		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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.

I. IDPH License ID Number: 0057430

Facility Name: All American Vlge Nrsg Rhb

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: 07/01/2022

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mendel S 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 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed) See Accountant's Report Attached (Date)
(Print Name and Title)
(Firm Name & Address) Mendel S Schneider & Associates CPA PC, 4051 Old Orchard Rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	17,520	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 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	4,738		1,724		397	1,254	121	8,234	8
9	SNF/PED									9
10	ICF		41,825						41,825	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,738	41,825	1,724		397	1,254	121	50,059	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 95.24%

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

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

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

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

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 07/01/22

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/22 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 48

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	608,789	46,345	10,116	665,250		665,250		665,250			1
2	Food Purchase		441,492		441,492		441,492	(374)	441,118			2
3	Housekeeping	415,315	78,279	46,550	540,144		540,144		540,144			3
4	Laundry	61,596	11,528		73,124		73,124		73,124			4
5	Heat and Other Utilities			137,155	137,155		137,155	3,293	140,448			5
6	Maintenance	182,565		101,849	284,414		284,414	5,611	290,025			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,268,265	577,644	295,670	2,141,579		2,141,579	8,530	2,150,109			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	4,248,731	114,378	26,038	4,389,147		4,389,147		4,389,147			10
10a	Therapy											10a
11	Activities	125,848	2,520		128,368		128,368		128,368			11
12	Social Services	194,891	83,796	19,371	298,058		298,058		298,058			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,569,470	200,694	63,409	4,833,573		4,833,573		4,833,573			16
	C. General Administration											
17	Administrative	147,820		566,110	713,930		713,930	(566,110)	147,820			17
18	Directors Fees											18
19	Professional Services			92,280	92,280		92,280	117,075	209,355			19
20	Dues, Fees, Subscriptions & Promotions			107,339	107,339		107,339	(17,037)	90,302			20
21	Clerical & General Office Expenses	792,196	102,862	155,688	1,050,746		1,050,746	100,562	1,151,308			21
22	Employee Benefits & Payroll Taxes			881,450	881,450		881,450		881,450			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,097	2,097		2,097		2,097			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			542,393	542,393		542,393	944	543,337			26
27	Other (specify):* **Allocated Benefits**							25,263	25,263			27
28	**TOTAL General Administration**	940,016	102,862	2,347,357	3,390,235		3,390,235	(339,303)	3,050,932			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,777,751	881,200	2,706,436	10,365,387		10,365,387	(330,773)	10,034,614			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 Vlge Nrsg Rhb #0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			50,337	50,337		50,337	571,476	621,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							565,566	565,566			32
33	Real Estate Taxes			181,999	181,999		181,999		181,999			33
34	Rent-Facility & Grounds			720,907	720,907		720,907	(717,477)	3,430			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bad Debt**			215,521	215,521		215,521	(215,521)				36
37	**TOTAL Ownership**			1,168,764	1,168,764		1,168,764	204,044	1,372,808			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,210	339,428	441,638		441,638		441,638			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			909,388	909,388		909,388		909,388			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		102,210	1,248,816	1,351,026		1,351,026		1,351,026			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,777,751	983,410	5,124,016	12,885,177		12,885,177	(126,729)	12,758,448			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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	565,088	30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(374)	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	(4,539)	21		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	(215,521)	36		24
25	Fund Raising, Advertising and Promotional	(8,684)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,000)	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)**	$ 326,923		$	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)	(445,299)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (445,299)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (118,376)		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 Vlge Nrsg Rhb

ID# 0057430

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (8,353)	20	1
2	Other Expenses Related to Lobbying Activities			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**	(8,353)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(374)	0	0	0	0	0	0	0	0	0	0	(374)	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	3,293	0	0	0	0	0	0	0	0	3,293	5
6	Maintenance	0	0	5,611	0	0	0	0	0	0	0	0	5,611	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(374)	0	8,904	0	0	0	0	0	0	0	0	8,530	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	(566,110)	0	0	0	0	0	0	0	0	(566,110)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	117,075	0	0	0	0	0	0	0	0	117,075	19
20	Fees, Subscriptions & Promotions	(17,037)	0	0	0	0	0	0	0	0	0	0	(17,037)	20
21	Clerical & General Office Expenses	(13,539)	53	114,048	0	0	0	0	0	0	0	0	100,562	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	0	0	0	0	0	0	0	0	0	0	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	944	0	0	0	0	0	0	0	0	944	26
27	Other (specify):*	0	0	25,263	0	0	0	0	0	0	0	0	25,263	27
28	**TOTAL General Administration**	(30,576)	53	(308,780)	0	0	0	0	0	0	0	0	(339,303)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,950)	53	(299,876)	0	0	0	0	0	0	0	0	(330,773)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	565,088	6,388	0	0	0	0	0	0	0	0	0	571,476	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47)	565,613	0	0	0	0	0	0	0	0	0	565,566	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(720,907)	3,430	0	0	0	0	0	0	0	0	(717,477)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(215,521)	0	0	0	0	0	0	0	0	0	0	(215,521)	36
37	TOTAL Ownership	349,520	(148,906)	3,430	0	0	0	0	0	0	0	0	204,044	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)	318,570	(148,853)	(296,446)	0	0	0	0	0	0	0	0	(126,729)	45

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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	$ 720,907	All American Village Property LLC	100.00%	$	$ (720,907)	1
2	V	32	Interest		All American Village Property LLC		565,613	565,613	2
3	V	30	Depreciation		All American Village Property LLC		6,388	6,388	3
4	V	21	Office		All American Village Property LLC		53	53	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			$ 720,907			$ 572,054	$ * (148,853)	14

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

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	17	Management Fees	$ 566,110	Jade Financial Services		$	$ (566,110)	15
16	V	21	Office		Jade Financial Services		31,801	31,801	16
17	V	19	Professional Fees		Jade Financial Services		117,075	117,075	17
18	V	5	Utilities		Jade Financial Services		3,293	3,293	18
19	V	6	Repairs & Maintenance		Jade Financial Services		5,611	5,611	19
20	V	34	Rent		Jade Financial Services		3,430	3,430	20
21	V	21	Clerical Wages		Jade Financial Services		82,247	82,247	21
22	V	27	Allocated Benefits		Jade Financial Services		25,263	25,263	22
23	V	26	Insurance		Jade Financial Services		944	944	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			$ 566,110			$ 269,664	$ * (296,446)	39

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

STATE OF ILLINOIS **Ownership Listing-1**

All American Vlge Nrsg Rhb

ID# 0057430

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Jake	0	Mashiach	Chicago	Il	20.00000			1
2	Yechiel	0	Mashiach	Lincolnwood	Il	20.00000			2
3	Rhonda	0	Mashiach	Lincolnwood	Il	20.00000			3
4	Rita	0	Lipshitz	Skokie	Il	20.00000			4
5	Atied Associates, LLC	0	0	0	0	0.00000			5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000			6
7	Benificiaries	0	0	0	0	0.00000			7
8	Rebecca	0	Rudolph	Evanston	Il	0.23077			8
9	Michael	0	Rudolph	Evanston	Il	0.23077			9
10	Zahava	0	Vales	Evanston	Il	0.23077			10
11	Raban	0	Vales	Evanston	Il	0.23077			11
12	Natan	0	Vales	Deerfield	Il	0.23077			12
13	Amidei	0	Vales	Deerfield	Il	0.23077			13
14	Cary	0	Silvers	Evanston	Il	0.23077			14
15	Jonathan	0	Silvers	Highland Park	Il	0.23077			15
16	Jacob	0	Silvers	Highland Park	Il	0.23077			16
17	Noam	0	Rothner	Teaneck	NJ	0.23077			17
18	Yonit	0	Rothner	Teaneck	NJ	0.23077			18
19	Hanna	0	Levine	Skokie	Il	0.23077			19
20	Nathan	0	Levine	Evanston	IL	0.23077			20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000			21
22	Benificiaries	0	0	0	0	0.00000			22
23	Melisa	0	Rothner	Skokie	Il	0.75000			23
24	Daniel	0	Rothner	Teaneck	NJ	0.75000			24
25	William	0	Rothner	Skokie	Il	0.75000			25
26	Rachel	0	Rothner	Beachwood	OH	0.75000			26
27	0	0	0	0	0	0.00000			27
28	Daniel Rothner Accumu	0	0	0	0	0.00000			28
29	Benificiaries	0	0	0	0	0.00000			29
30	Daniel	0	Rothner	Teaneck	NJ	1.00000			30
31	William RothnerAccumu	0	0	0	0	0.00000			31
32	Benificiaries	0	0	0	0	0.00000			32
33	William	0	Rothenr	Skokie	IL	1.00000			33
34	Mellisa Rothner Accumu	0	0	0	0	0.00000			34
35	Benificiaries	0	0	0	0	0.00000			35
36	Mellisa	0	Rothner	Skokie	IL	1.00000			36
37	Rachel Rothner Accumu	0	0	0	0	0.00000			37
38	Rachel	0	Rothner	Beachwood	OH	1.00000			38
39	Adam Vales Accumulati	0	0	0	0	0.00000			39
40	Adam	0	Vales	Deerfield	Il	1.00000			40
41	Kathryn Vales Accumul	0	0	0	0	0.00000			41
42	kathryn	0	Vales	Highland park	Il	1.00000			42
43	Kimberly Vales Accumu	0	0	0	0	0.00000			43
44	Kimberly	0	Vales	Highland Park	Il	1.00000			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									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

All American Vlge Nrsg Rhb

ID# **0057430**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76	Melisa	0	Rothner	Skokie	Il	1.00000			76
77	Daniel	0	Rothner	Teaneck	NJ	1.00000			77
78	William	0	Rothner	Skokie	Il	1.00000			78
79	Rachel	0	Rothner	Beachwood	OH	1.00000			79
80	Adam	0	Vales	Deerfield	Il	1.00000			80
81	Kathryn	0	Silvers	Highland Park	Il	1.00000			81
82	Kimberly	0	Rudolph	Highland Park	Il	1.00000			82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
96									96
97									97
98									98
99									99
100									100
101									101
102									102
103									103
104									104
105									105
106									106
107									107
108									108
109									109
110									110
111									111
112									112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125									125
126									126
127									127
128									128
129									129
130									130
131									131
132									132
133									133
134									134
135									135
136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CE	Joliet	Jade Financial Svc	Skokie, ILL	Mgmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis	All Amer. Vil Prop	Chicago	Bldg Rental	2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION (	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATIO	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION C	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITA	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER LI	Tucson				8
9	ELMWOOD NURSING & REHABILITATION	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER I	Crestwood	DEVON GABLES REHABILITATION CENTE	Tucson				10
11	KENSINGTON NURSING AND REHABILITA	Chicago	ST. JAMES WELLNESS REHAB & VILLAS L	Crete				11
12	ABBINGTON VILLAGE NURSING AND REH	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILI	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHAB	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	westwood Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION C	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION C	Rushville	RUSHVILLE NURSING REHABILITATION (	Rushville				20
21	NEIGHBORS REHABILITATION CENTER LI	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER L	Champaign	PARK VILLA NURSING & REHABILITATIO	Palos Heights				22
23	Sheridan Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REH	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Wheaton Village & Nursing Center	Wheaton	UNIVERSITY REHABILITATION CENTER C	Urbana				25
26			PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27			BURBANK REHABILITATION CENTER LLC	Burbank				27
28			COUNTRYSIDE NURSING & REHABILITAT	Dolton				28
29								29
30								30

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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: Jade Financial services LLC
Street Address: 8707 Skokie Blvd
City / State / Zip Code: Skokie, ILL 60077
Phone Number: (847-213-1060
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office	Number of Beds	1,231	10	$ 271,852	$	144	$ 31,801	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		144	117,075	2
3	5	Utilities	Number of Beds	1,231	10	28,149		144	3,293	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		144	5,611	4
5	34	Rent	Number of Beds	1,231	10	29,319		144	3,430	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	144	82,247	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		144	25,263	7
8	26	Insurance	Number of Beds	1,231	10	8,068		144	944	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					$ 2,305,240	$ 703,094		$ 269,664	25

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	Old National Bank		X	Mortgage			$	$ 7,434,397			$ 565,613	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,434,397			$ 565,613	9
	B. Non-Facility Related*											
10	Interest Income		X								(47)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (47)	14
15	TOTALS (line 9+line14)						$	$ 7,434,397			$ 565,566	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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	412,643	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.)	$	283,163	2
3. Under or (over) accrual (line 2 minus line 1).	$	(129,480)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$	311,479	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.	$	181,999	7

Assessed Value from Real Estate Tax Bill:	2024	1,303,503	8
Real Estate Tax Bill for Calendar Year:	2020	201,628	9
	2021	321,012	10
	2022	296,277	11
	2023	392,994	12
	2024	283,163	13

Line 4: 283163 x 1.10

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME All American Vlge Nrsg Rhb COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0057430

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

TELEPHONE 847-933-1274 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-113-017-0000	LTC Property	$ 250,315.55	$ 250,315.55
2.	14-08-113-018-0000	LTC Property	$ 15,440.17	$ 15,440.17
3.	14-08-113-019-0000	LTC Property	$ 8,874.99	$ 8,874.99
4.	14-08-113-020-0000	LTC Property	$ 8,531.99	$ 8,531.99
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 283,162.70	$ 283,162.70

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 [ ] (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 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).

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

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

K. 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	Facility		2022	$ 253,983	1
2					2
3	TOTALS			$ 253,983	3

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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		2022	1969	$ 5,218,507	$	10	$ 521,851	$ 521,851	$ 1,826,478	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install A/C			2022	12,000		10	1,200	1,200	4,000	9
10	Furnish & Install New Gal Track on Elevator			2022	4,850		10	485	485	1,576	10
11	Install 100 Amp Shunt Trip Breaker,Fire Alarm Smoke Detector			2022	8,440		10	844	844	2,602	11
12	Other Repairs			2023	13,140		10	1,314	1,314	3,618	12
13	Replace Bad Pull Station by 4th Floor West Fire Doors			2024	3,353		10	335	335	670	13
14	Weld Freight Elevator Pit Access Ladder			2024	2,650		10	265	265	530	14
15	Repaired Leaking Hot Water Heater & Steam Water Pipe			2024	5,420		10	542	542	1,084	15
16	Pressure Tested & Cleared Out Office on Circuit 2,Cleared			2024	5,645		10	565	565	1,130	16
17	Coils, Replaced Pully on Main										17
18	Replace Broken Stop Switch in Elevator Car			2024	6,150		10	615	615	1,230	18
19	Dining Room HVAC Motor Replacement			2025	3,258		15	217	217	217	19
20	Replace Hot Water Heater			2025	10,755		15	717	717	717	20
21	Repair Groundfault L1M518			2025	6,570		15	438	438	438	21
22	Replace Leaking Section 4 Inch Main Sprinkler System			2025	5,140		15	343	343	343	22
23	Replace 10 Painted Fire Sprinkler Heads			2025	3,980		15	265	265	265	23
24	Replace Leaking Jockey Pump Release Valve			2025	5,980		15	399	399	399	24
25	Replace 40 Inches Corroded Main in Closet			2025	5,180		15	345	345	345	25
26	Capatalize Repair on Freight Elevator			2025	3,089		15	206	206	206	26
27	Replace Blower Motor & Bracket 3rd Floor Furnace			2025	3,208		15	214	214	214	27
28	Capataize Repair-No A/C in Lobby			2025	3,062		15	204	204	204	28
29	Repair Main RTU Lockout HVAC			2025	5,645		15	376	376	376	29
30	Replace Leaking Pump Motor Steam Boiler			2025	10,104		15	674	674	674	30
31	Replace Injector Pump in Laundry			2025	6,450		15	430	430	430	31
32	Replace Cylinder,Stopswitch,Door Clutch in Elevator 1			2025	120,000		15	8,000	8,000	8,000	32
33	Install 2 New Grease Traps in Kitchen			2025	7,600		15	507	507	507	33
34	Replace Piping in Hot Water Supply			2025	9,207		15	614	614	614	34
35	Install New Door in Smoking Area			2025	5,395		15	360	360	360	35
36	Replace Boiler 1 Gas Valve			2025	11,265		15	751	751	751	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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	Sand & Wax Floor,Apply Moldings Throughout 1st Floor	2025	$ 12,129	$	15	$ 809	$ 809	$ 809	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59	Financial Statement Depreciation			56,725			(56,725)		59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,518,172	$ 56,725		$ 543,885	$ 487,160	$ 1,858,787	70

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

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 578,632	$	$ 57,863	$ 57,863	10	$ 197,877	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 578,632	$	$ 57,863	$ 57,863		$ 197,877	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		23 Ford E450	2022	$ 140,453	$	$ 20,065	$ 20,065	7	$ 63,539	76
77										77
78										78
79										79
80	TOTALS			$ 140,453	$	$ 20,065	$ 20,065		$ 63,539	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)	$ 6,491,240	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 56,725	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 621,813	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 565,088	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,120,203	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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	Allocated from Jade				3,430			6
7	TOTAL				$ 3,430 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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 Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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.

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	39-3	hrs	$		$ 164,650	$		$ 164,650	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,386			26,386	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			148,392			148,392	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				19,212		19,212	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					82,998		82,998	12
13	Other (specify):									13
14	TOTAL			$		$ 339,428	$ 102,210		$ 441,638	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.

STATE OF ILLINOIS

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025 (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	$ 61,546	$ 61,546	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,136,830	2,136,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	893,035	893,035	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related	2,472,527	2,472,527	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,563,938	$ 5,563,938	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		253,983	13
14	Buildings, at Historical Cost		5,218,507	14
15	Leasehold Improvements, at Historical Cost	279,204	279,204	15
16	Equipment, at Historical Cost	163,968	705,799	16
17	Accumulated Depreciation (book methods)	(106,113)	(1,552,586)	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): Security Deposit	19,255	19,255	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 356,314	$ 4,924,162	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,920,252	$ 10,488,100	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,762,445	$ 1,762,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	500,581	500,581	28
29	Short-Term Notes Payable	70,629	70,629	29
30	Accrued Salaries Payable	183,365	183,365	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,737	13,737	31
32	Accrued Real Estate Taxes(Sch.IX-B)	311,479	311,479	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due Prior Owner	136,039	136,039	36
37	Due Others	314,756	314,756	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,293,031	$ 3,293,031	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,434,397	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)**	$	$ 7,434,397	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,293,031	$ 10,727,428	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,627,221	$ (239,328)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,920,252	$ 10,488,100	48

*(See instructions.)

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,066,018	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,066,018	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,561,203	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)**	$ 1,561,203	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)**	$ 2,627,221	24 *

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

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$ 14,446,333	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,446,333	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***	47	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,446,380	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,141,579	31
32	Health Care	4,833,573	32
33	General Administration	3,390,235	33
	B. Capital Expense		
34	Ownership	1,168,764	34
	C. Ancillary Expense		
35	Special Cost Centers	441,638	35
36	Provider Participation Fee	909,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,885,177	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,561,203	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,561,203	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,197,800.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	11,457,800.00	45
46	MMAI-Medicaid is the Primary Payer	437,173.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	78,600.00	48
49	Medicare Part A	946,775.00	49
50	Other-(specify) **Medicare-B**	217,475.00	50
51	Other-(specify) **Insurance**	110,710.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,446,333	56

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	2,016	2,145	$ 122,802	$ 57.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,393	8,341	431,149	51.69	3
4	Licensed Practical Nurses	28,357	30,781	1,398,493	45.43	4
5	CNAs & Orderlies	70,131	77,301	2,088,595	27.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,885	1,969	41,517	21.09	9
10	Activity Assistants	3,740	4,148	84,331	20.33	10
11	Social Service Workers	7,063	7,451	194,891	26.16	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,080	55,940	26.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,113	24,660	552,849	22.42	15
16	Dishwashers					16
17	Maintenance Workers	5,784	6,429	182,565	28.40	17
18	Housekeepers	18,465	20,350	415,315	20.41	18
19	Laundry	2,387	2,707	61,596	22.75	19
20	Administrator	1,968	2,055	147,820	71.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,888	9,485	473,257	49.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,993	2,113	40,131	18.99	31
32	Other Health C: MDS	3,431	3,487	167,561	48.05	32
33	Other(specify) Security	13,744	15,535	318,939	20.53	33
34	TOTAL (lines 1 - 33)	201,230	221,037	$ 6,777,751 *	$ 30.66	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	$ 10,116	1-3	35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,861	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	19,371	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 58,348		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	156	$ 9,387	10-3	50
51	Licensed Practical Nurses	105	5,790	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	261	$ 15,177		53

Facility Name & ID Number All American Vlge Nrsg Rhb # 0057430 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Orlando Arjona	Administrator	0	$ 26,141
Noggojupola Labiyi	Administrator	0	121,679
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 147,820

B. Administrative - Other

Description	Amount
Jade Financial-Mgmt Fees	$ 566,110
TOTAL (agree to Schedule V, line 17, col. 3)	$ 566,110
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider CPA	Accounting	$ 10,400
Much Shelist	Legal	840
Sher LLP	Legal	13,740
Legat	Architech	3,064
Elizabeth Nash	Reimb Cons	28,800
Guided Care	Case Mgmt	24,084
Goodnicki LLP	Legal	3,932
Stout	Appraisal	5,530
IWC	Legionnela	900
Personnel Planners	UC Tax Consultant	990
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 92,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,894
Unemployment Compensation Insurance	21,373
FICA Taxes	504,530
Employee Health Insurance	286,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 881,450

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	59,302
Health Care Worker Background Check	2,666
(Indicate # of checks performed)	
Patient Background Checks	275
Association Dues (total from pg 22, #4)	25,057
Netsmart	3,828
RADAR	2,500
Various	3,037
Less: Public Relations Expense	( )
PAC and Lobbying payments	(8,353)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 90,302

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Various	2,097
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,097

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	16,704
	16,704 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	8,353
	8,353 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	25,057
	25,057 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 18,232 Line 10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 909,388
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

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

(12) 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? 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?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(15) 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.