

Facility Name & ID Number Aperion Care Springfield

0051086 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	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					8
9	SNF/PED					9
10	ICF	21,735	761	48	22,544	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,735	761	48	22,544	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.02%

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 09/01/2010

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

YES Date 09/01/2010 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Aperion Care Springfield

0051086

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
	A. General Services										
1	Dietary	129,532	9,745	6,177	145,454		145,454	6,473	151,927		1
2	Food Purchase		98,780		98,780		98,780	(33)	98,747		2
3	Housekeeping	86,769	7,950		94,719		94,719		94,719		3
4	Laundry	10,309	6,776		17,085		17,085		17,085		4
5	Heat and Other Utilities			69,978	69,978		69,978	(2,044)	67,934		5
6	Maintenance	37,244	8,847	26,576	72,667		72,667	12,535	85,202		6
7	Other (specify):*							1,395	1,395		7
8	TOTAL General Services	263,854	132,098	102,731	498,683		498,683	18,326	517,009		8
	B. Health Care and Programs										
9	Medical Director			22,800	22,800		22,800		22,800		9
10	Nursing and Medical Records	642,428	26,466	37,417	706,311		706,311	(5,535)	700,776		10
10a	Therapy										10a
11	Activities	26,302	3,977	2,075	32,354		32,354		32,354		11
12	Social Services	82,322			82,322		82,322		82,322		12
13	CNA Training										13
14	Program Transportation							1,493	1,493		14
15	Other (specify):*							2,334	2,334		15
16	TOTAL Health Care and Programs	751,052	30,443	62,292	843,787		843,787	(1,708)	842,079		16
	C. General Administration										
17	Administrative	67,097		31,714	98,811		98,811	1,856	100,667		17
18	Directors Fees										18
19	Professional Services			138,195	138,195	(153)	138,042	(80,931)	57,111		19
20	Dues, Fees, Subscriptions & Promotions			22,495	22,495		22,495	(11,815)	10,680		20
21	Clerical & General Office Expenses	24,319		104,907	129,226		129,226	(15,305)	113,921		21
22	Employee Benefits & Payroll Taxes			136,226	136,226		136,226		136,226		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,232	3,232		3,232	949	4,181		24
25	Other Admin. Staff Transportation			6,726	6,726		6,726	3,273	9,999		25
26	Insurance-Prop.Liab.Malpractice			34,278	34,278		34,278	4,070	38,348		26
27	Other (specify):*							8,328	8,328		27
28	TOTAL General Administration	91,416		477,773	569,189	(153)	569,036	(89,575)	479,461		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,106,322	162,541	642,796	1,911,659	(153)	1,911,506	(72,957)	1,838,549		29

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

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

Facility Name & ID Number Aperion Care Springfield

#0051086

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	
	D. Ownership											
30	Depreciation			46,131	46,131		46,131	30,921	77,052			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,616	10,616		10,616	35,338	45,954			32
33	Real Estate Taxes					153	153	18,842	18,995			33
34	Rent-Facility & Grounds			189,079	189,079		189,079	(188,825)	254			34
35	Rent-Equipment & Vehicles			7,139	7,139		7,139	3,083	10,222			35
36	Other (specify):*			7,215	7,215		7,215	(7,215)	(0)			36
37	TOTAL Ownership			260,180	260,180	153	260,333	(107,857)	152,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,024	172,024		172,024		172,024			42
43	Other (specify):*			64,282	64,282		64,282	(64,282)	(0)			43
44	TOTAL Special Cost Centers			236,306	236,306		236,306	(64,282)	172,024			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,106,322	162,541	1,139,282	2,408,145		2,408,145	(245,096)	2,163,049			45

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

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,399)	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	(18,822)	30		9
10	Interest and Other Investment Income	(195)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(925)	21		19
20	Contributions	(12,167)	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	(15,239)	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	(126,989)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (176,769)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(68,327)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (68,327)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (245,096)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Aperion Care Springfield

Report Period Beginning: 01/01/14
 Ending: 12/31/14

ID# 0051086

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Advertising/Marketing	\$ (11,676)	43	1
2	Promotional Products	(2,147)	43	2
3	Bank Charges	(44,454)	21	3
4	Theft & Damage Loss	(52)	21	4
5	Amortization	(7,215)	36	5
6	Bldg Co. - Bank Charges	(315)	21	6
7	Bldg Co. - Bookkeeping Fees	(6,000)	19	7
8	Bldg Co. - Licenses & Permits	(250)	20	8
9	Bldg Co. - Home Office Expense	(6,000)	19	9
10	Non Allowable Expense	(48,959)	43	10
11	Additional R&M	6,064	06	11
12	PAC Dues	(984)	20	12
13	Non Allowable Building Rental	(5,000)	34	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(126,989)	49

Aperion Care Springfield

Report Period Beginning: 01/01/14
 Ending: 12/31/14

ID# 0051086

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	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Springfield# 0051086

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					3,571	86	2,816					6,473	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,399)					162		193				(2,044)	5
6	Maintenance	6,064		1,775		1,470	1,405	1,590	231				12,535	6
7	Other (specify):*			117		732	278	268					1,395	7
8	TOTAL General Services	3,632		1,892		5,773	1,931	4,674	424				18,326	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			1,537		(78)		(6,994)					(5,535)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							1,493					1,493	14
15	Other (specify):*			115		1,496		723					2,334	15
16	TOTAL Health Care and Programs			1,652		1,418		(4,778)					(1,708)	16
	C. General Administration													
17	Administrative			5,160	1,047		5,063	(9,414)					1,856	17
18	Directors Fees													18
19	Professional Services	(12,000)	12,000	(19,427)	(16,324)	51	(42,515)	(1,597)	392	(1,511)			(80,931)	19
20	Fees, Subscriptions & Promotions	(13,401)	250	1,084	15	5	205	9	18				(11,815)	20
21	Clerical & General Office Expenses	(60,985)	315	11,794	14,516	629	13,562	4,373	491				(15,305)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			482	9	142	90	226					949	24
25	Other Admin. Staff Transportation			1,368	15	1,072	613	205					3,273	25
26	Insurance-Prop.Liab.Malpractice			361	3,030		635	44					4,070	26
27	Other (specify):*			2,302		74	5,359	593					8,328	27
28	TOTAL General Administration	(86,386)	12,565	3,124	2,308	1,973	(16,988)	(5,561)	901	(1,511)			(89,575)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,754)	12,565	6,668	2,308	9,164	(15,057)	(5,665)	1,325	(1,511)			(72,957)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Springfield

0051086

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	(18,822)	47,611			7	527		1,598				30,921	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(195)	33,989				241		1,303				35,338	32
33	Real Estate Taxes		17,566						1,276				18,842	33
34	Rent-Facility & Grounds	(5,000)	(172,079)	498			(1,573)		(10,671)				(188,825)	34
35	Rent-Equipment & Vehicles			1,215	78	389	423	792	186				3,083	35
36	Other (specify):*	(7,215)											(7,215)	36
37	TOTAL Ownership	(31,233)	(72,913)	1,713	78	396	(382)	792	(6,308)				(107,857)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(62,782)						(1,500)					(64,282)	43
44	TOTAL Special Cost Centers	(62,782)						(1,500)					(64,282)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(176,769)	(60,348)	8,381	2,386	9,560	(15,439)	(6,373)	(4,983)	(1,511)			(245,096)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 172,079	Centralia Property, LLC	100.00%	\$	\$ (172,079)	1
2	V	21 Bank Charges		Centralia Property, LLC	100.00%	315	315	2
3	V	19 Bookkeeping Fees - YAM		Centralia Property, LLC	100.00%	6,000	6,000	3
4	V	20 Business Licenses & Permits		Centralia Property, LLC	100.00%	250	250	4
5	V	30 Depreciation		Centralia Property, LLC	100.00%	47,611	47,611	5
6	V	19 Home Office Expense		Centralia Property, LLC	100.00%	6,000	6,000	6
7	V	33 Real Estate Taxes		Centralia Property, LLC	100.00%	17,566	17,566	7
8	V	32 Interest		Centralia Property, LLC	100.00%	33,989	33,989	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 172,079			\$ 111,731	\$ * (60,348)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS & MAINTENANCE		APERION CARE	100.00%	1,775	\$ 1,775 15
16	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	117	117 16
17	V	10 SALARY- NURSE		APERION CARE	100.00%	1,537	1,537 17
18	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	115	115 18
19	V	17 ADMINISTRATIVE		APERION CARE	100.00%	21,874	21,874 19
20	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	2,275	2,275 20
21	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,084	1,084 21
22	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	11,794	11,794 22
23	V	24 SEMINARS		APERION CARE	100.00%	482	482 23
24	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	1,368	1,368 24
25	V	26 INSURANCE		APERION CARE	100.00%	361	361 25
26	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	2,302	2,302 26
27	V	34 RENT		APERION CARE	100.00%	498	498 27
28	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	16	16 28
29	V	35 AUTO LEASE		APERION CARE	100.00%	1,199	1,199 29
30	V	17 MANAGEMENT FEE	16,714	APERION CARE	100.00%		(16,714) 30
31	V	19 HOME OFFICE	20,471	APERION CARE	100.00%		(20,471) 31
32	V	19 DATA PROCESSING	1,231	APERION CARE	100.00%		(1,231) 32
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 38,416			\$ 46,797	\$ * 8,381 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%	1,047	\$ 1,047
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	425	425
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	15	15
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	14,516	14,516
19	V	24 SEMINARS		APERION FINANCIAL	100.00%	9	9
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	15	15
21	V	26 INSURANCE		APERION FINANCIAL	100.00%	3,030	3,030
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	78	78
23	V	19 HOME OFFICE EXPENSE	16,749	APERION FINANCIAL	100.00%		(16,749)
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		\$ 16,749			\$ 19,135	\$ * 2,386

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	APERION CONSULTING	100.00%	\$ 3,571	\$ 3,571
16	V	5 UTILITIES		APERION CONSULTING	100.00%		
17	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	1,470	1,470
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	732	732
19	V	10 SALARY NURSE		APERION CONSULTING	100.00%	10,288	10,288
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	1,496	1,496
21	V	17 ADMINISTRATIVE		APERION CONSULTING	100.00%		
22	V	19 PROFESSIONAL FEES		APERION CONSULTING	100.00%	51	51
23	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	5	5
24	V	21 CLERICAL & GENERAL		APERION CONSULTING	100.00%	629	629
25	V	24 SEMINARS		APERION CONSULTING	100.00%	142	142
26	V	25 AUTO AND TRAVEL		APERION CONSULTING	100.00%	1,072	1,072
27	V	26 INSURANCE		APERION CONSULTING	100.00%		
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	74	74
29	V	30 DEPRECIATION		APERION CONSULTING	100.00%	7	7
30	V	35 AUTO LEASE		APERION CONSULTING	100.00%	389	389
31	V	10 CONSULTING	10,366	APERION CONSULTING	100.00%		(10,366)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 10,366			\$ 19,926	\$ * 9,560

* 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>	<u>100.00%</u>	\$ <u>86</u>	\$	<u>86</u> <u>15</u>
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>162</u>		<u>162</u> <u>16</u>
17	V	<u>6</u> <u>REPAIRS & MAINTENANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>1,405</u>		<u>1,405</u> <u>17</u>
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. & DIETARY</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>278</u>		<u>278</u> <u>18</u>
19	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>5,063</u>		<u>5,063</u> <u>19</u>
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>1,612</u>		<u>1,612</u> <u>20</u>
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>205</u>		<u>205</u> <u>21</u>
22	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>27,140</u>		<u>27,140</u> <u>22</u>
23	V	<u>24</u> <u>SEMINARS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>90</u>		<u>90</u> <u>23</u>
24	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>613</u>		<u>613</u> <u>24</u>
25	V	<u>26</u> <u>INSURANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>635</u>		<u>635</u> <u>25</u>
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>5,359</u>		<u>5,359</u> <u>26</u>
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>527</u>		<u>527</u> <u>27</u>
28	V	<u>32</u> <u>INTEREST</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>241</u>		<u>241</u> <u>28</u>
29	V	<u>33</u> <u>REAL ESTATE TAX</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			
30	V	<u>34</u> <u>RENT</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>3,288</u>		<u>3,288</u> <u>30</u>
31	V	<u>34</u> <u>PARKING RENTAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>139</u>		<u>139</u> <u>31</u>
32	V	<u>35</u> <u>AUTO LEASE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>423</u>		<u>423</u> <u>32</u>
33	V	<u>19</u> <u>DATA PROCESSING</u>	<u>1,450</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(1,450)</u> <u>33</u>
34	V	<u>19</u> <u>ACCOUNTING</u>	<u>6,463</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(6,463)</u> <u>34</u>
35	V							
36	V	<u>19</u> <u>BOOKKEEPING</u>	<u>36,214</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(36,214)</u> <u>36</u>
37	V	<u>21</u> <u>CORPORATE EVENTS</u>	<u>13,578</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(13,578)</u> <u>37</u>
38	V	<u>34</u> <u>RENT</u>	<u>5,000</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(5,000)</u> <u>38</u>
39	Total		\$ 62,705			\$ 47,266	\$ *	(15,439) 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> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	\$ <u>2,816</u>	\$ <u>2,816</u>
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		
17	V	<u>6</u> <u>REPAIRS & MAINTENANCE</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>1,590</u>	<u>1,590</u>
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>268</u>	<u>268</u>
19	V	<u>10</u> <u>NURSE SALARY</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>11,906</u>	<u>11,906</u>
20	V	<u>15</u> <u>EMP. BEN.-NURSE</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>723</u>	<u>723</u>
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>5,586</u>	<u>5,586</u>
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>1,653</u>	<u>1,653</u>
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>9</u>	<u>9</u>
24	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>4,373</u>	<u>4,373</u>
25	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>226</u>	<u>226</u>
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>205</u>	<u>205</u>
27	V	<u>26</u> <u>INSURANCE</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>44</u>	<u>44</u>
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>593</u>	<u>593</u>
29	V	<u>14</u> <u>NURSE TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>1,493</u>	<u>1,493</u>
30	V	<u>32</u> <u>INTEREST</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		
31	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>	<u>792</u>	<u>792</u>
32	V	<u>10</u> <u>NURSE CONSULTING</u>	<u>18,900</u>	<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		<u>(18,900)</u>
33	V	<u>19</u> <u>DATA PROCESSING</u>	<u>3,250</u>	<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		<u>(3,250)</u>
34	V						
35	V	<u>17</u> <u>ADMINISTRATIVE CONSULTANT</u>	<u>15,000</u>	<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		<u>(15,000)</u>
36	V	<u>43</u> <u>MARKETING</u>	<u>1,500</u>	<u>YAM CONSULTING, LLC</u>	<u>100.00%</u>		<u>(1,500)</u>
37	V						
38	V						
39	Total		\$ 38,650			\$ 32,277	\$ * (6,373)

* 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%	\$ 193	\$	193	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		231		231	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		392		392	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		18		18	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		491		491	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,598		1,598	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,303		1,303	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		254		254	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		186		186	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,276		1,276	24
25	V								25
26	V	34 RENT	10,925	8131 N. MONTICELLO, LLC				(10,925)	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		\$ 10,925			\$ 5,942	\$ *	(4,983)	39

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

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning: 01/01/14

Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Expense	\$ 7,193	ProPay HR LLC	24.00%	\$ 5,682	\$ (1,511)
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		\$ 7,193			\$ 5,682	\$ * (1,511)

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ML EQUITY PARTNERS LLC	5.00%	Aperion Care Amboy	Amboy	YAM MANAGEMENT (1/1/14-6/30/14)	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.00%	Aperion Care Jacksonville	Jacksonville	YAM CONSULTING (1/1/14-6/30/14)	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.00%	River Crossing Rehab	Galesburg	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING CO.	3
4	DAVID BERKOWITZ	36.50%	Aperion Care Dolton	Dolton	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	DECLARATION OF TRUST OF YOSEF MEYSTEL	34.50%	Riverwood Rehab	East Moline	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	JAY MEYSTEL TRUST	4.00%	Aperion Care Bridgeport	Bridgeport	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	STEVEN TUROFSKY	1.00%	Aperion Care Litchfield	Litchfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	FREDERICK S. FRANKEL	1.00%	Aperion Care Evanston	Evanston	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	CHRISTINA INFRE	1.00%	Aperion Care Burbank	Burbank	APERION ESTATES PERU	PERU, IN	ALF	9
10	42170 LIMITED PARTNERSHIP	2.50%	Aperion Care Midlothian	Midlothian	APERION CARE COPPERAS HOLLOW	CALDWELL, TX	ALF	10
11	1219 LIMITED PARTNERSHIP	2.50%	Aperion Care St. Elmo	St. Elmo	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	11
12	257 LTD. PARTNERSHIP	2.50%	Aperion Care Chicago Heights	Chicago Heights	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	12
13	417A, LLC	2.50%	Aperion Care Forest Park	Forest Park				13
14			Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Arbors Michigan City	Michigan City, IN				20
21			Aperion Care Demotte	Demotte, IN				21
22			Aperion Care Kokomo	Kokomo, IN				22
23			Aperion Care Peru	Peru, IN				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Valparaiso	Valparaiso, IN				25
26			Aperion Care Copperas Hollow	Caldwell, TX				26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 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	Yosef Meystel	Relative	Administrative		See Attached	1.1	2.75%	Alloc. Salary	\$ 5,265	17-7	1
2	Jay Meystel	Relative	Administrative		See Attached	0.6	1.50%	Alloc. Salary	879	17-7	2
3	Joel Meystel	Relative	Administrative		See Attached	0.6	3.00%	Alloc. Salary	1,129	17-7	3
4	Cynthia Meystel	Relative	Clerical		See Attached	0.1	3.03%	Alloc. Salary	579	21-7	4
5	Shimon Meystel	Relative	Clerical		See Attached	1.1	2.75%	Alloc. Salary	1,062	21-7	5
6	David Berkowitz	Owner	Administrative	36.5%	See Attached	1.1	2.75%	Alloc. Salary	5,265	17-7	6
7	Fred Frankel	Owner	Administrative	1.0%	See Attached	1.1	2.75%	Alloc. Salary	3,801	17-7	7
8	Steve Turofsky	Owner	Administrative	1.0%	See Attached	1.1	2.75%	Alloc. Salary	4,156	17-7	8
9	Christina Inofre	Owner	Nursing	1.0%	See Attached	1.1	2.75%	Alloc. Salary	3,208	10-7	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	\$ 25,344		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 Springfield

0051086

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 Springfield

0051086

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	11,321	1,775	1
2	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	431,728	30	4,451		11,321	117	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	11,321	1,537	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381		11,321	115	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	11,321	21,874	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759		11,321	2,275	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339		11,321	1,084	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	11,321	11,794	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383		11,321	482	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156		11,321	1,368	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783		11,321	361	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772		11,321	2,302	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000		11,321	498	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601		11,321	16	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731		11,321	1,199	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		\$ 46,797	25

Facility Name & ID Number Aperion Care Springfield

0051086

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	39,916	11,321	1,047	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	16,216	11,321	425	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	570	11,321	15	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	553,558	596,633	14,516	4
5	24	SEMINARS	ACTUAL CENSUS	431,728	30	342	11,321	9	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	585	11,321	15	6
7	26	INSURANCE	ACTUAL CENSUS	431,728	30	115,531	11,321	3,030	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	2,974	11,321	78	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 729,692	\$ 596,633		\$ 19,135	25

Facility Name & ID Number Aperion Care Springfield

0051086

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	11,321	\$ 3,571	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30			11,321		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	11,321	1,470	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		11,321	732	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	11,321	10,288	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		11,321	1,496	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			11,321		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		11,321	51	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		11,321	5	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	11,321	629	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		11,321	142	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		11,321	1,072	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			11,321		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		11,321	74	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		11,321	7	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		11,321	389	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 759,903	\$ 603,946		\$ 19,926	25

Facility Name & ID Number Aperion Care Springfield

0051086

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	11,223	\$ 86	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432	11,223	162	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	11,223	1,405	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302	11,223	278	4	
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	11,223	5,063	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925	11,223	1,612	6	
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855	11,223	205	7	
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	11,223	27,140	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004	11,223	90	9	
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508	11,223	613	10	
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257	11,223	635	11	
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286	11,223	5,359	12	
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623	11,223	527	13	
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053	11,223	241	14	
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26		11,223		15	
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000	11,223	3,288	16	
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655	11,223	139	17	
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167	11,223	423	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,581,370	\$ 845,178	\$ 47,266	25	

Facility Name & ID Number Aperion Care Springfield

0051086

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	11,223	\$ 2,816	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26			11,223		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	11,223	1,590	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		11,223	268	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	11,223	11,906	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		11,223	723	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	11,223	5,586	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		11,223	1,653	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		11,223	9	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	11,223	4,373	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		11,223	226	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		11,223	205	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		11,223	44	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		11,223	593	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		11,223	1,493	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		11,223		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		11,223	792	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,079,857	\$ 872,186		\$ 32,277	25

Facility Name & ID Number Aperion Care Springfield

0051086

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	\$ 22,544	\$ 193	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268	22,544	231	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051	22,544	392	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646	22,544	18	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570	22,544	491	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207	22,544	1,598	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653	22,544	1,303	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100	22,544	254	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667	22,544	186	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673	22,544	1,276	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 212,760	\$	\$	\$ 5,942	25

Facility Name & ID Number Aperion Care Springfield

0051086

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
 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		\$	\$		\$ 5,682	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				\$	\$		\$ 5,682	25

Facility Name & ID Number Aperion Care Springfield

0051086 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 Springfield

0051086

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 Springfield

0051086

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		7	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			
A. Directly Facility Related																		
Long-Term																		
1	Bank Financial		X	Mortgage			\$	\$ 621,368			\$	33,989						
2	Ally		X	Auto Loan				15,063				1,642						
3																		
4																		
5																		
Working Capital																		
6	Bank Financial		X	Line of Credit								8,398						
7	Assurance		X	Insurance Financing								576						
8																		
9	TOTAL Facility Related						\$	\$ 636,431			\$	44,605						
B. Non-Facility Related*																		
10	Interest Income		X									(195)						
11	Allocated from 8131 N. Montice	X										1,303						
12	Allocated from YAM Managem	X										241						
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	1,349						
15	TOTALS (line 9+line14)						\$	\$ 636,431			\$	45,954						

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 Springfield

0051086

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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	<u>16,907</u>	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>18,512</u>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,605</u>	3															
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>17,236</u>	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	<u>153</u>	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>18,994</u>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010	<u>16,079</u>	9																
	2011	<u>16,491</u>	10																
	2012	<u>16,907</u>	11																
	2013	<u>17,236</u>	12																
<u>2014 Accrual = 2013 Tax</u>																			
<u>Allocated from 8131 N. Monticello = \$1,276</u>																			

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Springfield COUNTY Sangamon
 FACILITY IDPH LICENSE NUMBER 0051086
 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>14-35.0-157-019</u>	<u>Long Term Care Property</u>	\$ <u>17,236.42</u>	\$ <u>17,236.42</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>64,433.32</u>	\$ <u>1,576.34</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>81,669.74</u></u>	\$ <u><u>18,812.76</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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Aperion Care Springfield

0051086 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Centralia Property, LLC</u>		<u>2011</u>	<u>\$ 183,518</u>	1
2	<u>Allocated from 8131 N. Monticello</u>			<u>2,486</u>	2
3	TOTALS			\$ 186,004	3

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1	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	65		2011	1972	\$ 639,905	\$ 47,611	35	\$ 18,283	\$ (29,328)	\$ 79,226
5										
6										
7										
8										
	Improvement Type**									
9										
10										
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31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			30,975	2,120	1,135	(985)	4,800	68
69				46,131		(46,131)		69
70			\$ 670,880	\$ 95,862		\$ 19,418	\$ (76,444)	\$ 84,026 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	Totals from Page 12A, Carried Forward		\$ 670,880	\$ 95,862		\$ 19,418	\$ (76,444)	\$ 84,026	1
2	Bathroom Tile, Grout, Walls	2011	13,000		20	1,300	1,300	4,658	2
3	Water Heater	2011	6,082		20	1,216	1,216	4,257	3
4	3 Bathrooms & Hall Remodel, Walls, Tiles, Fixtures, Sinks, Toilet	2012	22,000		20	1,100	1,100	3,117	4
5	Hvac-Condensing Unit & Air Handlers	2012	20,500		20	1,025	1,025	2,819	5
6	New Asphalt	2012	12,836		20	856	856	2,425	6
7	50 Wall Units With Sleeves	2012	32,650		20	6,530	6,530	15,781	7
8	48 Window Units	2012	42,000		20	8,400	8,400	18,900	8
9	Phone System	2012	4,646		20	929	929	2,478	9
10	Patio & Patiodoor Repair	2012	4,750		20	238	238	633	10
11	Kitchen Remodel - Walls, Cabinets, & Countertops	2012	3,000		20	150	150	400	11
12	Sink, Disposer, & Redo Plumbing	2012	8,558		20	428	428	1,284	12
13	Water Heater	2012	4,200		20	210	210	595	13
14	Electric Breakers	2012	6,467		20	323	323	889	14
15	Fire Door	2013	2,828		20	141	141	283	15
16	Installation Of New Cat 5 Cables In All Work Stations	2013	4,800		20	240	240	280	16
17	American Backflow Prevention New Backflow Preventer With Shu	2014	7,200		20	180	180	180	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)		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	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
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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	TOTAL (lines 1 thru 33)		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	34

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

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	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
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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)		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 866,397	\$ 95,862		\$ 42,684	\$ (53,178)	\$ 143,004	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	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

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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	Totals from Page 12G, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	19,313	574	35	495	(79)	2,208	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from 8131 N. Monticello	2010	8,651	869	20	433	(436)	1,963	9
10	Allocated from 8131 N. Monticello	2013	1,505	150	20	75	(75)	150	10
11									11
12	Allocated from Aperion Care	2010	864		20	86	86	369	12
13	Allocated from Aperion Care	2012	545		20	36	36	91	13
14	Allocated from Aperion Care	2013	97		20	10	10	19	14
15									15
16	Allocated Depreciation from YAM Management			527			(527)		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 30,975	\$ 2,120		\$ 1,135	\$ (985)	\$ 4,800	34

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

Facility Name & ID Number Aperion Care Springfield

0051086

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 30,975	\$ 2,120		\$ 1,135	\$ (985)	\$ 4,800	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 30,975	\$ 2,120		\$ 1,135	\$ (985)	\$ 4,800	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	\$ 218,335	\$	\$ 25,275	\$ 25,275	10	\$ 85,912	71
72	Current Year Purchases	10,353	11	908	897	10	908	72
73	Fully Depreciated Assets	13,797				10	13,797	73
74								74
75	TOTALS	\$ 242,485	\$ 11	\$ 26,182	\$ 26,171		\$ 100,617	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		2010 FORD E350 - Transfer from	2012	\$ 47,641	\$	\$ 7,162	\$ 7,162	5	\$ 21,381	76
77		2005 DODGE CARAVAN USED	2014	5,626		844	844	5	844	77
78		Allocated from Aperion Care	2014	892		178	178	5	626	78
79										79
80	TOTALS			\$ 54,159	\$	\$ 8,184	\$ 8,184		\$ 22,851	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)	\$ 1,349,045	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,873	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,051	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,822)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 266,472	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from 8131 N. Monticello</u>				<u>254</u>			5
6								6
7	TOTAL				\$ 254			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: \$ 7,842

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>792</u>	17
18	<u>Allocated from Aperion Care</u>			<u>1,199</u>	18
19	<u>Allocated from Aperion Consulting</u>			<u>389</u>	19
20					20
21	TOTAL		\$	\$ 2,380	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	N/A	hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): See Supplemental									13	
14	TOTAL			\$		\$	\$		\$	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Aperion Care Springfield# 0051086Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,832	\$ 38,938	1
2	Cash-Patient Deposits	36,061	36,061	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	357,044	357,044	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,292	44,292	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	28,561	28,561	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 467,790	\$ 504,896	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,518	13
14	Buildings, at Historical Cost		342,849	14
15	Leasehold Improvements, at Historical Cost	89,973	113,585	15
16	Equipment, at Historical Cost	223,683	405,978	16
17	Accumulated Depreciation (book methods)	(144,150)	(350,099)	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):	445,282	458,782	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 614,788	\$ 1,154,613	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,082,578	\$ 1,659,509	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 130,676	\$ 101,256	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,548	36,548	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,586	51,586	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,381	1,381	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,236	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	28,651	28,651	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 248,842	\$ 236,658	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,063	15,063	39
40	Mortgage Payable		621,368	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,489,139	1,781,632	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,504,202	\$ 2,418,063	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,753,044	\$ 2,654,721	46
47	TOTAL EQUITY(page 18, line 24)	\$ (670,466)	\$ (995,212)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,082,578	\$ 1,659,509	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (481,189)	1
2	Restatements (describe):		2
3	Due Jacksonville	(142,468)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (623,657)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(46,809)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (46,809)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (670,466)	24 *

* 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		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 3,491,590		1
2	Discounts and Allowances for all Levels	(1,130,449)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,361,141		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	195		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 195		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,361,336		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	498,683		31
32	Health Care	843,787		32
33	General Administration	569,189		33
B. Capital Expense				
34	Ownership	260,180		34
C. Ancillary Expense				
35	Special Cost Centers	64,282		35
36	Provider Participation Fee	172,024		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,408,145		40
41	Income before Income Taxes (line 30 minus line 40)**	(46,809)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (46,809)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,230,459	44
45	Private Pay - Net Inpatient Revenue	124,960	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify) <u>Veteran</u>	5,722	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,361,141	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 Springfield

0051086

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	2,104	2,144	\$ 63,159	\$ 29.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,154	4,509	93,637	20.77	3
4	Licensed Practical Nurses	8,645	9,258	181,517	19.61	4
5	CNAs & Orderlies	23,937	26,050	272,944	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,728	1,837	22,299	12.14	9
10	Activity Assistants	425	425	4,003	9.42	10
11	Social Service Workers	3,679	4,084	82,322	20.16	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,486	28,274	11.37	13
14	Head Cook	3,200	3,431	31,056	9.05	14
15	Cook Helpers/Assistants	6,872	7,507	70,202	9.35	15
16	Dishwashers					16
17	Maintenance Workers	2,993	3,081	37,244	12.09	17
18	Housekeepers	7,700	8,732	86,769	9.94	18
19	Laundry	10,584	1,116	10,309	9.24	19
20	Administrator	2,112	2,160	67,097	31.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,112	2,160	24,319	11.26	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	2,098	2,312	31,171	13.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,375	81,292	\$ 1,106,322 *	\$ 13.61	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	112	\$ 6,177	01-03	35
36	Medical Director	Monthly	22,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	390	29,266	10-03	38
39	Pharmacist Consultant	126	6,318	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	38	2,075	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric MD	Monthly	1,833	10-03	47
48					48
49	TOTAL (lines 35 - 48)	667	\$ 68,469		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	
Jackie Liddell	Administrator	0	\$ 67,097	Workers' Compensation Insurance	\$ 21,253	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,155	Advertising: Employee Recruitment	218	
				FICA Taxes	83,223	Health Care Worker Background Check		
				Employee Health Insurance	11,659	(Indicate # of checks performed <u>207</u>)	2,067	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,700	
				Other Employee Benefits	936	Licenses & Permits	1,359	
						Allocated from 8131 N. Monticello	18	
						Allocated from YAM Consulting	9	
						See Supplemental Schedule	1,309	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 136,226	\$ 10,680		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Administrative Consultant - YAM Consulting							Out-of-State Travel	
\$ 15,000							\$	
Management Fees - Aperion Care, Inc.								
16,714							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 31,714				\$			3,232	
							Allocated from YAM Consulting	
							226	
							Allocated from YAM Management	
							90	
							See Supplemental Schedule	
							633	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			TOTAL	
\$ 138,194				\$			\$ 4,181	

* 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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Aperion Care Springfield# 0051086

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? Yes
If YES, give association name and amount. ICLTC \$2,983
- (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. \$ 576 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. \$ 172,024
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. \$ No 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? Yes
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.