



Facility Name & ID Number Aperion Care Decatur

# 0051482 Report Period Beginning: 01/01/14 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	140	Skilled (SNF)	140	51,100	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	140	TOTALS	140	51,100	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	35,495	2,074	3,314	40,883	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,495	2,074	3,314	40,883	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.01%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 05/01/2011

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/2011 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 140 and days of care provided 2,464

Medicare Intermediary Wisconsin Physician 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.

Facility Name &amp; ID Number

Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	209,529	19,675	16,023	245,227		245,227	10,345	255,572		1
2	Food Purchase		174,815		174,815		174,815	(89)	174,726		2
3	Housekeeping	137,258	13,786		151,044		151,044		151,044		3
4	Laundry	78,310	10,151		88,461		88,461		88,461		4
5	Heat and Other Utilities			140,687	140,687		140,687	(24,318)	116,369		5
6	Maintenance	91,190	15,555	59,688	166,433		166,433	21,402	187,835		6
7	Other (specify):*							2,533	2,533		7
8	<b>TOTAL General Services</b>	516,287	233,982	216,398	966,667		966,667	9,873	976,540		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			64,000	64,000		64,000		64,000		9
10	Nursing and Medical Records	2,056,808	132,137	53,916	2,242,861		2,242,861	12,050	2,254,911		10
10a	Therapy	68,487			68,487		68,487		68,487		10a
11	Activities	67,941	2,486	2,302	72,729		72,729		72,729		11
12	Social Services	115,084		20	115,104		115,104		115,104		12
13	CNA Training										13
14	Program Transportation			1,136	1,136		1,136	2,690	3,826		14
15	Other (specify):*							4,243	4,243		15
16	<b>TOTAL Health Care and Programs</b>	2,308,320	134,623	121,374	2,564,317		2,564,317	18,983	2,583,300		16
	<b>C. General Administration</b>										
17	Administrative	81,116		21,000	102,116		102,116	40,014	142,130		17
18	Directors Fees										18
19	Professional Services			241,150	241,150	(277)	240,873	(150,181)	90,692		19
20	Dues, Fees, Subscriptions & Promotions			45,571	45,571		45,571	(8,161)	37,410		20
21	Clerical & General Office Expenses	73,449		681,846	755,295		755,295	(520,027)	235,268		21
22	Employee Benefits & Payroll Taxes			488,356	488,356		488,356		488,356		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,919	1,919		1,919	1,724	3,643		24
25	Other Admin. Staff Transportation			22,037	22,037		22,037	5,955	27,992		25
26	Insurance-Prop.Liab.Malpractice			112,205	112,205		112,205	7,413	119,618		26
27	Other (specify):*							15,060	15,060		27
28	<b>TOTAL General Administration</b>	154,565		1,614,084	1,768,649	(277)	1,768,372	(608,203)	1,160,168		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,979,172	368,605	1,951,856	5,299,633	(277)	5,299,356	(579,347)	4,720,009		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aperion Care Decatur

#0051482

Report Period Beginning:

01/01/14

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			84,490	84,490		84,490	(21,373)	63,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,837	45,837		45,837	2,575	48,412			32
33	Real Estate Taxes			52,507	52,507	277	52,784	2,313	55,097			33
34	Rent-Facility & Grounds			717,090	717,090		717,090	(11,539)	705,551			34
35	Rent-Equipment & Vehicles			12,290	12,290		12,290	5,597	17,887			35
36	Other (specify):*			31,315	31,315		31,315		31,315			36
37	<b>TOTAL Ownership</b>			943,529	943,529	277	943,806	(22,427)	921,379			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,841	426,271	556,112		556,112	(66,592)	489,520			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			308,124	308,124		308,124		308,124			42
43	Other (specify):*			171,887	171,887		171,887	(171,887)	0			43
44	<b>TOTAL Special Cost Centers</b>		129,841	906,282	1,036,123		1,036,123	(238,479)	797,644			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,979,172	498,446	3,801,667	7,279,285		7,279,285	(840,252)	6,439,033			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(24,962)	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	(25,232)	30		9
10	Interest and Other Investment Income	(222)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(89)	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	(3,594)	21		18
19	Entertainment	(2,696)	21		19
20	Contributions	(10,293)	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	(544,439)	21		24
25	Fund Raising, Advertising and Promotional				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	(225,479)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (837,005)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)	(3,247)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (3,247)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (840,252)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

Aperion Care Decatur

ID# 0051482

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Advertising/Marketing	\$ (26,235)	43	1
2	Promotional Products	(12,152)	43	2
3	Bank Charges	(53,122)	21	3
4	Theft & Damage Loss	(462)	21	4
5	Jury Duty Income	(27)	10	5
6	Additional R&M	10,866	06	6
7	Marketing Consultants	(7,500)	43	7
8	Every Vote Counts	(300)	20	8
9	Non Allowable Expense	(120,000)	43	9
10	Non Allowable Legal	(2,577)	19	10
11	Non Allowable Building Rent	(5,000)	34	11
12	CMS Penalty	(8,970)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(225,479)	49

Aperion Care Decatur

ID# 0051482

Report Period Beginning: 01/01/14

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 Decatur# 0051482

Report Period Beginning:

01/01/14

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					6,167	154	4,024					10,345	1
2	Food Purchase	(89)											(89)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(24,962)					293		351				(24,318)	5
6	Maintenance	10,866		3,238		1,482	2,532	2,865	419				21,402	6
7	Other (specify):*			213		1,337	501	482					2,533	7
8	<b>TOTAL General Services</b>	<b>(14,185)</b>		<b>3,451</b>		<b>8,986</b>	<b>3,480</b>	<b>7,371</b>	<b>770</b>				<b>9,873</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(27)		2,805		6,418		2,854					12,050	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							2,690					2,690	14
15	Other (specify):*			210		2,730		1,303					4,243	15
16	<b>TOTAL Health Care and Programs</b>	<b>(27)</b>		<b>3,015</b>		<b>9,148</b>		<b>6,847</b>					<b>18,983</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			39,914	1,910		9,124	(10,934)					40,014	17
18	Directors Fees													18
19	Professional Services	(2,577)		(47,117)	(40,655)	94	(53,185)	(4,022)	712		(3,431)		(150,181)	19
20	Fees, Subscriptions & Promotions	(10,593)		1,978	27	9	369	16	33				(8,161)	20
21	Clerical & General Office Expenses	(613,283)		21,521	26,488	1,147	35,329	7,881	890				(520,027)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			880	16	260	162	406					1,724	24
25	Other Admin. Staff Transportation			2,496	28	1,956	1,105	370					5,955	25
26	Insurance-Prop.Liab.Malpractice			660	5,528		1,145	80					7,413	26
27	Other (specify):*			4,200		136	9,656	1,068					15,060	27
28	<b>TOTAL General Administration</b>	<b>(626,453)</b>		<b>24,532</b>	<b>(6,658)</b>	<b>3,602</b>	<b>3,705</b>	<b>(5,135)</b>	<b>1,635</b>		<b>(3,431)</b>		<b>(608,203)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(640,665)</b>		<b>30,998</b>	<b>(6,658)</b>	<b>21,736</b>	<b>7,185</b>	<b>9,083</b>	<b>2,405</b>		<b>(3,431)</b>		<b>(579,347)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14 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	(25,232)				13	949		2,897				(21,373)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(222)					434		2,363				2,575	32
33	Real Estate Taxes								2,313				2,313	33
34	Rent-Facility & Grounds	(5,000)		909			6,176		(13,624)				(11,539)	34
35	Rent-Equipment & Vehicles			2,217	142	709	763	1,428	338				5,597	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(30,454)</b>		<b>3,126</b>	<b>142</b>	<b>722</b>	<b>8,322</b>	<b>1,428</b>	<b>(5,713)</b>				<b>(22,427)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(66,592)			(66,592)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(165,887)						(6,000)					(171,887)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(165,887)</b>						<b>(6,000)</b>		<b>(66,592)</b>			<b>(238,479)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(837,005)		34,124	(6,516)	22,458	15,507	4,511	(3,308)	(66,592)	(3,431)		(840,252)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	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%	3,238	\$	3,238	15
16	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	213		213	16
17	V	10 SALARY- NURSE		APERION CARE	100.00%	2,805		2,805	17
18	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	210		210	18
19	V	17 ADMINISTRATIVE		APERION CARE	100.00%	39,914		39,914	19
20	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	4,151		4,151	20
21	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,978		1,978	21
22	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	21,521		21,521	22
23	V	24 SEMINARS		APERION CARE	100.00%	880		880	23
24	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	2,496		2,496	24
25	V	26 INSURANCE		APERION CARE	100.00%	660		660	25
26	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	4,200		4,200	26
27	V	34 RENT		APERION CARE	100.00%	909		909	27
28	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	29		29	28
29	V	35 AUTO LEASE		APERION CARE	100.00%	2,188		2,188	29
30	V								30
31	V	19 HOME OFFICE	50,694	APERION CARE	100.00%			(50,694)	31
32	V	19 DATA PROCESSING	574	APERION CARE	100.00%			(574)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 51,268			\$ 85,392	\$ *	34,124	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%	1,910	\$ 1,910
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	776	776
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	27	27
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	26,488	26,488
19	V	24 SEMINARS		APERION FINANCIAL	100.00%	16	16
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	28	28
21	V	26 INSURANCE		APERION FINANCIAL	100.00%	5,528	5,528
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	142	142
23	V	19 HOME OFFICE EXPENSE	41,431	APERION FINANCIAL	100.00%		(41,431)
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		\$ 41,431			\$ 34,915	\$ * (6,516)

\* 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>APERION CONSULTING</u>	100.00%	\$ 6,517	\$ 6,517
16	V	<u>5</u> <u>UTILITIES</u>		<u>APERION CONSULTING</u>	100.00%		
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>APERION CONSULTING</u>	100.00%	2,682	2,682
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>APERION CONSULTING</u>	100.00%	1,337	1,337
19	V	<u>10</u> <u>SALARY NURSE</u>		<u>APERION CONSULTING</u>	100.00%	18,773	18,773
20	V	<u>15</u> <u>PAYROLL TAXES/GROUP INSURANCE</u>		<u>APERION CONSULTING</u>	100.00%	2,730	2,730
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>APERION CONSULTING</u>	100.00%		
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>APERION CONSULTING</u>	100.00%	94	94
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APERION CONSULTING</u>	100.00%	9	9
24	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>APERION CONSULTING</u>	100.00%	1,147	1,147
25	V	<u>24</u> <u>SEMINARS</u>		<u>APERION CONSULTING</u>	100.00%	260	260
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APERION CONSULTING</u>	100.00%	1,956	1,956
27	V	<u>26</u> <u>INSURANCE</u>		<u>APERION CONSULTING</u>	100.00%		
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>APERION CONSULTING</u>	100.00%	136	136
29	V	<u>30</u> <u>DEPRECIATION</u>		<u>APERION CONSULTING</u>	100.00%	13	13
30	V	<u>35</u> <u>AUTO LEASE</u>		<u>APERION CONSULTING</u>	100.00%	709	709
31	V	<u>10</u> <u>CONSULTING</u>	12,355	<u>APERION CONSULTING</u>	100.00%		(12,355)
32	V	<u>01</u> <u>DIETICIAN</u>	350	<u>APERION CONSULTING</u>	100.00%		(350)
33	V	<u>06</u> <u>PAINTER</u>		<u>APERION CONSULTING</u>	100.00%		
34	V	<u>06</u> <u>PROJECT MANAGER</u>	1,200	<u>APERION CONSULTING</u>	100.00%		(1,200)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 13,905			\$ 36,363	\$ * 22,458

\* 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 MANAGEMENT, LLC</u>	100.00%	\$ 154	\$	154	15
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	293		293	16
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	2,532		2,532	17
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	501		501	18
19	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	9,124		9,124	19
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	2,904		2,904	20
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	369		369	21
22	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	48,907		48,907	22
23	V	<u>24</u> <u>SEMINARS</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	162		162	23
24	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	1,105		1,105	24
25	V	<u>26</u> <u>INSURANCE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	1,145		1,145	25
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	9,656		9,656	26
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	949		949	27
28	V	<u>32</u> <u>INTEREST</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	434		434	28
29	V	<u>33</u> <u>REAL ESTATE TAX</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%				29
30	V	<u>34</u> <u>RENT</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	5,925		5,925	30
31	V	<u>34</u> <u>PARKING RENTAL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	251		251	31
32	V	<u>35</u> <u>AUTO LEASE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	763		763	32
33	V								33
34	V	<u>19</u> <u>ACCOUNTING</u>	6,463	<u>YAM MANAGEMENT, LLC</u>	100.00%			(6,463)	34
35	V	<u>19</u> <u>DATA PROCESSING</u>	3,688	<u>YAM MANAGEMENT, LLC</u>	100.00%			(3,688)	35
36	V	<u>19</u> <u>BOOKKEEPING</u>	45,938	<u>YAM MANAGEMENT, LLC</u>	100.00%			(45,938)	36
37	V	<u>21</u> <u>CORPORATE EVENTS</u>	13,578	<u>YAM MANAGEMENT, LLC</u>	100.00%			(13,578)	37
38	V	<u>34</u> <u>RENT</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%				38
39	Total		\$ 69,667			\$ 85,174	\$ *	15,507	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	<u>1</u> DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 5,074	\$ 5,074
16	V	<u>5</u> UTILITIES		YAM CONSULTING, LLC	100.00%		
17	V	<u>6</u> REPAIRS & MAINTENANCE		YAM CONSULTING, LLC	100.00%	2,865	2,865
18	V	<u>7</u> EMP. BEN.-GEN. SERV.		YAM CONSULTING, LLC	100.00%	482	482
19	V	<u>10</u> NURSE SALARY		YAM CONSULTING, LLC	100.00%	21,454	21,454
20	V	<u>15</u> EMP. BEN.-NURSE		YAM CONSULTING, LLC	100.00%	1,303	1,303
21	V	<u>17</u> ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	10,066	10,066
22	V	<u>19</u> PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	2,978	2,978
23	V	<u>20</u> FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	16	16
24	V	<u>21</u> CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	7,881	7,881
25	V	<u>24</u> SEMINARS		YAM CONSULTING, LLC	100.00%	406	406
26	V	<u>25</u> AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	370	370
27	V	<u>26</u> INSURANCE		YAM CONSULTING, LLC	100.00%	80	80
28	V	<u>27</u> EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,068	1,068
29	V	<u>14</u> NURSE TRAVEL		YAM CONSULTING, LLC	100.00%	2,690	2,690
30	V	<u>32</u> INTEREST		YAM CONSULTING, LLC	100.00%		
31	V	<u>35</u> AUTO RENTAL		YAM CONSULTING, LLC	100.00%	1,428	1,428
32	V	<u>10</u> NURSE CONSULTING	18,600	YAM CONSULTING, LLC	100.00%		(18,600)
33	V	<u>19</u> DATA PROCESSING	7,000	YAM CONSULTING, LLC	100.00%		(7,000)
34	V	<u>1</u> DIETICIAN	1,050	YAM CONSULTING, LLC	100.00%		(1,050)
35	V	<u>17</u> ADMINISTRATIVE CONSULTANT	21,000	YAM CONSULTING, LLC	100.00%		(21,000)
36	V	<u>43</u> MARKETING	6,000	YAM CONSULTING, LLC	100.00%		(6,000)
37	V						
38	V						
39	Total		\$ 53,650			\$ 58,161	\$ * 4,511

\* 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%	\$ 351	\$	351	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		419		419	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		712		712	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		33		33	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		890		890	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		2,897		2,897	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		2,363		2,363	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		461		461	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		338		338	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,313		2,313	24
25	V								25
26	V	34 RENT	14,085	8131 N. MONTICELLO, LLC				(14,085)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 14,085			\$ 10,777	\$ *	(3,308)	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	\$ 391,717	Renewal Rehab	100.00%	\$ 325,125	\$ (66,592)
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		\$ 391,717			\$ 325,125	\$ * (66,592)

\* 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	\$ 16,338	ProPay HR LLC	24.00%	\$ 12,907	\$ (3,431)
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		\$ 16,338			\$ 12,907	\$ * (3,431)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

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	Declaration of Trust Yosef Meystel	12.75%	Aperion Care Amboy	Amboy	YAM MANAGEMENT (1/1/14-6/30/14)	SKOKIE	MANAGEMENT CO.	1
2	David Berkowitz Revocable Trust	16.75%	Aperion Care Jacksonville	Jacksonville	YAM CONSULTING (1/1/14-6/30/14)	SKOKIE	CONSULTING CO.	2
3	Jay Meystel Trust	5.00%	River Crossing Rehab	Galesburg	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	Steven Turofsky	0.50%	Aperion Care Dolton	Dolton	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Frederick S. Frankel	0.50%	Riverwood Rehab	East Moline	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Christina Inofre	0.50%	Aperion Care Bridgeport	Bridgeport	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	257 Ltd. Partnership	17.00%	Aperion Care Litchfield	Litchfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	42170 Limited Partnership	8.50%	Aperion Care Springfield	Springfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	1219 Limited Partnership	8.50%	Aperion Care Burbank	Burbank	APERION ESTATES PERU	PERU, IN	ALF	9
10	Marlee Associates	10.00%	Aperion Care Midlothian	Midlothian	APERION CARE COPPERAS HOLLOW	CALDWELL, TX	ALF	10
11	David Kleiner	4.00%	Aperion Care St. Elmo	St. Elmo	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	11
12	Gary Bider	8.00%	Aperion Care Chicago Heights	Chicago Heights				12
13	417A, LP	4.00%	Aperion Care Forest Park	Forest Park				13
14	Shmyer Breuer	2.00%	Aperion Care Oak Lawn	Oak Lawn				14
15	S&D Investments	2.00%	Aperion Care Highwood	Highwood				15
16			Aperion Care Evanston	Evanston				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 Decatur # 0051482 Report Period Beginning: 01/01/14 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	Jay Meystel	Relative	Administrative	0	See Attached	1.0	2.50%	Alloc. Salary	\$ 1,595	17-7	1	
2	Joel Meystel	Relative	Administrative	0	See Attached	1.0	5.00%	Alloc. Salary	2,048	17-7	2	
3	Cynthia Meystel	Relative	Clerical	0	See Attached	0.2	6.06%	Alloc. Salary	1,050	21-7	3	
4	Fred Frankel	Owner	Administrative	0.50%	See Attached	2.0	5.00%	Alloc. Salary	6,893	17-7	4	
5	Steve Turofsky	Owner	Administrative	0.50%	See Attached	2.0	5.00%	Alloc. Salary	7,537	17-7	5	
6	Christina Inofre	Owner	Nursing	0.50%	See Attached	2.0	5.00%	Alloc. Salary	5,817	10-7	6	
7	Shimon Meystel	Relative	Clerical	0	See Attached	2.0	5.00%	Alloc. Salary	1,927	21-7	7	
8	Yosef Meystel	Relative	Administrative	0	See Attached	2.0	5.00%	Alloc. Salary	9,607	17-7	8	
9	David Berkowitz	Relative	Administrative	0	See Attached	2.0	5.00%	Alloc. Salary	9,607	17-7	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	\$ 46,081		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 Decatur

# 0051482 Report Period Beginning: 01/01/14 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 Decatur

# 0051482

Report Period Beginning:

01/01/14

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 CARE  
 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	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	67,680	59,564	20,658	3,238	1
2	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	431,728	30	4,451	20,658	20,658	213	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	20,658	2,805	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381	20,658	20,658	210	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	20,658	39,914	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759	20,658	20,658	4,151	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339	20,658	20,658	1,978	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	20,658	21,521	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383	20,658	20,658	880	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156	20,658	20,658	2,496	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783	20,658	20,658	660	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772	20,658	20,658	4,200	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000	20,658	20,658	909	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601	20,658	20,658	29	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731	20,658	20,658	2,188	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	\$	85,392	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	39,916	20,658	1,910	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	16,216	20,658	776	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	570	20,658	27	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	553,558	596,633	26,488	4
5	24	SEMINARS	ACTUAL CENSUS	431,728	30	342	20,658	16	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	585	20,658	28	6
7	26	INSURANCE	ACTUAL CENSUS	431,728	30	115,531	20,658	5,528	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	2,974	20,658	142	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	\$	34,915	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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 CONSULTING  
 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	431,728	30	\$ 136,198	\$ 136,198	20,658	\$ 6,517	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30		20,658			2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	20,658	2,682	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		20,658	1,337	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	20,658	18,773	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		20,658	2,730	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			20,658		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		20,658	94	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		20,658	9	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	20,658	1,147	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		20,658	260	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		20,658	1,956	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			20,658		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		20,658	136	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		20,658	13	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		20,658	709	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 759,903	\$ 603,946		\$ 36,363	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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	20,224	\$ 154	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432	20,224	293	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	20,224	2,532	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302	20,224	501	4	
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	20,224	9,124	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925	20,224	2,904	6	
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855	20,224	369	7	
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	20,224	48,907	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004	20,224	162	9	
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508	20,224	1,105	10	
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257	20,224	1,145	11	
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286	20,224	9,656	12	
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623	20,224	949	13	
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053	20,224	434	14	
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26		20,224		15	
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000	20,224	5,925	16	
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655	20,224	251	17	
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167	20,224	763	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,581,370	\$ 845,178	\$ 85,174	25	

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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	20,224	\$ 5,074	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26			20,224		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	20,224	2,865	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		20,224	482	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	20,224	21,454	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		20,224	1,303	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	20,224	10,066	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		20,224	2,978	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		20,224	16	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	20,224	7,881	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		20,224	406	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		20,224	370	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		20,224	80	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		20,224	1,068	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		20,224	2,690	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		20,224		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		20,224	1,428	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,079,857	\$ 872,186		\$ 58,161	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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	\$ 40,882	\$ 351	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268	40,882	419	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051	40,882	712	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646	40,882	33	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570	40,882	890	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207	40,882	2,897	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653	40,882	2,363	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100	40,882	461	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667	40,882	338	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673	40,882	2,313	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	\$		\$ 10,777	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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 Renewal Rehab  
 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	39	Therapy Services	Direct		\$	\$		\$ 325,125	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				\$	\$		\$ 325,125	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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 St  
 City / State / Zip Code Evanston, Illinois 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		\$	\$		\$ 12,907	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				\$	\$		\$ 12,907	25

Facility Name & ID Number Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Aperion Care Decatur

# 0051482

Report Period Beginning:

01/01/14

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	The Private Bank		X	Line of Credit				799,110			44,025					
7	Assurance		X	Insurance Financing							1,812					
8																
9	<b>TOTAL Facility Related</b>						\$	\$ 799,110			\$ 45,837					
	<b>B. Non-Facility Related*</b>															
10	Interest Income		X								(222)					
11	Allocated from 8131 N. Montice	X									2,363					
12	Allocated from YAM Managem	X									434					
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 2,575					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 799,110			\$ 48,412					

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 Decatur

# 0051482

Report Period Beginning:

01/01/14

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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	<b>TOTAL Long-Term</b>																
	<b>Working Capital</b>																
8							\$	\$			\$						
9																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Working Capital</b>																
	<b>B. Non-Facility Related*</b>																
15							\$	\$			\$						
16																	
17																	
18																	
19																	
20	<b>TOTAL Non-Facility Related</b>																

\* 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.)



## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Decatur COUNTY Macon  
 FACILITY IDPH LICENSE NUMBER 0051482  
 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>04-12-03-251-002</u>	<u>Long Term Care Property</u>	\$ <u>53,465.96</u>	\$ <u>53,465.96</u>
2. <u>Allocated from 8131 N. Monticello</u>	<u>Home Office Allocation</u>	\$ <u>64,433.32</u>	\$ <u>2,858.59</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>117,899.28</u></u>	\$ <u><u>56,324.55</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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,340 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>			\$ <u>4,507</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>4,507</u>	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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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			56,188	3,840	2,060	(1,780)	8,713	68
69				84,490		(84,490)		69
70		\$	56,188	\$ 88,330		\$ 2,060	\$ (86,270)	\$ 8,713 70

\*\*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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 56,188	\$ 88,330		\$ 2,060	\$ (86,270)	\$ 8,713	1
2	Framing & Dry Wall	2011	5,500		20	550	550	1,925	2
3	Mag Locks, Plates & Key Pads	2011	10,476		20	2,095	2,095	7,159	3
4	Heating & Cooling (Rooftop)	2011	4,500		20	450	450	1,575	4
5	Heating & Cooling (Rooftop)	2011	4,455		20	446	446	1,522	5
6	Toilets	2011	8,467		20	423	423	1,305	6
7	Tpo Roofing System On Flat Roof	2012	98,800		20	9,880	9,880	29,640	7
8	Stainless Steel Fire Shutter Door	2012	3,865		20	387	387	966	8
9	Digital Watchdog/ Camera	2012	12,560		20	2,512	2,512	6,489	9
10	Therapy Room Flooring & Painting	2012	14,526		20	726	726	1,997	10
11	Lobby Flooring & Wallcovering	2012	12,753		20	638	638	1,754	11
12	Medicare Corridor Wallcovering	2012	60,266		20	3,013	3,013	8,287	12
13	Activity Room Floor & Blinds	2012	7,195		20	360	360	989	13
14	Dining Room Flooring, Railings, Wallcovering & Fans	2012	37,514		20	1,876	1,876	5,158	14
15	Light Fixtures In Lobby, Reception, Smoke Lounge, Medicare Corridor	2012	21,188		20	1,059	1,059	2,913	15
16	Wallpaper In Lobby, Corridors, Large Dining Room	2012	61,394		20	3,070	3,070	8,442	16
17	Signage	2012	13,012		20	651	651	1,789	17
18	Installed Wiring In Dialysis Room	2013	2,740		20	274	274	343	18
19	New Voip And Data Lines	2014	3,600		20	360	360	360	19
20	Install Front Name Sign & 2 Face Panels	2014	6,358		20	177	177	177	20
21	New Voip And Data Lines	2014	3,600		20	300	300	300	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>		\$ 448,957	\$ 88,330		\$ 31,307	\$ (57,023)	\$ 91,803	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	<b>Totals from Page 12B, Carried Forward</b>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</b>	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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16									16
17									17
18									18
19									19
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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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</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		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 12C, Carried Forward</b>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</b>	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
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</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 12D, Carried Forward</b>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</b>	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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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>		\$ <b>448,957</b>	\$ <b>88,330</b>		\$ <b>31,307</b>	\$ <b>(57,023)</b>	\$ <b>91,803</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 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1 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 12F, Carried Forward</b>		\$	\$		\$	\$	\$	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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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	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>35,023</b>	<b>1,042</b>	<b>35</b>	<b>898</b>	<b>(144)</b>	<b>4,004</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>15,688</b>	<b>1,576</b>	<b>20</b>	<b>784</b>	<b>(792)</b>	<b>3,560</b>	9
10	<b>Allocated from 8131 N. Monticello</b>	<b>2013</b>	<b>2,729</b>	<b>273</b>	<b>20</b>	<b>136</b>	<b>(137)</b>	<b>273</b>	10
11									11
12	<b>Allocated from Aperion Care</b>	<b>2010</b>	<b>1,576</b>		<b>20</b>	<b>158</b>	<b>158</b>	<b>674</b>	12
13	<b>Allocated from Aperion Care</b>	<b>2012</b>	<b>995</b>		<b>20</b>	<b>66</b>	<b>66</b>	<b>167</b>	13
14	<b>Allocated from Aperion Care</b>	<b>2013</b>	<b>177</b>		<b>20</b>	<b>18</b>	<b>18</b>	<b>35</b>	14
15									15
16	<b>Allocated Depreciation from YAM Management</b>			<b>949</b>			<b>(949)</b>		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>		<b>\$ 56,188</b>	<b>\$ 3,840</b>		<b>\$ 2,060</b>	<b>\$ (1,780)</b>	<b>\$ 8,713</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 12H, Carried Forward</b>		\$ <b>56,188</b>	\$ <b>3,840</b>		\$ <b>2,060</b>	\$ <b>(1,780)</b>	\$ <b>8,713</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>56,188</b>	\$ <b>3,840</b>		\$ <b>2,060</b>	\$ <b>(1,780)</b>	\$ <b>8,713</b>	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	\$ 185,428	\$	\$ 30,152	\$ 30,152	10	\$ 102,088	71
72	Current Year Purchases	8,681	20	1,334	1,314	10	1,334	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 194,109	\$ 20	\$ 31,486	\$ 31,466		\$ 103,422	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2014	\$ 1,627	\$	\$ 325	\$ 325	5	\$ 1,143	76
77										77
78										78
79										79
80	TOTALS			\$ 1,627	\$	\$ 325	\$ 325		\$ 1,143	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)	\$ 649,200	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,118	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (25,232)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 196,368	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: FNR Decatur, LLC

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:	<u>1975</u>	<u>140</u>	<u>5/1/2011</u>	\$ <u>705,090</u>			3
4	Additions							4
5	<u>Allocated from 8131 N. Monticello</u>				<u>461</u>			5
6								6
7	TOTAL		<u>140</u>		\$ <u>705,551</u>			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: \$ 12,799 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	<u>Allocated from YAM Consulting</u>		\$ _____	\$ <u>1,428</u>	17
18	<u>Allocated from YAM Management</u>			<u>763</u>	18
19	<u>Allocated from Aperion Consulting</u>			<u>709</u>	19
20	<u>Allocated from Aperion Care</u>			<u>2,188</u>	20
21	TOTAL		\$ _____	\$ <u>5,088</u>	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.

**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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	160,387	\$		\$	160,387	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				109,422				109,422	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				121,911				121,911	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				563	129,841			130,404	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>						33,988				33,988	13
14	<b>TOTAL</b>			\$		\$	426,271	\$	129,841	\$	556,112	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 Decatur

# 0051482

Report Period Beginning: 01/01/14

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	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,000	\$	1
2	Cash-Patient Deposits	89,139		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,547,430		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,565		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	54,502		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,787,636</b>	<b>\$</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	354,552		15
16	Equipment, at Historical Cost	279,531		16
17	Accumulated Depreciation (book methods)	(247,106)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	243,386		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 630,363</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,417,999</b>	<b>\$</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 817,426	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	799,110		29
30	Accrued Salaries Payable	158,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,666		32
33	Accrued Interest Payable	1,730		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	12,501		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,851,329</b>	<b>\$</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attached Schedule	1,955,811		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 1,955,811</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 3,807,140</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ (1,389,141)</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,417,999</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(161,238)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Late Entry</b>	<b>(1,847)</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>(163,085)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,226,056)</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>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>(1,226,056)</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>(1,389,141)</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	\$ 6,684,992	1
2	Discounts and Allowances for all Levels	(815,171)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,869,821</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,661	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 83,661</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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,497	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,230	19
20	Radiology and X-Ray	885	20
21	Other Medical Services	11,886	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 99,498</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	222	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 222</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	27	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 27</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,053,229</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	966,667	31
32	Health Care	2,564,317	32
33	General Administration	1,768,649	33
<b>B. Capital Expense</b>			
34	Ownership	943,529	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	727,999	35
36	Provider Participation Fee	308,124	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>\$ 7,279,285</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,226,056)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,226,056)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,397,927	44
45	Private Pay - Net Inpatient Revenue	335,295	45
46	Medicare - Net Inpatient Revenue	1,010,016	46
47	Other-(specify) <u>Insurance</u>	126,583	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,869,821</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 Decatur

# 0051482

Report Period Beginning:

01/01/14

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	1,888	2,310	\$ 76,762	\$ 33.23	1
2	Assistant Director of Nursing	2,000	2,223	64,930	29.21	2
3	Registered Nurses	13,435	14,537	394,552	27.14	3
4	Licensed Practical Nurses	23,592	25,343	580,093	22.89	4
5	CNAs & Orderlies	69,358	75,314	917,523	12.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,056	2,352	68,487	29.12	8
9	Activity Director	1,282	1,478	16,919	11.45	9
10	Activity Assistants	5,084	5,371	48,881	9.10	10
11	Social Service Workers	5,200	5,494	115,084	20.95	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	43,842	21.08	13
14	Head Cook	5,545	6,157	75,537	12.27	14
15	Cook Helpers/Assistants	8,183	9,012	90,150	10.00	15
16	Dishwashers					16
17	Maintenance Workers	6,148	6,507	91,190	14.01	17
18	Housekeepers	12,953	14,170	137,258	9.69	18
19	Laundry	6,579	7,140	78,310	10.97	19
20	Administrator	2,048	2,152	78,942	36.68	20
21	Assistant Administrator		121	2,174	17.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,217	6,616	73,449	11.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,713	1,881	22,948	12.20	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	239	239	2,141	8.96	33
34	TOTAL (lines 1 - 33)	175,504	190,497	\$ 2,979,172 *	\$ 15.64	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	291	\$ 16,023	01-03	35
36	Medical Director	Monthly	64,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	413	30,955	10-03	38
39	Pharmacist Consultant	219	10,961	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	46	2,302	11-03	44
45	Social Service Consultant	1	20	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	970	\$ 136,261		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	
Teri Rebstock	Administrator	0	\$ 78,942	Workers' Compensation Insurance	\$ 97,317	IDPH License Fee	\$ 1,990	
Kristin Chaudoin	Asst. Admin.	0	2,174	Unemployment Compensation Insurance	144,061	Advertising: Employee Recruitment	17,442	
				FICA Taxes	227,490	Health Care Worker Background Check (Indicate # of checks performed)	4,483	
				Employee Health Insurance	12,400	Patient Background Checks		
				Employee Meals	523	Dues & Subscriptions	8,947	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,116	
				401K Expense	450	Allocated from 8131 N. Monticello	33	
				Employee Physicals	400	Allocated from YAM Consulting	16	
				Other Employee Benefits	5,715	See Supplemental Schedule	2,383	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,116	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 488,356		\$ 37,410		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
YAM Consulting - Administrative Consultant			\$ 21,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 21,000	TOTAL		\$	Seminar Expense	1,919
							Allocated from YAM Consulting	406
							Allocated from YAM Management	162
							See Supplemental Schedule	1,156
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,643
C. Professional Services								
Vendor/Payee	Type	Amount						
Frost, Ruttenberg, & Rothblatt	Accounting	\$ 10,925						
YAM Management	Accounting	6,463						
McGuire, Yuhas, Huffman & Buckle	Accounting	330						
Aperion Financial	Home Office Expense	41,431						
Aperion Care, Inc.	Home Office Expense	50,694						
YAM Management	Bookkeeping	45,938						
Pro Pay HR	Payroll Processing	16,338						
Pro Payroll Solutions	Payroll Processing	2,227						
YAM Consulting	Data Processing	7,000						
E-Health Data Solutions	MDS Software	3,145						
American Data	Electronic Charting System	7,046						
See Supplemental Schedule		49,613						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 241,149					

\* 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 Decatur# 0051482

Report Period Beginning:

01/01/14

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (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. \$ 6,771 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES 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. \$ 308,124  
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. \$ 523 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- 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.