		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 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: 05/08/1981

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: Mendel Schneider **Telephone Number:** (847)933-1274
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 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) See Accountant's report Attached
(Firm Name & Address) Mendel S Schneider C.P.A & Associates
4051 Old Orchard Rd
(Telephone) (847)933-1274 Fax # (847)933-1283

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: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	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	47,117	349		47,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,117	349		47,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.06%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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 Fiscal Year: 12/31

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	438,122	31,871	7,534	477,527		477,527	10,331	487,858			1
2	Food Purchase		282,017		282,017		282,017	(183)	281,834			2
3	Housekeeping	396,675	47,639	17,784	462,098		462,098		462,098			3
4	Laundry	11,521	5,106	8,470	25,097		25,097		25,097			4
5	Heat and Other Utilities			111,442	111,442		111,442	2,128	113,570			5
6	Maintenance	133,688		159,571	293,259		293,259	2,525	295,784			6
7	Other (specify):* Security Guard	236,279			236,279		236,279		236,279			7
8	TOTAL General Services	1,216,285	366,633	304,801	1,887,719		1,887,719	14,801	1,902,520			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,128,722	149,208	28,754	2,306,684		2,306,684		2,306,684			10
10a	Therapy											10a
11	Activities	110,000	1,564		111,564		111,564		111,564			11
12	Social Services	159,141			159,141		159,141		159,141			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,397,863	150,772	43,754	2,592,389		2,592,389		2,592,389			16
	C. General Administration											
17	Administrative	107,203		427,500	534,703		534,703	(332,624)	202,079			17
18	Directors Fees											18
19	Professional Services			115,981	115,981		115,981	(91,998)	23,983			19
20	Dues, Fees, Subscriptions & Promotions			35,916	35,916		35,916	(3,165)	32,751			20
21	Clerical & General Office Expenses	87,823	71,646	139,734	299,203		299,203	210,673	509,876			21
22	Employee Benefits & Payroll Taxes			643,521	643,521		643,521		643,521			22
23	Inservice Training & Education											23
24	Travel and Seminar			374	374		374	170	544			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			224,700	224,700		224,700	4,785	229,485			26
27	Other (specify):* Allocated Benifets							93,347	93,347			27
28	TOTAL General Administration	195,026	71,646	1,587,726	1,854,398		1,854,398	(118,812)	1,735,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,809,174	589,051	1,936,281	6,334,506		6,334,506	(104,011)	6,230,495			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: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			117,265	117,265		117,265	78,672	195,937			30
31	Amortization of Pre-Op. & Org.							8,575	8,575			31
32	Interest			8,951	8,951		8,951	109,586	118,537			32
33	Real Estate Taxes			184,816	184,816		184,816	6,581	191,397			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles							12,226	12,226			35
36	Other (specify):*											36
37	TOTAL Ownership			611,032	611,032		611,032	(84,360)	526,672			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			367,175	367,175		367,175		367,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			367,175	367,175		367,175		367,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,809,174	589,051	2,914,488	7,312,713		7,312,713	(188,371)	7,124,342			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: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,167)	30		9
10	Interest and Other Investment Income	(7,252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	2		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	(3,240)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,473)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,315)		$	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)	(161,056)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (161,056)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (188,371)		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: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	0	0	10,331	0	0	0	0	0	0	0	0	10,331	1
2	Food Purchase	(183)	0	0	0	0	0	0	0	0	0	0	(183)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,128	0	0	0	0	0	0	0	0	2,128	5
6	Maintenance	0	0	2,525	0	0	0	0	0	0	0	0	2,525	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(183)	0	14,984	0	0	0	0	0	0	0	0	14,801	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(332,624)	0	0	0	0	0	0	0	0	(332,624)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(93,319)	1,321	0	0	0	0	0	0	0	(91,998)	19
20	Fees, Subscriptions & Promotions	(3,240)	75	0	0	0	0	0	0	0	0	0	(3,165)	20
21	Clerical & General Office Expenses	(11,473)	0	221,919	227	0	0	0	0	0	0	0	210,673	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	170	0	0	0	0	0	0	0	0	170	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,463	1,322	0	0	0	0	0	0	0	4,785	26
27	Other (specify):*	0	0	93,347	0	0	0	0	0	0	0	0	93,347	27
28	**TOTAL General Administration**	(14,713)	75	(107,044)	2,870	0	0	0	0	0	0	0	(118,812)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,896)	75	(92,060)	2,870	0	0	0	0	0	0	0	(104,011)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Nursing Home # 0026294 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(5,167)	83,839	0	0	0	0	0	0	0	0	0	78,672	30
31	Amortization of Pre-Op. & Org.	0	8,575	0	0	0	0	0	0	0	0	0	8,575	31
32	Interest	(7,252)	116,718	0	120	0	0	0	0	0	0	0	109,586	32
33	Real Estate Taxes	0	0	0	6,581	0	0	0	0	0	0	0	6,581	33
34	Rent-Facility & Grounds	0	(300,000)	26,275	(26,275)	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	12,226	0	0	0	0	0	0	0	0	12,226	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(12,419)	(90,868)	38,501	(19,574)	0	0	0	0	0	0	0	(84,360)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(27,315)	(90,793)	(53,559)	(16,704)	0	0	0	0	0	0	0	(188,371)	45

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jeffrey webster	50	Arbour Health Care Center, LTD	Chicago	Zikanim Partnership	Chicago	Bldg Rental
Howard Wengrow	50	Atrium Health Care Center, LTD	Chicago	Double You Realty	Lincolnwood	Bldg Company
		Abbington Rehan & Nursing, LTD	Roselle	Staycare Management	Lincolnwood	Mgmt
		Hickory Nursing Pavilion,Inc	Hickory Hills			

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	$ 300,000	Zikanim Building Partnership	100.00%	$	$ (300,000)	1
2	V	32	Interest		Zikanim Building Partnership		116,718	116,718	2
3	V	31	Amortization		Zikanim Building Partnership		8,575	8,575	3
4	V	20	License		Zikanim Building Partnership		75	75	4
5	V	30	Depreciation		Zikanim Building Partnership		83,839	83,839	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			$ 300,000			$ 209,207	$ * (90,793)	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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	STAYCARE MANAGEMENT	100.00%	$ 2,128	$ 2,128	15
16	V	6	Repairs & Maintenance		STAYCARE MANAGEMENT	100.00%	2,525	2,525	16
17	V	17	Admin Salary-H Wengrow		STAYCARE MANAGEMENT	100.00%	45,478	45,478	17
18	V	17	Admin Salary-J Webster		STAYCARE MANAGEMENT	100.00%	49,398	49,398	18
19	V	19	Professional Fees		STAYCARE MANAGEMENT	100.00%	646	646	19
20	V	21	Clerical Salaries		STAYCARE MANAGEMENT	100.00%	262,942	262,942	20
21	V	21	Office Supplies		STAYCARE MANAGEMENT	100.00%	16,575	16,575	21
22	V	26	Insurance		STAYCARE MANAGEMENT	100.00%	3,463	3,463	22
23	V	27	Health Insurance		STAYCARE MANAGEMENT	100.00%	56,697	56,697	23
24	V	1	Dietary Salary-S Webster		STAYCARE MANAGEMENT	100.00%	2,603	2,603	24
25	V	1	Dietary Salary-D Wengrow		STAYCARE MANAGEMENT	100.00%	7,728	7,728	25
26	V	24	Seminars		STAYCARE MANAGEMENT	100.00%	170	170	26
27	V	34	Rent		STAYCARE MANAGEMENT	100.00%	26,275	26,275	27
28	V	27	Payroll taxes		STAYCARE MANAGEMENT	100.00%	23,367	23,367	28
29	V	27	Employee Benifets		STAYCARE MANAGEMENT	100.00%	13,283	13,283	29
30	V	35	Equipment Rental -Auto		STAYCARE MANAGEMENT	100.00%	12,226	12,226	30
31	V								31
32	V	17	Management Fees	427,500	STAYCARE MANAGEMENT	100.00%		(427,500)	32
33	V	19	Administrative Consultant	93,965	STAYCARE MANAGEMENT	100.00%		(93,965)	33
34	V	21	Admissions Director	24,795	STAYCARE MANAGEMENT	100.00%		(24,795)	34
35	V	21	Reimbursement Consultant	32,803	STAYCARE MANAGEMENT	100.00%		(32,803)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 579,063			$ 525,504	$ * (53,559)	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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	DOUBLE YOU REALTY	100.00%	$ 1,321	$ 1,321	15
16	V	26	Insurance		DOUBLE YOU REALTY	100.00%	1,322	1,322	16
17	V	30	Depreciation		DOUBLE YOU REALTY	100.00%	0		17
18	V	32	Interest Expense		DOUBLE YOU REALTY	100.00%	120	120	18
19	V	33	Real Estate Taxes		DOUBLE YOU REALTY	100.00%	6,581	6,581	19
20	V	21	Office Supplies		DOUBLE YOU REALTY	100.00%	227	227	20
21	V								21
22	V	34	Rent	26,275	DOUBLE YOU REALTY	100.00%		(26,275)	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			$ 26,275			$ 9,571	$ * (16,704)	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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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	Administartive	50.00	142,363	8	20.00	Alloc Salary	$ 49,398	17-07	1
2	Howard Wengrow	Owner	Administartive	50.00	131,067	8	20.00	Alloc Salary	45,478	17-07	2
3	Sara Webster	Relative	Dietary		7,501	8	20.00	Alloc Salary	2,603	01-07	3
4	Deborah Wengrow	Relative	Dietary		22,272	8	20.00	Alloc Salary	7,728	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 105,207		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: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: STAYCARE MANAGEMENT
Street Address: 3737 W ARTHUR AVE
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	Number of Beds	559	5	$ 8,261	$	144	$ 2,128	1
2	6	Repairs & Maintenance	Number of Beds	559	5	9,800		144	2,525	2
3	17	Admin Salary-H Wengrow	Number of Beds	559	5	176,545	176,545	144	45,478	3
4	17	Admin Salary-J Webster	Number of Beds	559	5	191,761	191,761	144	49,398	4
5	19	Professional Fees	Number of Beds	559	5	2,509		144	646	5
6	21	Clerical Salaries	Number of Beds	559	5	1,020,725	1,020,725	144	262,942	6
7	21	Office Supplies	Number of Beds	559	5	64,344		144	16,575	7
8	26	Insurance	Number of Beds	559	5	13,444		144	3,463	8
9	27	Health Insurance	Number of Beds	559	5	220,093		144	56,697	9
10	1	Dietary Salary-S Webster	Number of Beds	559	5	10,104	10,104	144	2,603	10
11	1	Dietary Salary-D Wengrow	Number of Beds	559	5	30,000	30,000	144	7,728	11
12	24	Seminars	Number of Beds	559	5	660		144	170	12
13	34	Rent	Number of Beds	559	5	102,000		144	26,275	13
14	27	Payroll taxes	Number of Beds	559	5	90,708		144	23,367	14
15	27	Employee Benifets	Number of Beds	559	5	51,563		144	13,283	15
16	35	Equipment Rental -Auto	Number of Beds	559	5	47,460		144	12,226	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,039,977	$ 1,429,135		$ 525,504	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Double You Realty
Street Address: 3737 W Arthur
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	19	Professional Fees	Number of Beds	559	5	$ 5,127	$	144	$ 1,321	1
2	26	Insurance	Number of Beds	559	5	5,130		144	1,322	2
3	30	Depreciation	Number of Beds	559	5					3
4	32	Interest Expense	Number of Beds	559	5	465		144	120	4
5	33	Real Estate Taxes	Number of Beds	559	5	25,547		144	6,581	5
6	21	Office Supplies	Number of Beds	559	5	881		144	227	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					$ 37,150	$		$ 9,571	25

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Fifth Third Bank		X	Mortgage			$	$ 2,362,597			$ 116,718	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Fifth Third Bank		X								8,951	6
7	Allocated from Double You Realty										120	7
8												8
9	TOTAL Facility Related						$	$ 2,362,597			$ 125,789	9
	B. Non-Facility Related*											
10	Interest Income										(7,252)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,252)	14
15	TOTALS (line 9+line14)						$	$ 2,362,597			$ 118,537	15

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

* 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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 184,344	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.)		$ 181,852	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,492)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 187,308	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 191,397	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	172,392	8
	2016	187,930	9
	2017	201,775	10
	2018	178,975	11
	2019	181,852	12

2020 Real Estate tax Accrual 181,852 x 1.03=187,308
Allocated from Double You Realty 6581

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

NOTES:

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

2019 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 Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-113-017-0000	Long Term Care Property	$ 147,925.75	$ 147,925.75
2.	14-08-113-018-0000	Long Term Care Property	$ 13,634.53	$ 13,634.53
3.	14-08-113-019-0000	Long Term Care Property	$ 10,271.65	$ 10,271.65
4.	14-08-113-020-0000	Long Term Care Property	$ 10,020.25	$ 10,020.25
5.	10-35-329-014-0000	Home Office Allocation	$ 25,547.37	$ 6,581.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 207,399.55	$ 188,433.18

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 42,875 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 8,575 4. Dates Incurred: 09/01/18

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		1981	$ 87,895	1
2	Allocated from Double You Realty LLC			9,781	2
3	TOTALS			$ 97,676	3

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	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	1,617	1,617	24,124	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			58,572	28
29	Various			1997	37,873		20			37,867	29
30	Various			1998	20,369		20			20,369	30
31	Various			1999	27,926		20			27,926	31
32	Various			2000	17,615		20	466	466	17,615	32
33	Various			2001	22,954		20	847	847	22,684	33
34	Various			2002	20,041		20			20,041	34
35	Various			2003	3,863		20	193	193	3,378	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2004	$ 15,301	$	20	$ 765	$ 765	$ 12,664	37
38	Various	2005	25,109		20	1,260	1,260	24,485	38
39	Various	2006	36,422		20	1,821	1,821	32,818	39
40	Various	2007	105,232		20	5,829	5,829	96,471	40
41	Various	2008	51,323		20			51,323	41
42	Various	2009	130,246		20			130,246	42
43	Various	2010	24,165		20	1,560	1,560	19,382	43
44	Various	2011	6,379		20			6,379	44
45	Various	2012	13,928		20	1,000	1,000	11,488	45
46	Various	2013	68,744		20	5,563	5,563	45,645	46
47	Various	2014	133,616		20	6,681	6,681	43,412	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	Related Building Company (Page 12C&12D)			83,839			(83,839)		66
67	Related Party Alllocation (Page12E)								67
68	Financial Statement Depreciation			117,265			(117,265)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,162,266	$ 201,104		$ 27,602	$ (173,502)	$ 1,983,970	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: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,162,266	$ 201,104		$ 27,602	$ (173,502)	$ 1,983,970	1
2	Install Sprinkler Heads South Stairwell, Bathroom & 2nd Floor	2015	6,350		20	318	318	1,880	2
3	New Elevator Submercible Pump & Motor	2015	6,752		20	338	338	1,942	3
4	Movfr Door Operator	2015	5,528		20	276	276	1,496	4
5	Door Screen And Operator Board	2015	3,182		20	159	159	822	5
6	Heat Work	2015	7,832		20	392	392	2,350	6
7	Replace Drain Pipe	2015	6,200		20	310	310	1,576	7
8	Floor in Rear Corridor	2015	6,093		20	305	305	1,575	8
9	Install New Traps & Cut pipes in Tunnel	2015	3,300		20	165	165	990	9
10	2nd Floor East A/C Unit Install	2015	8,160		20	408	408	2,278	10
11	Elevator Motor	2016	5,450		20	273	273	1,250	11
12	Elevator Car Sill	2016	3,300		20	165	165	743	12
13	Bumper Guards & End Caps	2016	7,370		20	369	369	1,721	13
14	Furnish & Install Back Double Doors	2016	3,850		20	193	193	883	14
15	Freezer Compressor	2017	2,583		20	129	129	502	15
16	Water Heater	2017	8,993		20	450	450	1,387	16
17	Commercial Water Heater	2018	14,893		20	124	124	372	17
18	Fabrication,Paint, Install Baseboard for resident rooms	2019	9,875		20	494	494	988	18
19	2 steel Doors for Patio	2019	5,790		20	290	290	580	19
20	60 LB Rigid Mount Washer	2019	9,786		20	489	489	978	20
21	Relocate Start,Furnish and install scissor grate on freight elevator	2019	4,149		20	207	207	414	21
22	Install 49 surveilance cameras, conduits, crimps,jacks, and patch pa	2019	9,060		20	453	453	906	22
23	install pump,motor, and parts for boiler	2020	3,168		20	158	158	158	23
24	new cubicle curtains and tracks for resident rooms	2020	3,233		20	162	162	162	24
25	install cameras, back boxes, switches throughout nursing home	2020	20,047		20	1,002	1,002	1,002	25
26	and parking lot								26
27	install carport in parking lot	2020	4,990		20	250	250	250	27
28	Install new Sprinkler Panel and converted chimes to speakers	2020	8,075		20	404	404	404	28
29	New condensing Unit, refrigerant and parts for walk in cooler	2020	5,099		20	255	255	255	29
30	New commercial water heater	2020	16,093		20	805	805	805	30
31	Elevator Project: relocate start,install new gate and track	2020	9,681		20	484	484	484	31
32	replacement of 4th floor east ac system	2020	4,042		20	202	202	202	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,375,190	$ 201,104		$ 37,631	$ (163,473)	$ 2,013,325	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: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,375,190	$ 201,104		$ 37,631	$ (163,473)	$ 2,013,325	1
2	Building Company								2
3									3
4	Leasehold Improvements:								4
5	East elavor Canopy Erection, Demolition,Steel Work-	2017	1,324,940		20	66,247	66,247	264,988	5
6	Window Replacements, Concrete Removal/Infill& Strip	2017							6
7	Frontage,Steelwork,Rebuild South Elevation	2017							7
8	Drawings & Rendition for Exterior Frame	2017	24,322		20	1,216	1,216	4,864	8
9	Structural Report/Drawings/Detail/Permits	2017							9
10	Furnish/Install 18 Temp Heaters,Lobby Insulation-	2017	208,260		20	10,413	10,413	41,652	10
11	Baseboard Heater/Gas Line Install/ Scaffolding Tarp	2017							11
12	Patio Installation,Roofing, Roof Silver Coating	2017							12
13	Piping in Dining Area	2017	12,200		20	610	610	2,440	13
14	E, corner guardsconocare-Handrail, end caps	2017	10,605		20	530	530	2,120	14
15	Open Masonry walls to expose damage sewer pipes	2017	28,856		20	1,443	1,443	5,772	15
16	Pipes in 18 rooms	2017	39,305		20	1,965	1,965	7,861	16
17	Upgrade electrical service to 1600 amp	2017	7,295		20	365	365	1,460	17
18	Relocate exiting pump, repair pump, install new booster pump	2017	12,000		20	600	600	2,400	18
19	for new 18 rooms(2-4 fl) and rest of bldg	2017							19
20	Electrical- install conduit and junction boxes for	2017	9,000		20	450	450	1,800	20
21	emergency call & nurse call in 18 rms	2017							21
22	install 2 wood lintels & frame support for front entrance	2017	2,650		20	133	133	531	22
23	install steel piping on 3 tiers, radiators and steam returns 18 rm	2017	120,300		20	6,015	6,015	24,060	23
24	shorting of 18 sprinkler pipes	2017	6,380		20	319	319	1,276	24
25	Rising Development- Install 39 cable boxes in 18 rms	2017	7,339		20	367	367	1,468	25
26	Roof Permit	2017	525		20	26	26	105	26
27	Tee Jay-Sliding door	2017	6,505		20	325	325	1,301	27
28	Replacement of 3rd Fl AC System	2017	8,420		20	421	421	4,684	28
29	36 Exit signs	2017	13,860		20	693	693	2,772	29
30	Frontage and Door Entry metal panel	2018	5,450		20	273	273	819	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,223,402	$ 201,104		$ 130,042	$ (71,062)	$ 2,385,698	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: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,223,402	$ 201,104		$ 130,042	$ (71,062)	$ 2,385,698	1
2	Exterior Frame Walls for 18 Rooms, Permits, Plans & Drawings	2018	358,803		20	17,940	17,940	53,820	2
3	Repaired columns/beams,brick & limestone, weld certification	2018							3
4	39 Led lights, repaired toilet flanges, steam risers,electrical work	2018							4
5	repaired drains, fixtures/showers/lavs/toilets/faucets/wall reframing	2018							5
6	installed wiring for nurse call stations	2018	7,800		20	390	390	1,170	6
7	Install VCT, wall base, ceramic tile in resident rooms & baths	2018	195,425		20	9,771	9,771	29,313	7
8	Carpentry, painting, drywall, repaired ceilings,bathroom doors,clos	2018							8
9	Installed wood blinds, entry lights, cubicle tracks	2018							9
10	Work done on 3 Crown Steam Boilers	2018	4,300		20	215	215	645	10
11	Installed boiler parts/observation glass/gaskets	2018	7,710		20	386	386	1,158	11
12	Elevator-Installed one new tank unit	2018	8,940		20	447	447	1,341	12
13	Furnished & installed 5 new doors	2018	3,420		20	171	171	513	13
14	Installed 60 feet of custom baseboard covers	2018	5,410		20	270	270	810	14
15	Replaced ceiling grid/tile in lobby, bathroom, and by elevator	2018	17,570		20	879	879	2,637	15
16	4th Floor lighting, outlets, wall board, flooring/base,paint/door/fran	2018	9,985		20	499	499	1,497	16
17	North corridor- flooring tiles, doors,frames,drywall & ceiling	2018	10,700		20	535	535	1,605	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,853,465	$ 201,104		$ 161,545	$ (39,559)	$ 2,480,207	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: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,853,465	$ 201,104		$ 161,545	$ (39,559)	$ 2,480,207	1
2	Related Party								2
3	Buildings:								3
4	Allocated from Double You Realty LLC	2003	93,490		35	2,397	2,397	43,051	4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Allocated from Staycare management	2016	5,086		20	254	254	1,186	9
10	Allocated from Staycare Management	2003	4,331		20	217	217	3,803	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)		$ 4,956,372	$ 201,104		$ 164,413	$ (36,691)	$ 2,528,247	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: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 292,913	$	$ 29,291	$ 29,291	10	$ 273,709	71
72	Current Year Purchases	22,334		2,233	2,233	10	2,233	72
73	Fully Depreciated Assets	421,702					421,702	73
74								74
75	TOTALS	$ 736,949	$	$ 31,524	$ 31,524		$ 697,644	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 Management		$ 6,620	$	$	$		$ 6,620	76
77										77
78										78
79										79
80	TOTALS			$ 6,620	$	$	$		$ 6,620	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,797,617	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,104	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 195,937	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,167)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,232,511	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 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	Allocated from Staycare Mgmt		$	$ 12,226	17
18					18
19					19
20					20
21	TOTAL		$	$ 12,226	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: 01/01/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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):									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: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,317,539	$ 1,456,737	1
2	Cash-Patient Deposits	45,993	45,993	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	565,621	565,621	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,873	60,873	6
7	Other Prepaid Expenses	144,982	144,982	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,135,008	$ 2,274,206	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	1,190,426	3,585,267	15
16	Equipment, at Historical Cost	685,227	685,227	16
17	Accumulated Depreciation (book methods)	(1,645,791)	(3,938,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		42,875	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(20,509)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 229,862	$ 2,405,961	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,364,870	$ 4,680,167	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 246,370	$ 246,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,993	45,993	28
29	Short-Term Notes Payable	687,262	687,262	29
30	Accrued Salaries Payable	269,123	269,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	514	514	31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,308	187,308	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Partnership	330,922		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,767,492	$ 1,436,570	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,362,597	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,362,597	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,767,492	$ 3,799,167	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 597,378	$ 881,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,364,870	$ 4,680,167	48

***(See instructions.)**

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 487,167	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 487,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,211	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)**	$ 110,211	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)**	$ 597,378	24 *

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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,980,214	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,980,214	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***	7,252	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,252	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	435,458	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 435,458	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,422,924	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,887,719	31
32	Health Care	2,592,389	32
33	General Administration	1,854,398	33
	B. Capital Expense		
34	Ownership	611,032	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	367,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,312,713	40
41	**Income before Income Taxes (line 30 minus line 40)****	110,211	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 110,211	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,909,149	44
45	Private Pay - Net Inpatient Revenue	71,065	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)	$ 6,980,214	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No, Cash Basi **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: 01/01/2020 Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,299	2,435	$ 103,892	$ 42.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,982	7,398	241,760	32.68	3
4	Licensed Practical Nurses	23,175	25,973	763,843	29.41	4
5	CNAs & Orderlies	51,364	58,446	938,448	16.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,531	1,827	36,194	19.81	8
9	Activity Director	1,861	2,141	41,334	19.31	9
10	Activity Assistants	4,046	4,501	68,666	15.26	10
11	Social Service Workers	7,403	8,214	159,141	19.37	11
12	Dietician					12
13	Food Service Supervisor	1,879	2,175	44,295	20.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,622	25,543	393,827	15.42	15
16	Dishwashers					16
17	Maintenance Workers	6,062	6,772	133,688	19.74	17
18	Housekeepers	22,135	24,894	396,676	15.93	18
19	Laundry	689	945	11,521	12.19	19
20	Administrator	1,944	2,168	107,203	49.45	20
21	Assistant Administrator					21
22	Other Administrative	4,169	4,785	87,823	18.35	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,725	2,347	44,584	19.00	31
32	Other Health Care(specify)					32
33	Other(specify) Security	13,782	15,507	236,279	15.24	33
34	TOTAL (lines 1 - 33)	173,668	196,071	$ 3,809,174 *	$ 19.43	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	$ 7,534	1-3	35
36	Medical Director	Monthly	15,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,520	10-3	39
40	Physical Therapy Consultant	300	14,975	10-3	40
41	Occupational Therapy Consultant	25	1,259	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	325	$ 51,288		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

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Claussen	Administrative	0	$ 107,203
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,203

B. Administrative - Other

Description	Amount
Staycare Management	$ 427,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 427,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 10,000
Personnel Planners	Ui Tax Consultant	1,050
Staycare management	Other Professional fees	93,965
Cukeirski & Cochram	Accounting	1,036
Ohagon Meyer	Legal	5,812
2401 Incorporated	Architecture	2,130
Much Shelist	Legal	1,988
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 115,981

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,261
Unemployment Compensation Insurance	13,380
FICA Taxes	292,276
Employee Health Insurance	197,648
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	3,596
Union Pension	44,360
TOTAL (agree to Schedule V, line 22, col.8)	$ 643,521

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	3,937
Advertising	3,240
Dues & Subs	25,632
Misc Licenses	1,117
Sec of State	75
Less: Public Relations Expense	( )
Non-allowable advertising	(3,240)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,751

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illinois Council	374
Allocated from Staycare	170
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 544

**See instructions.

Facility Name & ID Number All American Nursing Home # 0026294 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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. **Health Care Counsil 25,632**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,856** 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.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **367,175**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **No**
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **No**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.