

Facility Name & ID Number All American Nursing Home

0026294 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,042	0		48,042	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,042			48,042	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.40%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/08/1981

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	303,634	48,473	9,197	361,304		361,304	12,328	373,632		1
2	Food Purchase		226,250		226,250	(7,212)	219,038	(0)	219,038		2
3	Housekeeping	216,419	44,889		261,308		261,308		261,308		3
4	Laundry	38,688	17,233		55,921		55,921		55,921		4
5	Heat and Other Utilities			167,079	167,079		167,079	(2,596)	164,483		5
6	Maintenance	194,520	57,162	86,764	338,446		338,446	(28,282)	310,164		6
7	Other (specify):*							2,094	2,094		7
8	TOTAL General Services	753,261	394,007	263,040	1,410,308	(7,212)	1,403,096	(16,456)	1,386,640		8
	B. Health Care and Programs										
9	Medical Director			15,184	15,184		15,184		15,184		9
10	Nursing and Medical Records	1,695,428	47,513	10,214	1,753,155		1,753,155		1,753,155		10
10a	Therapy	27,765		6,566	34,331		34,331		34,331		10a
11	Activities	73,198	2,764	1,320	77,282		77,282		77,282		11
12	Social Services	136,619		7,530	144,149		144,149		144,149		12
13	CNA Training										13
14	Program Transportation			1,159	1,159		1,159		1,159		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,933,010	50,277	41,973	2,025,260		2,025,260		2,025,260		16
	C. General Administration										
17	Administrative	118,820		403,900	522,720		522,720	(303,795)	218,925		17
18	Directors Fees										18
19	Professional Services			71,408	71,408	(2,970)	68,438	6,131	74,569		19
20	Dues, Fees, Subscriptions & Promotions			33,699	33,699		33,699	(9,121)	24,578		20
21	Clerical & General Office Expenses	60,826	43,918	39,095	143,839		143,839	67,754	211,593		21
22	Employee Benefits & Payroll Taxes			548,287	548,287	7,212	555,499		555,499		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,208	1,208		1,208	203	1,411		24
25	Other Admin. Staff Transportation			1,939	1,939		1,939	4,738	6,677		25
26	Insurance-Prop.Liab.Malpractice			143,197	143,197		143,197	2,693	145,890		26
27	Other (specify):*							58,507	58,507		27
28	TOTAL General Administration	179,646	43,918	1,242,733	1,466,297	4,242	1,470,539	(172,890)	1,297,649		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,865,917	488,202	1,547,746	4,901,865	(2,970)	4,898,895	(189,346)	4,709,549		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:

01/01/15

Ending:

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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					9	10	
	D. Ownership											
30	Depreciation			95,311	95,311		95,311	8,176	103,487			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,394	3,394		3,394	(2,778)	616			32
33	Real Estate Taxes			171,855	171,855	2,970	174,825	5,401	180,226			33
34	Rent-Facility & Grounds			612,000	612,000		612,000	(612,000)				34
35	Rent-Equipment & Vehicles			7,651	7,651		7,651	7,787	15,438			35
36	Other (specify):*											36
37	TOTAL Ownership			890,211	890,211	2,970	893,181	(593,415)	299,766			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			371,391	371,391		371,391		371,391			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			371,391	371,391		371,391		371,391			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,865,917	488,202	2,809,348	6,163,467		6,163,467	(782,761)	5,380,706			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,424)	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	5,049	30		9
10	Interest and Other Investment Income	(4,857)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(0)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143)	21		24
25	Fund Raising, Advertising and Promotional	(501)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,733)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,536)	20		28
29	Other-Attach Schedule	(56,662)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (72,807)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(709,954)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (709,954)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (782,761)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

All American Nursing Home

ID# 0026294

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (300)	21	1
2	Building Co. - Accounting Fees	(1,250)	19	2
3	Building Co. - ILL. RT	(9,750)	21	3
4	Building Co. - Annual Report	(250)	20	4
5	Capitalized R&M	(35,835)	06	5
6	Collections	(1,734)	21	6
7	PAC Dues	(5,132)	20	7
8	Non-Allowable Legal Fees	(2,411)	19	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	(56,662)		49

All American Nursing Home

Report Period Beginning: ID# 0026294
 Ending: 01/01/15
 12/31/15

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:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				12,328								12,328	1
2	Food Purchase	(0)											(0)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,424)		1,828									(2,596)	5
6	Maintenance	(35,835)		1,863	5,690								(28,282)	6
7	Other (specify):*				2,094								2,094	7
8	TOTAL General Services	(40,259)		3,691	20,112								(16,456)	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			(371,130)	67,335								(303,795)	17
18	Directors Fees													18
19	Professional Services	(3,661)	1,250	8,209		333							6,131	19
20	Fees, Subscriptions & Promotions	(9,419)	250	48									(9,121)	20
21	Clerical & General Office Expenses	(19,660)	9,750	77,664									67,754	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			203									203	24
25	Other Admin. Staff Transportation			4,738									4,738	25
26	Insurance-Prop.Liab.Malpractice			2,190		503							2,693	26
27	Other (specify):*			53,888	4,619								58,507	27
28	TOTAL General Administration	(32,740)	11,250	(224,190)	71,954	835							(172,890)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,999)	11,250	(220,499)	92,066	835							(189,346)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Nursing Home# 0026294

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	5,049		497		2,630							8,176	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,857)				2,079							(2,778)	32
33	Real Estate Taxes					5,401							5,401	33
34	Rent-Facility & Grounds		(612,000)	15,841		(15,841)							(612,000)	34
35	Rent-Equipment & Vehicles			7,787									7,787	35
36	Other (specify):*													36
37	TOTAL Ownership	192	(612,000)	24,125		(5,732)							(593,415)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(72,807)	(600,750)	(196,374)	92,066	(4,896)							(782,761)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 612,000	Zikainim Building Partnership	100.00%	\$	\$ (612,000)	1
2	V	19 Accounting Fees		Zikainim Building Partnership	100.00%	1,250	1,250	2
3	V	21 ILL. RT		Zikainim Building Partnership	100.00%	9,750	9,750	3
4	V	20 Annual Report		Zikainim Building Partnership	100.00%	250	250	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		\$ 612,000			\$ 11,250	\$ * (600,750)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,828	\$ 1,828
16	V	6 REPAIRS AND MAINT.				1,863	1,863
17	V	17 ADMIN. SALARY				32,770	32,770
18	V	19 PROFESSIONAL FEES				8,209	8,209
19	V	20 DUES, SUBSCRIPTIONS				48	48
20	V	21 CLERICAL & GENERAL				77,664	77,664
21	V	24 SEMINARS				203	203
22	V	25 ADMIN. STAFF TRAVEL				4,738	4,738
23	V	26 INSURANCE				2,190	2,190
24	V	27 EMPLOYEE BENEFITS				53,888	53,888
25	V	30 DEPRECIATION				497	497
26	V	32 INTEREST EXPENSE					
27	V	34 BUILDING RENT				15,841	15,841
28	V	35 EQUIPMENT RENTAL				7,787	7,787
29	V						
30	V	17 MANAGEMENT FEES	403,900	STAYCARE MANAGEMENT, LTD.			(403,900)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 403,900			\$ 207,526	\$ * (196,374)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 3,106	\$	3,106	15
16	V	1 DIET. COMP - D. WENGROW				9,222		9,222	16
17	V	6 MAINT. COMP.				5,690		5,690	17
18	V	7 EMP. BEN. - S. WEBSTER				425		425	18
19	V	7 EMP. BEN. - D. WENGROW				955		955	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				714		714	20
21	V	17 ADMIN. COMP - H. WENGROW				53,431		53,431	21
22	V	17 ADMIN. COMP - J. WEBSTER				13,904		13,904	22
23	V	27 EMP. BEN. - H. WENGROW				3,727		3,727	23
24	V	27 EMP. BEN. - J. WEBSTER				892		892	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		\$			\$ 92,066	\$ *	92,066	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$		100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		333	333	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		503	503	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,630	2,630	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,079	2,079	19
20	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC				20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		5,401	5,401	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	15,841	DOUBLE YOU REALTY, LLC			(15,841)	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		\$ 15,841			\$ 10,945	\$ * (4,896)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

All American Nursing Home

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0026294

Report Period Beginning:

01/01/15

Ending:

12/31/15

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Jeffrey Webster	Owner	Administrative	50.00%	See Attached	5	7.14%	Alloc. Salary	\$ 13,904	17-07	1	
2	Howard Wengrow	Owner	Administrative	50.00%	See Attached	20	30.77%	Alloc. Salary	53,431	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	8.59	21.48%	Alloc. Salary	13,902	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	\$ 93,565		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:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	223,823	6	\$ 8,516	\$ 48,042	\$ 1,828	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	223,823	6	8,680	48,042	1,863	2	
3	17	ADMIN. SALARY	PATIENT DAYS	223,823	6	152,674	152,674	48,042	32,770	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	38,246	48,042	8,209	4	
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	223,823	6	222	48,042	48	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	223,823	6	361,830	307,546	48,042	77,664	6
7	24	SEMINARS	PATIENT DAYS	223,823	6	945	48,042	203	7	
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	223,823	6	22,074	48,042	4,738	8	
9	26	INSURANCE	PATIENT DAYS	223,823	6	10,203	48,042	2,190	9	
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	223,823	6	251,057	48,042	53,888	10	
11	30	DEPRECIATION	PATIENT DAYS	223,823	6	2,315	48,042	497	11	
12	32	INTEREST	PATIENT DAYS	223,823	6		48,042		12	
13	34	BUILDING RENT	PATIENT DAYS	223,823	6	73,800	48,042	15,841	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	223,823	6	36,278	48,042	7,787	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 966,840	\$ 460,220	\$ 207,526	25	

Facility Name & ID Number All American Nursing Home

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	2	3,106	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	2	9,222	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	9	5,690	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,381		2	425	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	3,107		2	955	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,328		9	714	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	173,652	173,652	20	53,431	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	194,652	194,652	5	13,904	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,114		20	3,727	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,481		5	892	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					\$ 467,329	\$ 434,918		\$ 92,066	25

Facility Name & ID Number All American Nursing Home

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Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	1,550	48,042	333	2
3	26	INSURANCE	PATIENT DAYS	223,823	6	2,342	48,042	503	3
4	30	DEPRECIATION	PATIENT DAYS	223,823	6	12,254	48,042	2,630	4
5	32	INTEREST EXPENSE	PATIENT DAYS	223,823	6	9,684	48,042	2,079	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	223,823	6		48,042		6
7	33	REAL ESTATE TAXES	PATIENT DAYS	223,823	6	25,161	48,042	5,401	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				\$	50,991	\$	10,945	25

Facility Name & ID Number All American Nursing Home

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

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Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

All American Nursing Home

0026294

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Allocated from Double You Realty		X	Mortgage			\$	\$			\$	2,079							
2																			
3																			
4																			
5																			
	Working Capital																		
6	MB Financial		X	Line of Credit								3,394							
7																			
8																			
9	TOTAL Facility Related						\$	\$			\$	5,473							
	B. Non-Facility Related*																		
10	Interest Income		X									(4,858)							
11																			
12																			
13																			
14	TOTAL Non-Facility Related						\$	\$			\$	(4,858)							
15	TOTALS (line 9+line14)						\$	\$			\$	615							

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:

01/01/15

Ending:

12/31/15

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**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
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:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>18,750</u>	<u>1981</u>	<u>\$ 87,895</u>	<u>1</u>
2	<u>Allocatd from Double You</u>		<u>2003</u>	<u>10,732</u>	<u>2</u>
3	TOTALS	18,750		\$ 98,627	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	144		1969	\$ 514,131	\$		\$	\$	\$ 514,131	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1968	2,650		20			2,650	9
10	Various		1972	5,248		20			5,248	10
11	Various		1974	6,075		20			6,075	11
12	Various		1975	22,572		20			22,572	12
13	Various		1978	24,379		20			24,379	13
14	Various		1979	217,961		20			217,961	14
15	Various		1980	41,050		20			41,050	15
16	Various		1981	9,192		20			9,192	16
17	Various		1985	30,550		20			30,550	17
18	Various		1986	49,476		20			49,476	18
19	Various		1987	32,346		20	95	95	20,640	19
20	Various		1988	11,000		20			11,000	20
21	Various		1989	60,399		20			60,399	21
22	Various		1990	10,050		20			10,050	22
23	Various		1991	38,074		20			38,074	23
24	Various		1992	22,062		20			22,062	24
25	Various		1993	15,250		20			15,250	25
26	Various		1994	42,293		20			42,293	26
27	Various		1995	185,841		20	4,817	4,817	183,532	27
28	Various		1996	60,561		20	3,028	3,028	57,618	28
29	Various		1997	37,873		20	1,894	1,894	35,182	29
30	Various		1998	20,369		20	1,018	1,018	18,005	30
31	Various		1999	27,926		20	1,396	1,396	23,044	31
32	Various		2000	17,615		20	881	881	13,626	32
33	Various		2001	22,954		20	847	847	18,450	33
34	Various		2002	20,041		20			20,041	34
35	Various		2003	3,863		20	193	193	2,413	35
36	Various		2004	15,301		20	765	765	8,839	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2005	\$ 25,109	\$	20	\$ 1,587	\$ 1,587	\$ 20,495	37
38 Various	2006	36,422		20	2,646	2,646	25,829	38
39 Various	2007	105,232		20	7,103	7,103	65,841	39
40 Various	2008	51,323		20	4,862	4,862	36,636	40
41 Various	2009	130,246		20	12,885	12,885	85,731	41
42 Various	2010	24,165		20	1,813	1,813	11,583	42
43 Various	2011	6,379		20	1,276	1,276	5,954	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 <u>Related Building Company (Pages 12F & 12G)</u>								67
68 <u>Related Party Allocations (Pages 12H & 12I)</u>		107,337	2,630		2,868	238	37,070	68
69 <u>Financial Statement Depreciation</u>			95,312			(95,312)		69
70 TOTAL (lines 4 thru 69)		\$ 2,053,315	\$ 97,942		\$ 49,975	\$ (47,967)	\$ 1,812,940	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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,053,315	\$ 97,942		\$ 49,975	\$ (47,967)	\$ 1,812,940	1
2	Water Heater	2012	7,369		20	614	614	2,405	2
3	Countertop And Built In Cabinetry	2012	2,700		20	540	540	1,755	3
4	Sprinkler System In Elevators	2012	3,859		20	386	386	1,383	4
5	New Transfer Switch	2013	6,500		20	650	650	1,842	5
6	Rooftop Heat Exchanger/Compressor	2013	15,950		20	1,595	1,595	4,120	6
7	Wrought Iron Fence	2013	14,300		20	953	953	2,224	7
8	Walk-In Cooler	2013	6,218		20	1,244	1,244	3,316	8
9	Parking Lot Surfacing	2013	14,500		20	967	967	2,256	9
10	A/C Improvements And Parts	2013	8,404		20	840	840	2,101	10
11	Re-Hung And Adjust Elevator Door	2013	2,872		20	144	144	311	11
12	Cylinder	2014	11,722		20	586	586	1,026	12
13	Replace Elevator Hydraulic Cylinder Repair	2014	24,500		20	1,225	1,225	1,940	13
14	Passenger 1 Elevator Hydraulic Cylinder Repair	2014	4,089		20	204	204	375	14
15	Lobby & Corridors-Remove & Install Wallcovering	2014	17,397		20	870	870	1,595	15
16	Doors, Unicombo Closer Reinforcement, Power Adjust Aluminum	2014	2,722		20	136	136	238	16
17	Install Fire Pump Annunciator	2014	2,679		20	134	134	223	17
18	Repair & Replace Burner Controls For Steam Boilers	2014	4,357		20	218	218	345	18
19	Replace Pipe In Crawlspace, Trench Tunnel & Replace Drain	2014	19,700		20	985	985	1,560	19
20	Piping - Replace 5 Risers	2014	4,200		20	210	210	315	20
21	Piping - Run 5 Risers, 1-Inch Copper Lines, 2 Inch Return Line	2014	6,000		20	300	300	400	21
22	Furnish & Install Pump For Steam Boilers	2014	6,900		20	345	345	403	22
23	Piping East Side / North Side Of Building	2014	25,100		20	1,255	1,255	1,360	23
24	Open Wall And Replace Piping	2014	4,250		20	213	213	213	24
25	Install Sprinkler Heads South Stairwell, Bathroom & 2Nd Fl Line	2015	6,350		20	291	291	291	25
26	New Elevator Submercible Pump & Motor	2015	6,752		20	253	253	253	26
27	Movfr Door Operator	2015	5,528		20	115	115	115	27
28	Door Screen And Operator Board	2015	3,182		20	27	27	27	28
29	Heat Work	2015	7,832		20	392	392	392	29
30	Replacing Drain Pipe	2015	6,200		20	310	310	310	30
31	Flooring In Rear Corridor	2015	6,093		20	305	305	305	31
32	Installed New Traps And Cut Pipes In Tunel	2015	3,300		20	165	165	165	32
33	2Nd Floor East Ac Unit Install	2015	8,160		20	408	408	408	33
34	TOTAL (lines 1 thru 33)		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	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)	\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,323,000	\$ 97,942		\$ 66,853	\$ (31,088)	\$ 1,846,908	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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.

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, LLC	2003	102,585	2,630	20	2,630		34,086	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Stavcare Management	2003	4,752		20	238	238	2,984	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)		\$ 107,337	\$ 2,630		\$ 2,868	\$ 238	\$ 37,070	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 107,337	\$ 2,630		\$ 2,868	\$ 238	\$ 37,070	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)	\$ 107,337	\$ 2,630		\$ 2,868	\$ 238	\$ 37,070	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:

01/01/15

Ending:

12/31/15

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	\$ 212,875	\$	\$ 25,758	\$ 25,758	10	\$ 126,941	71
72	Current Year Purchases	66,516		9,941	9,941	10	9,941	72
73	Fully Depreciated Assets	384,597				10	384,597	73
74								74
75	TOTALS	\$ 663,988	\$	\$ 35,699	\$ 35,699		\$ 521,479	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare	2012	\$ 7,264	\$ 497	\$ 935	\$ 438	5	\$ 3,835	76
77										77
78										78
79										79
80	TOTALS			\$ 7,264	\$ 497	\$ 935	\$ 438		\$ 3,835	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)	\$ 3,092,879	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,439	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,487	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,049	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,372,223	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	RX350 2014 Lexus	\$ 637.61	\$ 7,651	17
18	Allocated from Staycare			7,787	18
19					19
20					20
21	TOTAL		\$ 637.61	\$ 15,438	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>									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: 01/01/15

Ending:

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 911,449	\$ 935,225	1
2	Cash-Patient Deposits	25,890	25,890	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	816,857	816,857	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	170,160	170,160	6
7	Other Prepaid Expenses	3,980	3,980	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,841	1,841	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,930,177	\$ 1,953,953	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	980,782	980,782	15
16	Equipment, at Historical Cost	624,055	624,055	16
17	Accumulated Depreciation (book methods)	(1,339,644)	(3,252,894)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 265,193	\$ 403,943	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,195,370	\$ 2,357,896	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 361,051	\$ 361,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,890	25,890	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,921	210,921	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,705	1,705	31
32	Accrued Real Estate Taxes(Sch.IX-B)	174,296	174,296	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	2,926	2,926	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 776,789	\$ 776,789	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)	\$ 1,035,427	\$ 776,789	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,159,943	\$ 1,581,107	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,195,370	\$ 2,357,896	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 822,877	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 822,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	553,067	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	(216,000)	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)	\$ 337,067	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)	\$ 1,159,943	24 *

* This must agree with page 17, line 47.

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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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,710,539	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,710,539	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	838	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)	\$ 838	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,857	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,857	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	300	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,716,534	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,410,308	31
32	Health Care	2,025,260	32
33	General Administration	1,466,297	33
B. Capital Expense			
34	Ownership	890,211	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	371,391	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,163,467	40
41	Income before Income Taxes (line 30 minus line 40)**	553,067	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 553,067	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 6,710,539	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)	\$ 6,710,539	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.

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,672	2,839	\$ 109,959	\$ 38.73	1
2	Assistant Director of Nursing	1,264	1,493	48,844	32.72	2
3	Registered Nurses	4,965	5,202	151,712	29.16	3
4	Licensed Practical Nurses	19,186	21,755	552,524	25.40	4
5	CNAs & Orderlies	54,003	60,692	653,283	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,018	2,343	27,765	11.85	8
9	Activity Director	1,801	2,019	32,827	16.26	9
10	Activity Assistants	3,846	4,049	40,371	9.97	10
11	Social Service Workers	7,528	8,228	136,619	16.60	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,112	40,692	19.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,571	24,638	262,942	10.67	15
16	Dishwashers					16
17	Maintenance Workers	14,884	15,909	194,520	12.23	17
18	Housekeepers	18,241	19,973	216,419	10.84	18
19	Laundry	3,230	3,930	38,688	9.84	19
20	Administrator	1,872	2,068	87,007	42.07	20
21	Assistant Administrator	1,859	2,076	31,813	15.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,339	5,677	60,826	10.71	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	1,828	2,107	31,452	14.93	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,826	4,293	147,654	34.39	33
34	TOTAL (lines 1 - 33)	172,887	191,403	\$ 2,865,917 *	\$ 14.97	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 9,197	01-03	35
36	Medical Director	Monthly	15,184	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,214	10-03	39
40	Physical Therapy Consultant	Monthly	3,790	10a-03	40
41	Occupational Therapy Consultant	Monthly	2,684	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	92	10a-03	43
44	Activity Consultant	25	1,320	11-03	44
45	Social Service Consultant	78	4,230	12-03	45
46	Other(specify)				46
47	<u>Religious Services</u>	Monthly	3,300	3-Dec	47
48					48
49	TOTAL (lines 35 - 48)	104	\$ 50,011		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Claussen	Administrator	0	\$ 87,007	Workers' Compensation Insurance	\$ 82,571	IDPH License Fee	\$	
Ari Lebowich	Assist. Administrator	0	31,813	Unemployment Compensation Insurance	33,010	Advertising: Employee Recruitment	86	
				FICA Taxes	210,889	Health Care Worker Background Check	5,710	
				Employee Health Insurance	188,763	(Indicate # of checks performed <u>571</u>)		
				Employee Meals	7,212	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licences/Permits & Fees	8,314	
				Employee Benefits	373	Dues and Subscriptions	10,420	
				Union Pensions Expense	27,895	Dues, Subscriptions Alloc from Staycare	48	
				401K	4,154			
				Christmas Expense	633			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,820	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 555,499		\$ 24,578		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Staycare - Management Fees			\$ 403,900				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 403,900				Seminar Expense	1,208
							Allocated from Staycare	203
C. Professional Services								
Vendor/Payee	Type	Amount						
Staycare Management	Admissions Consulting	\$ 23,476						
FR&R/Marcum LLP	Accounting	26,665						
See Attached	Legal Fees	5,515						
Personnel Planners	Unemployment Consulting	1,265						
MDI Achieve	Computer Services	3,331						
KBC Computer Services	Computer Services	5,826						
First Real Estate Services, Ltd.	Real Estate Appraisal	2,750						
2401 Incorporated	Architectural Services	2,580						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 71,408	TOTAL			Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL \$ 1,411	

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$15,552
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,161 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. \$ 371,391
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. \$ 7,212 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.