,354	1,354	27,184	38
39	Various	2007	105,232		20	7,094	7,094	72,935	39
40	Various	2008	51,323		20	4,862	4,862	41,498	40
41	Various	2009	130,246		20	12,885	12,885	98,616	41
42	Various	2010	24,165		20	1,560	1,560	13,142	42
43	Various	2011	6,379		20	425	425	6,379	43
44	Various	2012	13,928		20	1,540	1,540	7,083	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)		108,109	7,861		2,923	(4,938)	38,415	68
69	Financial Statement Depreciation			50,567			(50,567)		69
70	TOTAL (lines 4 thru 69)		$ 2,068,015	$ 58,428		$ 41,176	$ (17,252)	$ 1,829,217	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,068,015	$ 58,428		$ 41,176	$ (17,252)	$ 1,829,217	1
2	New Transfer Switch	2013	6,500		20	650	650	2,492	2
3	Rooftop Heat Exchanger/Compressor	2013	15,950		20	1,595	1,595	5,715	3
4	Wrought Iron Fence	2013	14,300		20	953	953	3,178	4
5	Walk-In Cooler	2013	6,218		20	1,244	1,244	4,560	5
6	Parking Lot Surfacing	2013	14,500		20	967	967	3,222	6
7	A/C Improvements And Parts	2013	8,404		20	840	840	2,941	7
8	Re-Hung And Adjust Elevator Door	2013	2,872		20	144	144	455	8
9	Cylinder	2014	11,722		20	586	586	1,612	9
10	Replace Elevator Hydraulic Cylinder	2014	24,500		20	1,225	1,225	3,165	10
11	Passenger 1 Elevator Hydraulic Cylinder Repair	2014	4,089		20	204	204	579	11
12	Lobby & Corridors-Remove & Install Wallcovering	2014	17,397		20	870	870	2,465	12
13	Doors, Unicombo Closer Reinforcement, Power Adjust Aluminum	2014	2,722		20	136	136	374	13
14	Install Fire Pump Annunciator	2014	2,679		20	134	134	357	14
15	Repair & Replace Burner Controls For Steam Boilers	2014	4,357		20	218	218	563	15
16	Replace Pipe In Crawlspace, Trench Tunnel & Replace Drain	2014	19,700		20	985	985	2,545	16
17	Piping - Replace 5 Risers	2014	4,200		20	210	210	525	17
18	Piping - Run 5 Risers, 1-Inch Copper Lines, 2 Inch Return Line	2014	6,000		20	300	300	700	18
19	Furnish & Install Pump For Steam Boilers	2014	6,900		20	345	345	748	19
20	Piping East Side / North Side Of Building	2014	25,100		20	1,255	1,255	2,615	20
21	Open Wall & Install Piping	2014	4,250		20	213	213	443	21
22	Install Sprinkler Heads South Stairwell, Bathroom & 2Nd Floor L	2015	6,350		20	318	318	609	22
23	New Elevator Submercible Pump & Motor	2015	6,752		20	338	338	591	23
24	Movfr Door Operator	2015	5,528		20	276	276	392	24
25	Door Screen And Operator Board	2015	3,182		20	159	159	186	25
26	Heat Work	2015	7,832		20	392	392	783	26
27	Replace Drain Pipe	2015	6,200		20	310	310	336	27
28	Floor In Rear Corridor	2015	6,093		20	305	305	355	28
29	Install New Traps & Cut Pipes In Tunnel	2015	3,300		20	165	165	330	29
30	2Nd Floor East A/C Unit Install	2015	8,160		20	408	408	646	30
31	New Back Patio	2016	43,740		20	365	365	365	31
32	Elevator Motor	2016	5,450		20	159	159	159	32
33	Elevator Car Sill	2016	3,300		20	83	83	83	33
34	TOTAL (lines 1 thru 33)		$ 2,376,262	$ 58,428		$ 57,525	$ (903)	$ 1,873,302	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: 01/01/16 Ending: 12/31/16

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 12B, Carried Forward		$ 2,376,262	$ 58,428		$ 57,525	$ (903)	$ 1,873,302	1
2	Bumper Guards, End Caps,	2016	7,875		20	394	394	394	2
3	Furnish & Install Back Double Doors	2016	3,850		20	193	193	193	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)		$ 2,387,987	$ 58,428		$ 58,111	$ (317)	$ 1,873,888	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: 01/01/16 Ending: 12/31/16

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 12C, Carried Forward		$ 2,387,987	$ 58,428		$ 58,111	$ (317)	$ 1,873,888	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)		$ 2,387,987	$ 58,428		$ 58,111	$ (317)	$ 1,873,888	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: 01/01/16 Ending: 12/31/16

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 12D, Carried Forward		$ 2,387,987	$ 58,428		$ 58,111	$ (317)	$ 1,873,888	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)		$ 2,387,987	$ 58,428		$ 58,111	$ (317)	$ 1,873,888	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: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									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
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 # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 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 # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	98,216	2,518	35	2,518		35,153	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	4,550		20	227	227	3,084	9
10	Allocated from Staycare Management	2016	5,343	5,343	20	178	(5,165)	178	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)		$ 108,109	$ 7,861		$ 2,923	$ (4,938)	$ 38,415	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: 01/01/16 Ending: 12/31/16

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 12H, Carried Forward		$ 108,109	$ 7,861		$ 2,923	$ (4,938)	$ 38,415	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
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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)		$ 108,109	$ 7,861		$ 2,923	$ (4,938)	$ 38,415	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: 01/01/16 Ending: 12/31/16

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	$ 277,425	$	$ 38,963	$ 38,963	10	$ 173,878	71
72	Current Year Purchases	36,192		3,619	3,619	10	3,619	72
73	Fully Depreciated Assets	386,045				10	386,045	73
74								74
75	TOTALS	$ 699,662	$	$ 42,582	$ 42,582		$ 563,543	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	$ 6,955	$ 380	$ 847	$ 467	5	$ 4,519	76
77										77
78										78
79										79
80	TOTALS			$ 6,955	$ 380	$ 847	$ 467		$ 4,519	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)	$ 3,192,774	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,808	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,540	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,732	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,441,950	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	Demolition of Parapet in East E	$ 801,173	92
93			93
94			94
95		$ 801,173	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.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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	2014 Lexus RX350	$ 638	$ 7,967	17
18	Allocated from Staycare Management			5,875	18
19					19
20					20
21	TOTAL		$ 638	$ 13,842	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: 01/01/16 Ending: 12/31/16

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.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		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 prescrpts							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:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 340,706	$ 363,764	1
2	Cash-Patient Deposits	31,113	31,113	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,468,785	1,468,785	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	176,708	176,708	6
7	Other Prepaid Expenses	2,653	2,653	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	3,658	3,658	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,023,623	$ 2,046,681	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	1,077,336	1,077,336	15
16	Equipment, at Historical Cost	624,055	624,055	16
17	Accumulated Depreciation (book methods)	(1,390,211)	(3,303,461)	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): See Attached Schedule	801,175	801,175	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,112,355	$ 1,251,105	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,135,978	$ 3,297,786	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 309,105	$ 309,105	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,112	31,112	28
29	Short-Term Notes Payable	920,000	920,000	29
30	Accrued Salaries Payable	229,667	229,667	30
31	Accrued Taxes Payable (excluding real estate taxes)	878	878	31
32	Accrued Real Estate Taxes(Sch.IX-B)	177,563	177,563	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	3,808	3,808	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,672,133	$ 1,672,133	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	See Attached Schedule	258,638		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 258,638	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,930,771	$ 1,672,133	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,205,207	$ 1,625,653	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,135,978	$ 3,297,786	48

***(See instructions.)**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,159,943	1
2	Restatements (describe):		2
3	**Prior Year AR Adjustment**	(150,764)	3
4	**Rounding**	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,009,182	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	196,025	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)**	$ 196,025	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)**	$ 1,205,207	24 *

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 6,078,031	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,078,031	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,198	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,198	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	105,828	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 105,828	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,186,057	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,398,135	31
32	Health Care	1,983,914	32
33	General Administration	1,506,602	33
	B. Capital Expense		
34	Ownership	750,208	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	351,173	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,990,032	40
41	**Income before Income Taxes (line 30 minus line 40)****	196,025	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 196,025	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,078,031	44
45	Private Pay - Net Inpatient Revenue		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)	$ 6,078,031	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: 01/01/16 Ending: 12/31/16

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	2,134	2,334	$ 93,211	$ 39.94	1
2	Assistant Director of Nursing	1,621	1,865	61,079	32.75	2
3	Registered Nurses	5,342	5,424	156,924	28.93	3
4	Licensed Practical Nurses	18,289	20,297	528,378	26.03	4
5	CNAs & Orderlies	50,670	56,725	630,343	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,206	2,513	30,488	12.13	8
9	Activity Director	1,879	2,095	36,632	17.49	9
10	Activity Assistants	3,878	4,163	43,875	10.54	10
11	Social Service Workers	7,568	8,096	136,698	16.88	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,168	40,307	18.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,022	24,434	268,943	11.01	15
16	Dishwashers					16
17	Maintenance Workers	15,987	17,384	214,905	12.36	17
18	Housekeepers	20,113	22,394	244,373	10.91	18
19	Laundry	1,968	2,216	21,550	9.72	19
20	Administrator	1,924	2,080	89,414	42.99	20
21	Assistant Administrator	1,832	2,080	34,710	16.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,553	3,805	45,831	12.04	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	2,007	2,239	33,435	14.93	31
32	Other Health Care(specify)					32
33	Other(specify)	3,790	4,267	139,181	32.62	33
34	TOTAL (lines 1 - 33)	168,751	186,579	$ 2,850,277 *	$ 15.28	34

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

** See instructions.

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	$ 9,574	01-03	35
36	Medical Director	Monthly	16,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,606	10-03	39
40	Physical Therapy Consultant	Monthly	13,231	10a-03	40
41	Occupational Therapy Consultant	Monthly	7,418	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,560	11-03	44
45	Social Service Consultant	69	3,730	12-03	45
46	Other(specify)				46
47	Religious Services	Monthly	3,300	12-03	47
48					48
49	TOTAL (lines 35 - 48)	99	$ 64,419		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Claussen	Administrator	0	$ 89,414
Ari Lebowich	Asst. Admin.	0	34,710
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 124,124

B. Administrative - Other

Description	Amount
Staycare - Management Fees	$ 425,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 425,500

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 23,421
See Attached	Legal	16,186
Personnel Planners	Unemployment Consultant	555
Staycare Management	Reimbursement Consultant	25,911
KBC Computer Services, Ltd	Computer Service	5,859
Skidelsky & Associates	Real Estate Tax Appraisal	35,282
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 107,214

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,325
Unemployment Compensation Insurance	26,961
FICA Taxes	207,361
Employee Health Insurance	188,523
Employee Meals	7,565
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	163
401k	4,427
Union Pension Expense	28,563
Christmas Expense	2,062
TOTAL (agree to Schedule V, line 22, col.8)	$ 549,949

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	135
Health Care Worker Background Check	3,940
(Indicate # of checks performed 394)	
Patient Background Checks	
Licenses/Permits & Fees	10,383
Dues & Subscriptions	13,770
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,228

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,061
Allocated from Staycare	222
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,283

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. **ICLTC: $20,552**

(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. $ **5,278** 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. $ **351,173**
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. $ **7,565** 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% Ln 1**
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