



Facility Name & ID Number Aperion Care Bridgeport

# 0052688 Report Period Beginning: 02/01/14 Ending: 12/31/14

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	33,066	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	33,066	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,648	3,971	3,460	22,079	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,648	3,971	3,460	22,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.77%

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)

N/A

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 02/01/2014

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

YES  Date 02/01/2014 NO

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

YES  NO  If YES, enter number of beds certified 56 and days of care provided 3,245

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

**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
	<b>A. General Services</b>										
1	Dietary	149,569	16,056	9,333	174,958		174,958	6,372	181,330		1
2	Food Purchase		144,641		144,641		144,641	(1,341)	143,300		2
3	Housekeeping	116,771	18,081		134,852		134,852		134,852		3
4	Laundry	35,676	8,218		43,894		43,894		43,894		4
5	Heat and Other Utilities			66,653	66,653		66,653	(4,840)	61,813		5
6	Maintenance	35,437	17,854	41,147	94,438		94,438	18,938	113,376		6
7	Other (specify):*							1,380	1,380		7
8	<b>TOTAL General Services</b>	<b>337,453</b>	<b>204,850</b>	<b>117,133</b>	<b>659,436</b>		<b>659,436</b>	<b>20,509</b>	<b>679,945</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,300	5,300		5,300		5,300		9
10	Nursing and Medical Records	1,090,883	105,499	17,303	1,213,685		1,213,685	8,833	1,222,518		10
10a	Therapy	2,368	1,621		3,989		3,989		3,989		10a
11	Activities	66,437	2,064	1,667	70,168		70,168		70,168		11
12	Social Services	57,061		804	57,865		57,865		57,865		12
13	CNA Training										13
14	Program Transportation							1,387	1,387		14
15	Other (specify):*							2,330	2,330		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,216,749</b>	<b>109,184</b>	<b>25,074</b>	<b>1,351,007</b>		<b>1,351,007</b>	<b>12,550</b>	<b>1,363,557</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	69,658		141,027	210,685		210,685	(107,539)	103,146		17
18	Directors Fees										18
19	Professional Services			170,133	170,133	(150)	169,983	(116,333)	53,650		19
20	Dues, Fees, Subscriptions & Promotions			30,239	30,239		30,239	(17,693)	12,546		20
21	Clerical & General Office Expenses	75,177		132,421	207,598		207,598	(64,247)	143,351		21
22	Employee Benefits & Payroll Taxes			296,227	296,227		296,227		296,227		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,860	3,860		3,860	944	4,804		24
25	Other Admin. Staff Transportation			13,550	13,550		13,550	(6,131)	7,419		25
26	Insurance-Prop.Liab.Malpractice			54,717	54,717		54,717	4,122	58,839		26
27	Other (specify):*							7,973	7,973		27
28	<b>TOTAL General Administration</b>	<b>144,835</b>		<b>842,174</b>	<b>987,009</b>	<b>(150)</b>	<b>986,859</b>	<b>(298,904)</b>	<b>687,955</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,699,037</b>	<b>314,034</b>	<b>984,381</b>	<b>2,997,452</b>	<b>(150)</b>	<b>2,997,302</b>	<b>(265,845)</b>	<b>2,731,457</b>		<b>29</b>

\*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 Aperion Care Bridgeport

#0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,949	2,949		2,949	77,402	80,351			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,015	20,015		20,015	139,483	159,498			32
33	Real Estate Taxes					150	150	22,410	22,560			33
34	Rent-Facility & Grounds			317,510	317,510		317,510	(316,151)	1,359			34
35	Rent-Equipment & Vehicles			10,628	10,628		10,628	3,042	13,670			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			351,102	351,102	150	351,252	(73,814)	277,438			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,850	506,625	519,475		519,475	(68,015)	451,460			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,877	165,877		165,877		165,877			42
43	Other (specify):*			47,160	47,160		47,160	(47,160)				43
44	<b>TOTAL Special Cost Centers</b>		12,850	719,662	732,512		732,512	(115,175)	617,337			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,699,037	326,884	2,055,145	4,081,066		4,081,066	(454,835)	3,626,231			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 Aperion Care Bridgeport

# 0052688

Report Period Beginning: 02/01/14

Ending: 12/31/14

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,081)	02		4
5	Telephone, TV & Radio in Resident Rooms	(5,180)	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	75,341	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(260)	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	(18,480)	21		18
19	Entertainment	(2,255)	21		19
20	Contributions	(18,296)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,526)	21		24
25	Fund Raising, Advertising and Promotional	(17,160)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,174)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (126,072)		\$	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)	(328,763)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (328,763)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (454,835)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Aperion Care Bridgeport

ID# 0052688

Report Period Beginning: 02/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Charges	\$ (4,900)	21	1
2	Miscellaneous Income	(27,488)	21	2
3	Building Co - Amortization	(11,071)	36	3
4	Building Co - Bank Charges	(21)	21	4
5	Building Co - Licenses	(250)	21	5
6	Non Allowable Legal	(1,566)	19	6
7	Non Allowable Professional Fees	(300)	19	7
8	PAC Dues	(749)	20	8
9	Additional R&M	17,540	06	9
10	Non Allowable Fees	(30,000)	43	10
11	Non Allowable Travel	(9,419)	25	11
12	Capitalized R&M	(4,950)	06	12
13	Non Allowable Rent	(5,000)	34	13
14	Building Co- Bookkeeping Fees	(6,000)	19	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	<b>Total</b>		(84,174)	49

Aperion Care Bridgeport

ID# 0052688

Report Period Beginning: 02/01/14

Ending: 12/31/14

Sch. V Line

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

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Bridgeport# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary					3,677	80	2,615					6,372	1
2	Food Purchase	(1,341)											(1,341)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,180)					151		189				(4,840)	5
6	Maintenance	12,590		1,827		1,513	1,305	1,477	226				18,938	6
7	Other (specify):*			120		754	258	248					1,380	7
8	<b>TOTAL General Services</b>	<b>6,069</b>		<b>1,947</b>		<b>5,944</b>	<b>1,794</b>	<b>4,340</b>	<b>415</b>				<b>20,509</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			1,583		5,792		1,458					8,833	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							1,387					1,387	14
15	Other (specify):*			118		1,540		672					2,330	15
16	<b>TOTAL Health Care and Programs</b>			<b>1,701</b>		<b>7,332</b>		<b>3,517</b>					<b>12,550</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(117,008)	1,078		4,703	3,688					(107,539)	17
18	Directors Fees													18
19	Professional Services	(7,866)	12,000	(42,824)	(29,504)	53	(43,453)	(1,765)	384		(3,358)		(116,333)	19
20	Fees, Subscriptions & Promotions	(19,045)		1,116	15	5	190	8	18				(17,693)	20
21	Clerical & General Office Expenses	(107,920)	271	12,142	14,944	647	11,126	4,062	481				(64,247)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			496	9	147	83	209					944	24
25	Other Admin. Staff Transportation	(9,419)		1,408	16	1,104	569	191					(6,131)	25
26	Insurance-Prop.Liab.Malpractice			372	3,119		590	41					4,122	26
27	Other (specify):*			2,370		76	4,977	550					7,973	27
28	<b>TOTAL General Administration</b>	<b>(144,250)</b>	<b>12,271</b>	<b>(141,928)</b>	<b>(10,323)</b>	<b>2,032</b>	<b>(21,215)</b>	<b>6,984</b>	<b>883</b>		<b>(3,358)</b>		<b>(298,904)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(138,181)</b>	<b>12,271</b>	<b>(138,280)</b>	<b>(10,323)</b>	<b>15,308</b>	<b>(19,421)</b>	<b>14,841</b>	<b>1,298</b>		<b>(3,358)</b>		<b>(265,845)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	75,341				7	489		1,565				77,402	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		137,983				224		1,276				139,483	32
33	Real Estate Taxes		21,161						1,249				22,410	33
34	Rent-Facility & Grounds	(5,000)	(301,400)	513			183		(10,447)				(316,151)	34
35	Rent-Equipment & Vehicles			1,251	80	400	393	736	182				3,042	35
36	Other (specify):*	(11,071)	11,071											36
37	<b>TOTAL Ownership</b>	<b>59,270</b>	<b>(131,185)</b>	<b>1,764</b>	<b>80</b>	<b>407</b>	<b>1,289</b>	<b>736</b>	<b>(6,175)</b>				<b>(73,814)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(68,015)			(68,015)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(47,160)											(47,160)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(47,160)</b>								<b>(68,015)</b>			<b>(115,175)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(126,072)	(118,914)	(136,516)	(10,243)	15,715	(18,132)	15,577	(4,877)	(68,015)	(3,358)		(454,835)	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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 301,400	900 East Corporation	100.00%	\$	\$ (301,400)	1
2	V	36 Amortization		900 East Corporation	100.00%	11,071	11,071	2
3	V	19 Bookkeeping Fees		900 East Corporation	100.00%	6,000	6,000	3
4	V	19 Home Office Expense		900 East Corporation	100.00%	6,000	6,000	4
5	V	33 Real Estate Tax		900 East Corporation	100.00%	21,161	21,161	5
6	V	21 Bank Charges		900 East Corporation	100.00%	21	21	6
7	V	21 Licenses		900 East Corporation	100.00%	250	250	7
8	V	32 Interest		900 East Corporation	100.00%	137,983	137,983	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 301,400			\$ 182,486	\$ * (118,914)	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	6 REPAIRS & MAINTENANCE		APERION CARE	100.00%	1,827	\$ 1,827 15
16	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	120	120 16
17	V	10 SALARY- NURSE		APERION CARE	100.00%	1,583	1,583 17
18	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	118	118 18
19	V	17 ADMINISTRATIVE		APERION CARE	100.00%	22,519	22,519 19
20	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	2,342	2,342 20
21	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,116	1,116 21
22	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	12,142	12,142 22
23	V	24 SEMINARS		APERION CARE	100.00%	496	496 23
24	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	1,408	1,408 24
25	V	26 INSURANCE		APERION CARE	100.00%	372	372 25
26	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	2,370	2,370 26
27	V	34 RENT		APERION CARE	100.00%	513	513 27
28	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	16	16 28
29	V	35 AUTO LEASE		APERION CARE	100.00%	1,235	1,235 29
30	V	17 MANAGEMENT FEE	139,527	APERION CARE	100.00%		(139,527) 30
31	V	19 HOME OFFICE	38,973	APERION CARE	100.00%		(38,973) 31
32	V	19 DATA PROCESSING	2,893	APERION CARE	100.00%		(2,893) 32
33	V	19 HOME OFFICE	3,300	APERION CARE	100.00%		(3,300) 33
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 184,693			\$ 48,177	\$ * (136,516) 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	17 ADMINISTRATIVE		APERION FINANCIAL	100.00%	1,078	\$ 1,078
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	438	438
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	15	15
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	14,944	14,944
19	V	24 SEMINARS		APERION FINANCIAL	100.00%	9	9
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	16	16
21	V	26 INSURANCE		APERION FINANCIAL	100.00%	3,119	3,119
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	80	80
23	V	19 HOME OFFICE EXPENSE	27,242	APERION FINANCIAL	100.00%		(27,242)
24	V	19 HOME OFFICE EXPENSE	2,700	APERION FINANCIAL	100.00%		(2,700)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 29,942			\$ 19,699	\$ * (10,243)

\* 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 DIETARY	\$	APERION CONSULTING	100.00%	\$ 3,677	\$ 3,677
16	V	5 UTILITIES		APERION CONSULTING	100.00%		
17	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	1,513	1,513
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	754	754
19	V	10 SALARY NURSE		APERION CONSULTING	100.00%	10,592	10,592
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	1,540	1,540
21	V	17 ADMINISTRATIVE		APERION CONSULTING	100.00%		
22	V	19 PROFESSIONAL FEES		APERION CONSULTING	100.00%	53	53
23	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	5	5
24	V	21 CLERICAL & GENERAL		APERION CONSULTING	100.00%	647	647
25	V	24 SEMINARS		APERION CONSULTING	100.00%	147	147
26	V	25 AUTO AND TRAVEL		APERION CONSULTING	100.00%	1,104	1,104
27	V	26 INSURANCE		APERION CONSULTING	100.00%		
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	76	76
29	V	30 DEPRECIATION		APERION CONSULTING	100.00%	7	7
30	V	35 AUTO LEASE		APERION CONSULTING	100.00%	400	400
31	V	10 CONSULTING	4,800	APERION CONSULTING	100.00%		(4,800)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,800			\$ 20,515	\$ * 15,715

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

Facility Name & ID Number Aperion Care Bridgeport# 0052688Report Period Beginning: 02/01/14Ending: 12/31/14

## 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	<u>1</u> <u>DIETARY</u>	\$	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	\$ <u>80</u>	\$	<u>80</u>	<u>15</u>
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>151</u>		<u>151</u>	<u>16</u>
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>1,305</u>		<u>1,305</u>	<u>17</u>
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>258</u>		<u>258</u>	<u>18</u>
19	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>4,703</u>		<u>4,703</u>	<u>19</u>
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>1,497</u>		<u>1,497</u>	<u>20</u>
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>190</u>		<u>190</u>	<u>21</u>
22	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>25,208</u>		<u>25,208</u>	<u>22</u>
23	V	<u>24</u> <u>SEMINARS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>83</u>		<u>83</u>	<u>23</u>
24	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>569</u>		<u>569</u>	<u>24</u>
25	V	<u>26</u> <u>INSURANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>590</u>		<u>590</u>	<u>25</u>
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>4,977</u>		<u>4,977</u>	<u>26</u>
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>489</u>		<u>489</u>	<u>27</u>
28	V	<u>32</u> <u>INTEREST</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>224</u>		<u>224</u>	<u>28</u>
29	V	<u>33</u> <u>REAL ESTATE TAX</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>				<u>29</u>
30	V	<u>34</u> <u>RENT</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>3,054</u>		<u>3,054</u>	<u>30</u>
31	V	<u>34</u> <u>PARKING RENTAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>129</u>		<u>129</u>	<u>31</u>
32	V	<u>35</u> <u>AUTO LEASE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>393</u>		<u>393</u>	<u>32</u>
33	V								<u>33</u>
34	V	<u>19</u> <u>ACCOUNTING</u>	<u>8,000</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(8,000)</u>	<u>34</u>
35	V	<u>19</u> <u>DATA PROCESSING</u>	<u>366</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(366)</u>	<u>35</u>
36	V	<u>19</u> <u>BOOKKEEPING</u>	<u>36,584</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(36,584)</u>	<u>36</u>
37	V	<u>21</u> <u>CORPORATE EVENTS</u>	<u>14,082</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(14,082)</u>	<u>37</u>
38	V	<u>34</u> <u>RENT</u>	<u>3,000</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(3,000)</u>	<u>38</u>
39	Total		\$ <u>62,032</u>			\$ <u>43,900</u>	\$ *	<u>(18,132)</u>	<u>39</u>

\* 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	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 2,615	\$	2,615	15
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM CONSULTING, LLC</u>	100.00%				16
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,477		1,477	17
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	248		248	18
19	V	<u>10</u> <u>NURSE SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	11,058		11,058	19
20	V	<u>15</u> <u>EMP. BEN.-NURSE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	672		672	20
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	5,188		5,188	21
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,535		1,535	22
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	8		8	23
24	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	4,062		4,062	24
25	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	209		209	25
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	191		191	26
27	V	<u>26</u> <u>INSURANCE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	41		41	27
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	550		550	28
29	V	<u>14</u> <u>NURSE TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,387		1,387	29
30	V	<u>32</u> <u>INTEREST</u>		<u>YAM CONSULTING, LLC</u>	100.00%				30
31	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	736		736	31
32	V	<u>10</u> <u>NURSE CONSULTING</u>	9,600	<u>YAM CONSULTING, LLC</u>	100.00%			(9,600)	32
33	V	<u>19</u> <u>DATA PROCESSING</u>	3,300	<u>YAM CONSULTING, LLC</u>	100.00%			(3,300)	33
34	V								34
35	V	<u>17</u> <u>ADMINISTRATIVE CONSULTANT</u>	1,500	<u>YAM CONSULTING, LLC</u>	100.00%			(1,500)	35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 14,400			\$ 29,977	\$ *	15,577	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	5 UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 189	\$	189	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	226		226	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	384		384	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	18		18	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	481		481	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,565		1,565	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,276		1,276	21
22	V	34 RENT		8131 N. MONTICELLO, LLC	100.00%	249		249	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	182		182	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,249		1,249	24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC	100.00%			(7,000)	26
27	V	34 RENT	3,696	8131 N. MONTICELLO, LLC	100.00%			(3,696)	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		\$ 10,696			\$ 5,819	\$ *	(4,877)	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	39 Therapy Services	\$ 400,086	Renewal Rehab	100.00%	\$ 332,071	\$ (68,015)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 400,086			\$ 332,071	\$ * (68,015)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 15,989	ProPay HR LLC	24.00%	\$ 12,631	\$ (3,358)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 15,989			\$ 12,631	\$ * (3,358)

\* 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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BM EQUITIES	51.00%	Aperion Care Amboy	Amboy	YAM MANAGEMENT (1/1/14-6/30/14)	SKOKIE	MANAGEMENT CO.	1
2	MORRIS ESFORMES	10.00%	Aperion Care Jacksonville	Jacksonville	YAM CONSULTING (1/1/14-6/30/14)	SKOKIE	CONSULTING CO.	2
3	DELECIA ESFORMES TRUST	10.00%	River Crossing Rehab	Galesburg	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING CO.	3
4	JACK AND MARY YOLINSKY	10.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	SYLVIA YOLINSKY TRUST	10.00%	Riverwood Rehab	East Moline	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	257 LTD PARTNERSHIP	2.00%	Aperion Care Forest Park	Forest Park	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	1219 LTD PARTNERSHIP	2.00%	Aperion Care Litchfield	Litchfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	42170 LTD PARTNERSHIP	2.00%	Aperion Care Springfield	Springfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	FREDRICK S. FRANKEL	1.50%	Aperion Care Evanston	Evanston	APERION ESTATES PERU	PERU, IN	ALF	9
10	STEVEN TUROFSKY	1.50%	Aperion Care Midlothian	Midlothian	APERION CARE COPPERAS HOLLOW	CALDWELL, TX	ALF	10
11			Aperion Care St. Elmo	St. Elmo	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	11
12			Aperion Care Chicago Heights	Chicago Heights	900 EAST CORPORATION	SKOKIE	BUILDING CO.	12
13			Aperion Care Dolton	Dolton				13
14			Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Arbors Michigan City	Michigan City, IN				20
21			Aperion Care Demotte	Demotte, IN				21
22			Aperion Care Kokomo	Kokomo, IN				22
23			Aperion Care Peru	Peru, IN				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Valparaiso	Valparaiso, IN				25
26			Aperion Care Copperas Hollow	Caldwell, TX				26
27								27
28								28
29								29
30								30

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 02/01/14 Ending: 12/31/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.1	2.75%	Alloc. Salary	\$ 5,420	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	2.50%	Alloc. Salary	861	17-7	2	
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.5	2.50%	Alloc. Salary	1,106	17-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	567	21-7	4	
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.1	2.75%	Alloc. Salary	1,040	21-7	5	
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.1	2.75%	Alloc. Salary	5,420	17-7	6	
7	Fredrick Frankel	Owner	Administrative	1.50%	See Attached	1.1	2.75%	Alloc. Salary	3,723	17-7	7	
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	1.1	2.75%	Alloc. Salary	4,070	17-7	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	\$ 22,207		13	

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization APERION CARE  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	67,680	59,564	11,655	1,827	1
2	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	431,728	30	4,451		11,655	120	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	11,655	1,583	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381		11,655	118	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	11,655	22,519	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759		11,655	2,342	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339		11,655	1,116	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	11,655	12,142	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383		11,655	496	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156		11,655	1,408	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783		11,655	372	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772		11,655	2,370	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000		11,655	513	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601		11,655	16	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731		11,655	1,235	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,587	\$ 1,312,845		\$ 48,177	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization APERION FINANCIAL  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	39,916	11,655	1,078	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	16,216	11,655	438	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	570	11,655	15	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	553,558	596,633	14,944	4
5	24	SEMINARS	ACTUAL CENSUS	431,728	30	342	11,655	9	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	585	11,655	16	6
7	26	INSURANCE	ACTUAL CENSUS	431,728	30	115,531	11,655	3,119	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	2,974	11,655	80	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				\$ 729,692	\$ 596,633		\$ 19,699	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization APERION CONSULTING  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	DIETARY	ACTUAL CENSUS	431,728	30	\$ 136,198	\$ 136,198	11,655	\$ 3,677	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30			11,655		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	11,655	1,513	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		11,655	754	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	11,655	10,592	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		11,655	1,540	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			11,655		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		11,655	53	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		11,655	5	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	11,655	647	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		11,655	147	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		11,655	1,104	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			11,655		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		11,655	76	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		11,655	7	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		11,655	400	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 759,903	\$ 603,946		\$ 20,515	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization YAM MANAGEMENT, LLC  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	DIETARY	ACTUAL CENSUS	375,486	26	\$ 2,866	\$ 2,866	10,424	\$ 80	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432	10,424	151		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	10,424	1,305	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302	10,424	258		4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	10,424	4,703	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925	10,424	1,497		6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855	10,424	190		7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	10,424	25,208	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004	10,424	83		9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508	10,424	569		10
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257	10,424	590		11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286	10,424	4,977		12
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623	10,424	489		13
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053	10,424	224		14
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26		10,424			15
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000	10,424	3,054		16
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655	10,424	129		17
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167	10,424	393		18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,581,370	\$ 845,178	\$ 43,900		25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization YAM CONSULTING, LLC  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	DIETARY	ACTUAL CENSUS	375,486	26	\$ 94,203	\$ 94,203	10,424	\$ 2,615	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26		10,424			2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	10,424	1,477	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		10,424	248	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	10,424	11,058	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		10,424	672	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	10,424	5,188	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		10,424	1,535	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		10,424	8	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	10,424	4,062	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		10,424	209	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		10,424	191	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		10,424	41	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		10,424	550	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		10,424	1,387	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		10,424		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		10,424	736	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,079,857	\$ 872,186		\$ 29,977	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 8131 N. MONTICELLO, LLC  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	807,214	30	\$ 6,925	\$ 22,079	\$ 189	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268	22,079	226	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051	22,079	384	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646	22,079	18	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570	22,079	481	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207	22,079	1,565	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653	22,079	1,276	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100	22,079	249	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667	22,079	182	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673	22,079	1,249	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				\$ 212,760	\$		\$ 5,819	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization RENEWAL REHAB  
 Street Address 8131 N. MONTICELLO  
 City / State / Zip Code SKOKIE, ILLINOIS 60076  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

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	39	Therapy Sevices	Direct		\$	\$		\$ 332,071	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				\$	\$		\$ 332,071	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ProPay HR LLC  
 Street Address 2201 W. MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847) 905-3268  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 12,631	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				\$	\$		\$ 12,631	25

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1							\$	\$			\$					
2																
3																
4																
5																
<b>Working Capital</b>																
6	Bank Leumi		X	Mortgage				2,810,624			137,983					
7	Prior Owner		X					125,000								
8	See Supplemental Schedule							675,500			20,014					
9	<b>TOTAL Facility Related</b>						\$	\$ 3,611,124			\$ 157,997					
<b>B. Non-Facility Related*</b>																
10	Allocated from 8131 N. Monticello										1,276					
11	Allocated from YAM Management										224					
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,500					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,611,124			\$ 159,497					

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 Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	Bank Leumi		X	Line of Credit		\$	\$ 675,500			\$ 18,873	8							
9	Insurance Policies		X							1,141	9							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	<b>TOTAL Non-Facility Related</b>										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.)

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

B. Real Estate Taxes

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2013 report.		\$	<u>30,903</u>		1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>27,281</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(3,622)</u>		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>26,032</u>		4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>150</u>		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>22,560</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>31,145</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>27,092</u>	9																
	2011	<u>27,107</u>	10																
	2012	<u>11</u>	11																
	2013	<u>26,032</u>	12																
<u>Beginning Accrual Adjusted</u>																			
<u>Allocated from 8131 N. Monticello- \$1,249</u>																			
<u>2013 Tax = 2014 Accrual</u>																			

NOTES:

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

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bridgeport COUNTY Lawrence  
 FACILITY IDPH LICENSE NUMBER 0052688  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-000-701-0A</u>	<u>Long Term Care Facility</u>	\$ <u>26,031.80</u>	\$ <u>26,031.80</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>64,433.32</u>	\$ <u>1,543.83</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>90,465.12</u></u>	\$ <u><u>27,575.63</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

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

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Aperion Care Bridgeport

# 0052688 Report Period Beginning:

02/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>180,000</u>	1
2	<u>Allocated from 8131 N. Monticello</u>			<u>2,434</u>	2
3	<b>TOTALS</b>			\$ <b>182,434</b>	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	99		2014	1976	\$ 2,438,000	\$	39	\$ 62,513	\$ 62,513	\$ 62,513
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
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25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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			30,412	2,049	1,119	(930)	4,726	68
69				2,949		(2,949)		69
70			\$ 2,468,412	\$ 4,998		\$ 63,632	\$ 58,634	\$ 67,239 70

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

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,468,412	\$ 4,998		\$ 63,632	\$ 58,634	\$ 67,239	1
2	Data & Voip Line Installation	2014	6,000		20	200	200	200	2
3	Computer Installation And Back-Up	2014	4,910		20	327	327	327	3
4	New Phone System	2014	2,598		20	65	65	65	4
5	Remodel Design Work	2014	3,150		20				5
6	Installed 2 New Mixing Valves	2014	4,950		20	248	248	248	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	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
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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)		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	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
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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)		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	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
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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)		\$ 2,490,020	\$ 4,998		\$ 64,472	\$ 59,474	\$ 68,079	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	<b>Totals from Page 12E, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12F, Carried Forward</b>								
2									
3									
4									
5									
6									
7									
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25									
26									
27									
28									
29									
30									
31									
32									
33									
34	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	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	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>Allocated from 8131 N. Monticello</b>	<b>2010</b>	<b>18,915</b>	<b>562</b>	<b>35</b>	<b>485</b>	<b>(77)</b>	<b>2,162</b>	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<b>Allocated from 8131 N. Monticello</b>	<b>2010</b>	<b>8,473</b>	<b>851</b>	<b>20</b>	<b>424</b>	<b>(427)</b>	<b>1,923</b>	9
10	<b>Allocated from 8131 N. Monticello</b>	<b>2013</b>	<b>1,474</b>	<b>147</b>	<b>20</b>	<b>74</b>	<b>(73)</b>	<b>147</b>	10
11	<b>Allocated from YAM Management</b>			<b>489</b>			<b>(489)</b>		11
12	<b>Allocated from Aperion Care</b>	<b>2010</b>	<b>889</b>		<b>20</b>	<b>89</b>	<b>89</b>	<b>380</b>	12
13	<b>Allocated from Aperion Care</b>	<b>2012</b>	<b>561</b>		<b>20</b>	<b>37</b>	<b>37</b>	<b>94</b>	13
14	<b>Allocated from Aperion Care</b>	<b>2013</b>	<b>100</b>		<b>20</b>	<b>10</b>	<b>10</b>	<b>20</b>	14
15									15
16									16
17									17
18									18
19									19
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		<b>\$ 30,412</b>	<b>\$ 2,049</b>		<b>\$ 1,119</b>	<b>\$ (930)</b>	<b>\$ 4,726</b>	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 30,412	\$ 2,049		\$ 1,119	\$ (930)	\$ 4,726	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)		\$ 30,412	\$ 2,049		\$ 1,119	\$ (930)	\$ 4,726	34

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

**XI. OWNERSHIP COSTS (continued)**

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,887	\$	\$ 609	\$ 609	10	\$ 1,809	71
72	Current Year Purchases	152,567	11	15,269	15,258	10	15,269	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 156,454	\$ 11	\$ 15,878	\$ 15,867		\$ 17,078	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,828,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,009	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 80,350	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 75,341	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 85,157	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				1,110			5
6	Allocated from 8131 N. Monticello				249			6
7	TOTAL				\$ 1,359			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 10,907 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from YAM Consulting		\$	\$ 736	17
18	Allocated from YAM Management			393	18
19	Allocated from Aperion Care			1,235	19
20	Allocated from Aperion Consulting			400	20
21	TOTAL		\$	\$ 2,764	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 Aperion Care Bridgeport # 0052688 Report Period Beginning: 02/01/14 Ending: 12/31/14  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	134,643	\$					\$	134,643	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						110,798							110,798	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs						153,278							153,278	4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	39 - 03	# of prescripts						102,877							102,877	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>								5,029		12,850					17,879	13
14	<b>TOTAL</b>			\$				\$	506,625	\$	12,850			\$	519,475		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 Aperion Care Bridgeport

# 0052688

Report Period Beginning: 02/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,000	\$ 61,835	1
2	Cash-Patient Deposits	28,297	28,297	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	770,720	770,720	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,869	39,869	6
7	Other Prepaid Expenses	1,500	1,500	7
8	Accounts Receivable (owners or related parties)	2,356	2,356	8
9	Other(specify):	4,172	4,172	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 847,914</b>	<b>\$ 908,749</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,438,000	14
15	Leasehold Improvements, at Historical Cost	11,660	11,660	15
16	Equipment, at Historical Cost	22,538	174,538	16
17	Accumulated Depreciation (book methods)	(2,949)	(2,949)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,071)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,034,200	1,827,238	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,065,449</b>	<b>\$ 4,617,416</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 1,913,363</b>	<b>\$ 5,526,165</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 304,574	\$ 316,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,298	28,298	28
29	Short-Term Notes Payable	675,500	675,500	29
30	Accrued Salaries Payable	114,933	114,933	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,284	4,284	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,032	32
33	Accrued Interest Payable	2,328	14,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	62,228	62,228	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,192,145</b>	<b>\$ 1,242,279</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,935,624	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attached Schedule	802,649	1,310,779	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 802,649</b>	<b>\$ 4,246,403</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,994,794</b>	<b>\$ 5,488,682</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ (81,431)</b>	<b>\$ 37,483</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 1,913,363</b>	<b>\$ 5,526,165</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>15,069</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(96,500)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(81,431)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(81,431)</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,312,256	1
2	Discounts and Allowances for all Levels	1,629,886	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,942,142</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	108,661	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 108,661</b>	8
<b>C. Other Operating Revenue</b>			
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	1,081	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,701	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,120	19
20	Radiology and X-Ray	68	20
21	Other Medical Services	4,874	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 17,844</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	27,488	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 27,488</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,096,135</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	659,436	31
32	Health Care	1,351,007	32
33	General Administration	987,009	33
<b>B. Capital Expense</b>			
34	Ownership	351,102	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	566,635	35
36	Provider Participation Fee	165,877	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,081,066</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>15,069</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 15,069</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,821,304	44
45	Private Pay - Net Inpatient Revenue	566,828	45
46	Medicare - Net Inpatient Revenue	1,481,886	46
47	Other-(specify) <u>Insurance</u>	72,124	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 3,942,142</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Aperion Care Bridgeport

# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,752	1,856	\$ 58,655	\$ 31.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,063	13,221	312,887	23.67	3
4	Licensed Practical Nurses	9,540	10,723	169,452	15.80	4
5	CNAs & Orderlies	49,214	52,427	535,893	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	118	122	2,368	19.41	8
9	Activity Director	1,657	1,779	20,378	11.45	9
10	Activity Assistants	4,672	5,116	46,059	9.00	10
11	Social Service Workers	3,424	3,720	50,910	13.69	11
12	Dietician					12
13	Food Service Supervisor	1,688	1,840	28,311	15.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,372	13,338	121,258	9.09	15
16	Dishwashers					16
17	Maintenance Workers	2,487	2,650	35,437	13.37	17
18	Housekeepers	12,333	13,113	116,771	8.90	18
19	Laundry	3,768	3,918	35,676	9.11	19
20	Administrator	1,752	1,824	69,658	38.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,640	3,951	75,177	19.03	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	968	1,160	13,996	12.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	621	647	6,151	9.51	33
34	TOTAL (lines 1 - 33)	123,069	131,405	\$ 1,699,037 *	\$ 12.93	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	170	\$ 9,333	01-03	35
36	Medical Director	Monthly	5,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	192	14,400	10-03	38
39	Pharmacist Consultant	Monthly	2,903	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,667	11-03	44
45	Social Service Consultant	16	804	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 34,407		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	
Lori Waggoner	Administrator	0.00%	\$ 69,657	Workers' Compensation Insurance	\$ 78,147	IDPH License Fee	\$ 1,233	
				Unemployment Compensation Insurance	49,162	Advertising: Employee Recruitment	264	
				FICA Taxes	128,308	Health Care Worker Background Check	1,235	
				Employee Health Insurance	30,942	(Indicate # of checks performed <u>51</u> )		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues &amp; Subscriptions</u>	4,602	
				Employee Physicals	392	<u>Licenses &amp; Permits</u>	3,860	
				Employee Benefits- Other	9,275	<u>Allocated from YAM Consulting</u>	8	
						<u>Allocated from YAM Management</u>	190	
						<u>See Supplemental Schedule</u>	1,154	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 296,226			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Administrative Consultant- YAM Consulting							Out-of-State Travel	
\$ 1,500							\$	
Management Fees- Aperion Care								
139,527							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
							3,860	
\$ 141,027							<u>Allocated from YAM Consulting</u>	
							209	
C. Professional Services							<u>Allocated from YAM Management</u>	
Vendor/Payee							83	
Type							<u>See Supplemental Schedule</u>	
Amount							652	
Aperion Care							Entertainment Expense	
Home Office Expense							( )	
\$ 38,973							(agree to Sch. V, line 24, col. 8)	
Aperion Financial							TOTAL	
Home Office Expense							\$ 4,804	
27,242								
ProPay HR								
Payroll Processing								
15,989								
Various								
Legal								
1,892								
Pendulum, LLC								
Risk Management services								
1,604								
Personnel Planners								
Unemployment Consulting								
950								
Non Allowable Professional Fees								
Adj pg 5a								
300								
YAM Management								
Bookkeeping								
36,584								
YAM Management								
Accounting								
8,000								
YAM Consulting								
Data Processing								
3,300								
Aperion Care								
Data Processing								
2,893								
See Supplemental Schedule								
32,406								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 170,133								

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

Facility Name & ID Number Aperion Care Bridgeport# 0052688

Report Period Beginning:

02/01/14

Ending:

12/31/14**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC \$2,271
- (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. \$ 11,926 Line 10-02
- (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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 165,877  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,081
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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.