

Facility Name & ID Number Aperion Care St Elmo

0052696 Report Period Beginning: 02/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	14,028	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,012	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	20,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	633		1,676	2,309	8
9	SNF/PED					9
10	ICF	9,343	4,297		13,640	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,976	4,297	1,676	15,949	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.59%

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)

Meals on Wheels

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 02/01/2014

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

YES Date 02/01/2014 NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 1,624

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

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	105,343	9,573	4,602	119,518		119,518	4,611	124,129		1
2	Food Purchase		95,345		95,345		95,345	(2,124)	93,221		2
3	Housekeeping	65,631	10,118		75,749		75,749		75,749		3
4	Laundry	28,851	10,078		38,929		38,929		38,929		4
5	Heat and Other Utilities			39,591	39,591		39,591	(502)	39,089		5
6	Maintenance	19,008	10,645	20,850	50,503		50,503	11,093	61,596		6
7	Other (specify):*							1,001	1,001		7
8	TOTAL General Services	218,833	135,759	65,043	419,635		419,635	14,079	433,714		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	751,610	59,031	25,098	835,739		835,739	(5,042)	830,697		10
10a	Therapy										10a
11	Activities	37,988	866	2,200	41,054		41,054		41,054		11
12	Social Services	40,822		2,201	43,023		43,023		43,023		12
13	CNA Training										13
14	Program Transportation							982	982		14
15	Other (specify):*							1,695	1,695		15
16	TOTAL Health Care and Programs	830,420	59,897	39,499	929,816		929,816	(2,365)	927,451		16
	C. General Administration										
17	Administrative	99,383		103,341	202,724		202,724	(78,994)	123,730		17
18	Directors Fees										18
19	Professional Services			125,365	125,365	(108)	125,257	(77,748)	47,509		19
20	Dues, Fees, Subscriptions & Promotions			29,673	29,673		29,673	(18,207)	11,466		20
21	Clerical & General Office Expenses	11,868		95,878	107,746		107,746	(14,948)	92,798		21
22	Employee Benefits & Payroll Taxes			182,622	182,622		182,622		182,622		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,092	3,092		3,092	687	3,779		24
25	Other Admin. Staff Transportation			4,557	4,557		4,557	(88)	4,469		25
26	Insurance-Prop.Liab.Malpractice			47,612	47,612		47,612	3,012	50,624		26
27	Other (specify):*							5,713	5,713		27
28	TOTAL General Administration	111,251		592,140	703,391	(108)	703,283	(180,573)	522,710		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,160,504	195,656	696,682	2,052,842	(108)	2,052,734	(168,859)	1,883,875		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.

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			8,175	8,175		8,175	40,367	48,542			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,241	11,241		11,241	72,665	83,906			32
33	Real Estate Taxes					108	108	22,882	22,990			33
34	Rent-Facility & Grounds			172,850	172,850		172,850	(172,670)	180			34
35	Rent-Equipment & Vehicles			4,708	4,708		4,708	2,204	6,912			35
36	Other (specify):*											36
37	TOTAL Ownership			196,974	196,974	108	197,082	(34,552)	162,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,946	272,415	278,361		278,361	(37,340)	241,021			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,509	117,509		117,509		117,509			42
43	Other (specify):*			33,174	33,174		33,174	(33,174)				43
44	TOTAL Special Cost Centers		5,946	423,098	429,044		429,044	(70,514)	358,530			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,160,504	201,602	1,316,754	2,678,860		2,678,860	(273,925)	2,404,935			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 St Elmo

0052696

Report Period Beginning: 02/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(979)	02		4
5	Telephone, TV & Radio in Resident Rooms	(746)	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	38,885	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(257)	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	(1,120)	21		19
20	Contributions	(17,987)	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	(34,081)	21		24
25	Fund Raising, Advertising and Promotional	(17,174)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,362)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,821)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(200,104)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (200,104)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (273,925)		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

Aperion Care St Elmo

ID# 0052696

Report Period Beginning: 02/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Building Co- Amortization	\$ (2,563)	36	1
2	Building Co- Bank Fee	(3,779)	21	2
3	Building Co- Licenses	(250)	21	3
4	Bank Charges	(5,637)	21	4
5	Non Allowable Travel	(2,484)	25	5
6	PAC Dues	(909)	20	6
7	Meals on Wheels	(888)	02	7
8	Additional R&M	6,505	06	8
9	Non Allowable Fees	(16,000)	43	9
10	Non Allowable Legal	(1,566)	19	10
11	Non Allowable Dues	(300)	20	11
12	Website Expense	(1,491)	21	12
13	Building Co- Bookkeeping	(6,000)	19	13
14	Non-Allowable Rent	(5,000)	34	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		(40,362)	49

Aperion Care St Elmo

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

ID# 0052696

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 St Elmo# 0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 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					2,702	56	1,853					4,611	1
2	Food Purchase	(2,124)											(2,124)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(746)					107		137				(502)	5
6	Maintenance	6,505		1,343		1,112	924	1,046	163				11,093	6
7	Other (specify):*			88		554	183	176					1,001	7
8	TOTAL General Services	3,635		1,431		4,368	1,270	3,075	300				14,079	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			1,163		961		(7,166)					(5,042)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							982					982	14
15	Other (specify):*			87		1,132		476					1,695	15
16	TOTAL Health Care and Programs			1,250		2,093		(5,708)					(2,365)	16
	C. General Administration													
17	Administrative			(86,794)	792		3,332	3,676					(78,994)	17
18	Directors Fees													18
19	Professional Services	(7,566)	12,000	(24,076)	(20,556)	39	(34,619)	(913)	278		(2,335)		(77,748)	19
20	Fees, Subscriptions & Promotions	(19,196)		820	11	4	135	6	13				(18,207)	20
21	Clerical & General Office Expenses	(46,358)	4,029	8,922	10,981	476	3,777	2,878	347				(14,948)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			365	7	108	59	148					687	24
25	Other Admin. Staff Transportation	(2,484)		1,035	12	811	403	135					(88)	25
26	Insurance-Prop.Liab.Malpractice			273	2,292		418	29					3,012	26
27	Other (specify):*			1,741		56	3,526	390					5,713	27
28	TOTAL General Administration	(75,604)	16,029	(97,714)	(6,461)	1,494	(22,969)	6,349	638		(2,335)		(180,573)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(71,969)	16,029	(95,033)	(6,461)	7,955	(21,699)	3,716	938		(2,335)		(168,859)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care St Elmo# 0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	38,885				5	347		1,130				40,367	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		71,585				158		922				72,665	32
33	Real Estate Taxes		21,980						902				22,882	33
34	Rent-Facility & Grounds	(5,000)	(157,850)	377			(745)		(9,452)				(172,670)	34
35	Rent-Equipment & Vehicles			919	59	294	279	521	132				2,204	35
36	Other (specify):*	(2,563)	2,563											36
37	TOTAL Ownership	31,322	(61,722)	1,296	59	299	39	521	(6,366)				(34,552)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(37,340)			(37,340)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(33,174)											(33,174)	43
44	TOTAL Special Cost Centers	(33,174)								(37,340)			(70,514)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(73,821)	(45,693)	(93,737)	(6,402)	8,254	(21,660)	4,237	(5,428)	(37,340)	(2,335)		(273,925)	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	\$ 157,850	221 East Cumberland, LLC	100.00%	\$	\$ (157,850)	1
2	V	36 Amortization		222 East Cumberland, LLC	100.00%	2,563	2,563	2
3	V	21 Bank Fee		223 East Cumberland, LLC	100.00%	3,779	3,779	3
4	V	33 Real Estate Taxes		224 East Cumberland, LLC	100.00%	21,980	21,980	4
5	V	19 Bookkeeping Fees		225 East Cumberland, LLC	100.00%	6,000	6,000	5
6	V	19 Home Office Expense		226 East Cumberland, LLC	100.00%	6,000	6,000	6
7	V	21 Licenses & Permits		227 East Cumberland, LLC	100.00%	250	250	7
8	V	32 Interest Expense		228 East Cumberland, LLC	100.00%	71,585	71,585	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 157,850			\$ 112,157	\$ * (45,693)	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%	1,343	\$ 1,343
16	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	88	88
17	V	10 SALARY- NURSE		APERION CARE	100.00%	1,163	1,163
18	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	87	87
19	V	17 ADMINISTRATIVE		APERION CARE	100.00%	16,547	16,547
20	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	1,721	1,721
21	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	820	820
22	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	8,922	8,922
23	V	24 SEMINARS		APERION CARE	100.00%	365	365
24	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	1,035	1,035
25	V	26 INSURANCE		APERION CARE	100.00%	273	273
26	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	1,741	1,741
27	V	34 RENT		APERION CARE	100.00%	377	377
28	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	12	12
29	V	35 AUTO LEASE		APERION CARE	100.00%	907	907
30	V	17 MANAGEMENT FEE	103,341	APERION CARE	100.00%		(103,341)
31	V	19 HOME OFFICE	25,518	APERION CARE	100.00%		(25,518)
32	V	19 DATA PROCESSING	279	APERION CARE	100.00%		(279)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 129,138			\$ 35,401	\$ * (93,737)

* 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%	792	\$	792	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	322		322	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	11		11	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	10,981		10,981	18
19	V	24 SEMINARS		APERION FINANCIAL	100.00%	7		7	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	12		12	20
21	V	26 INSURANCE		APERION FINANCIAL	100.00%	2,292		2,292	21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	59		59	22
23	V	19 HOME OFFICE EXPENSE	20,878	APERION FINANCIAL	100.00%			(20,878)	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		\$ 20,878			\$ 14,476	\$ *	(6,402)	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	1 DIETARY	\$	APERION CONSULTING	100.00%	\$ 2,702	\$	2,702	15
16	V	5 UTILITIES		APERION CONSULTING	100.00%				16
17	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	1,112		1,112	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	554		554	18
19	V	10 SALARY NURSE		APERION CONSULTING	100.00%	7,783		7,783	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	1,132		1,132	20
21	V	17 ADMINISTRATIVE		APERION CONSULTING	100.00%				21
22	V	19 PROFESSIONAL FEES		APERION CONSULTING	100.00%	39		39	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	4		4	23
24	V	21 CLERICAL & GENERAL		APERION CONSULTING	100.00%	476		476	24
25	V	24 SEMINARS		APERION CONSULTING	100.00%	108		108	25
26	V	25 AUTO AND TRAVEL		APERION CONSULTING	100.00%	811		811	26
27	V	26 INSURANCE		APERION CONSULTING	100.00%				27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	56		56	28
29	V	30 DEPRECIATION		APERION CONSULTING	100.00%	5		5	29
30	V	35 AUTO LEASE		APERION CONSULTING	100.00%	294		294	30
31	V	10 CONSULTING	6,822	APERION CONSULTING	100.00%			(6,822)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 6,822			\$ 15,076	\$ *	8,254	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 MANAGEMENT, LLC</u>	<u>100.00%</u>	\$ <u>56</u>	\$	<u>56</u> <u>15</u>
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>107</u>		<u>107</u> <u>16</u>
17	V	<u>6</u> <u>REPAIRS & MAINTENANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>924</u>		<u>924</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>183</u>		<u>183</u> <u>18</u>
19	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>3,332</u>		<u>3,332</u> <u>19</u>
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>1,061</u>		<u>1,061</u> <u>20</u>
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>135</u>		<u>135</u> <u>21</u>
22	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>17,859</u>		<u>17,859</u> <u>22</u>
23	V	<u>24</u> <u>SEMINARS</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>59</u>		<u>59</u> <u>23</u>
24	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>403</u>		<u>403</u> <u>24</u>
25	V	<u>26</u> <u>INSURANCE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>418</u>		<u>418</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>3,526</u>		<u>3,526</u> <u>26</u>
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>347</u>		<u>347</u> <u>27</u>
28	V	<u>32</u> <u>INTEREST</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>158</u>		<u>158</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>2,163</u>		<u>2,163</u> <u>30</u>
31	V	<u>34</u> <u>PARKING RENTAL</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>92</u>		<u>92</u> <u>31</u>
32	V	<u>35</u> <u>AUTO LEASE</u>		<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>	<u>279</u>		<u>279</u> <u>32</u>
33	V							
34	V	<u>19</u> <u>ACCOUNTING</u>	<u>8,000</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(8,000)</u> <u>34</u>
35	V	<u>19</u> <u>DATA PROCESSING</u>	<u>2,492</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(2,492)</u> <u>35</u>
36	V	<u>19</u> <u>BOOKKEEPING</u>	<u>25,188</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(25,188)</u> <u>36</u>
37	V	<u>21</u> <u>CORPORATE EVENTS</u>	<u>14,082</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(14,082)</u> <u>37</u>
38	V	<u>34</u> <u>RENT</u>	<u>3,000</u>	<u>YAM MANAGEMENT, LLC</u>	<u>100.00%</u>			<u>(3,000)</u> <u>38</u>
39	Total		\$ <u>52,762</u>			\$ <u>31,102</u>	\$ *	<u>(21,660)</u> <u>39</u>

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 1,853	\$ 1,853	15
16	V	5 UTILITIES		YAM CONSULTING, LLC	100.00%			16
17	V	6 REPAIRS & MAINTENANCE		YAM CONSULTING, LLC	100.00%	1,046	1,046	17
18	V	7 EMP. BEN.-GEN. SERV.		YAM CONSULTING, LLC	100.00%	176	176	18
19	V	10 NURSE SALARY		YAM CONSULTING, LLC	100.00%	7,834	7,834	19
20	V	15 EMP. BEN.-NURSE		YAM CONSULTING, LLC	100.00%	476	476	20
21	V	17 ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	3,676	3,676	21
22	V	19 PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	1,087	1,087	22
23	V	20 FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	6	6	23
24	V	21 CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	2,878	2,878	24
25	V	24 SEMINARS		YAM CONSULTING, LLC	100.00%	148	148	25
26	V	25 AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	135	135	26
27	V	26 INSURANCE		YAM CONSULTING, LLC	100.00%	29	29	27
28	V	27 EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	390	390	28
29	V	14 NURSE TRAVEL		YAM CONSULTING, LLC	100.00%	982	982	29
30	V	32 INTEREST		YAM CONSULTING, LLC	100.00%			30
31	V	35 AUTO RENTAL		YAM CONSULTING, LLC	100.00%	521	521	31
32	V	10 NURSE CONSULTING	15,000	YAM CONSULTING, LLC	100.00%		(15,000)	32
33	V	19 DATA PROCESSING	2,000	YAM CONSULTING, LLC	100.00%		(2,000)	33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 17,000			\$ 21,237	\$ * 4,237	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 137	\$	137	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	163		163	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	278		278	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	13		13	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	347		347	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,130		1,130	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	922		922	21
22	V	34 RENT		8131 N. MONTICELLO, LLC	100.00%	180		180	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	132		132	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	902		902	24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC	100.00%			(7,000)	26
27	V	34 RENT	2,632	8131 N. MONTICELLO, LLC	100.00%			(2,632)	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		\$ 9,632			\$ 4,204	\$ *	(5,428)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 219,649	Renewal Rehab	100.00%	\$ 182,309	\$ (37,340)
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		\$ 219,649			\$ 182,309	\$ * (37,340)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 11,118	ProPay HR LLC	24.00%	\$ 8,783	\$ (2,335)
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		\$ 11,118			\$ 8,783	\$ * (2,335)

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BM EQUITIES	51.00%	Aperion Care Amboy	Amboy	221 EAST CUMBERLAND	SKOKIE	BUILDING CO.	1
2	MORRIS ESFORMES	10.00%	Aperion Care Jacksonville	Jacksonville	YAM MANAGEMENT (1/1/14-6/30/14)	SKOKIE	MANAGEMENT CO.	2
3	DELECIA ESFORMES TRUST	10.00%	River Crossing Rehab	Galesburg	YAM CONSULTING (1/1/14-6/30/14)	SKOKIE	CONSULTING CO.	3
4	JACK AND MARY YOLINSKY	10.00%	Aperion Care Dolton	Dolton	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING CO.	4
5	SYLVIA YOLINSKY TRUST	10.00%	Riverwood Rehab	East Moline	PROPAY	EVANSTON	PAYROLL SERVICES	5
6	257 LTD PARTNERSHIP	2.00%	Aperion Care Bridgeport	Bridgeport	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7	1219 LTD PARTNERSHIP	2.00%	Aperion Care Litchfield	Litchfield	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	7
8	42170 LTD PARTNERSHIP	2.00%	Aperion Care Springfield	Springfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	8
9	FREDRICK S. FRANKEL	1.50%	Aperion Care Evanston	Evanston	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	9
10	STEVEN TUROFSKY	1.50%	Aperion Care Midlothian	Midlothian	APERION ESTATES PERU	PERU, IN	ALF	10
11			Aperion Care Burbank	Burbank	APERION CARE COPPERAS HOLLOW	CALDWELL, TX	ALF	11
12			Aperion Care Chicago Heights	Chicago Heights	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	12
13			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

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 St Elmo # 0052696 Report Period Beginning: 02/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	\$ 3,983	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.4	2.00%	Alloc. Salary	622	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.4	2.00%	Alloc. Salary	799	17-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	409	21-7	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	0.8	2.00%	Alloc. Salary	752	21-7	5
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	3,983	17-7	6
7	Fredrick Frankel	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	2,689	17-7	7
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	2,940	17-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 16,177		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 St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization APERION 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	8,564	1,343	1
2	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	431,728	30	4,451		8,564	88	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	8,564	1,163	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381		8,564	87	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	8,564	16,547	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759		8,564	1,721	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339		8,564	820	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	8,564	8,922	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383		8,564	365	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156		8,564	1,035	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783		8,564	273	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772		8,564	1,741	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000		8,564	377	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601		8,564	12	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731		8,564	907	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		\$ 35,401	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	30	39,916		8,564	792	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	30	16,216		8,564	322	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	30	570		8,564	11	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	30	553,558	596,633	8,564	10,981	4
5	24	SEMINARS	ACTUAL CENSUS	30	342		8,564	7	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	30	585		8,564	12	6
7	26	INSURANCE	ACTUAL CENSUS	30	115,531		8,564	2,292	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	30	2,974		8,564	59	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		\$ 14,476	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization APERION 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	8,564	\$ 2,702	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30		8,564			2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	8,564	1,112	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		8,564	554	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	8,564	7,783	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		8,564	1,132	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			8,564		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		8,564	39	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		8,564	4	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	8,564	476	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		8,564	108	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		8,564	811	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			8,564		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		8,564	56	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		8,564	5	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		8,564	294	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 759,903	\$ 603,946		\$ 15,076	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	375,486	26	\$ 2,866	\$ 2,866	7,385	\$ 56	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432	7,385	107	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	7,385	924	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302	7,385	183	4	
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	7,385	3,332	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925	7,385	1,061	6	
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855	7,385	135	7	
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	7,385	17,859	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004	7,385	59	9	
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508	7,385	403	10	
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257	7,385	418	11	
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286	7,385	3,526	12	
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623	7,385	347	13	
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053	7,385	158	14	
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26		7,385		15	
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000	7,385	2,163	16	
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655	7,385	92	17	
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167	7,385	279	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,581,370	\$ 845,178	\$ 31,102	25	

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	375,486	26	\$ 94,203	\$ 94,203	7,385	\$ 1,853	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26			7,385		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	7,385	1,046	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		7,385	176	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	7,385	7,834	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		7,385	476	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	7,385	3,676	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		7,385	1,087	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		7,385	6	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	7,385	2,878	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		7,385	148	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		7,385	135	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		7,385	29	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		7,385	390	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		7,385	982	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		7,385		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		7,385	521	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,079,857	\$ 872,186		\$ 21,237	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	807,214	30	\$ 6,925	\$ 15,949	\$ 137	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268	15,949	163	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051	15,949	278	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646	15,949	13	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570	15,949	347	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207	15,949	1,130	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653	15,949	922	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100	15,949	180	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667	15,949	132	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673	15,949	902	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	\$	\$ 4,204	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		\$	\$		\$ 182,309	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				\$	\$		\$ 182,309	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 8,783	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				\$	\$		\$ 8,783	25

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6	Bank Leumi		X	Mortgage				1,405,313			71,585	6				
7	Prior Owner		X					125,000				7				
8	See Supplemental Schedule							472,000			11,241	8				
9	TOTAL Facility Related						\$	\$ 2,002,313			\$ 82,826	9				
	B. Non-Facility Related*															
10	Allocated from 8131 N. Monticello										922	10				
11	Allocated from YAM Management										158	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 1,080	14				
15	TOTALS (line 9+line14)						\$	\$ 2,002,313			\$ 83,906	15				

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 St Elmo

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

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

1	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	Bank Leumi		X	Line of Credit			\$	\$ 472,000			\$ 10,252					
9	Insurance Policies										989					
10																
11																
12																
13																
14	TOTAL Working Capital							472,000			11,241					
	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>23,766</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>23,775</u>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>9</u>		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>22,873</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>108</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>22,990</u>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	<u>20,985</u>	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> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2010	<u>19,364</u>	9												
	2011	<u>19,940</u>	10												
	2012	<u>11</u>	11												
	2013	<u>22,873</u>	12												
Beginning Accrual Adjusted															
2014 Accrual = 2013 Tax															
Allocated from 8131 N. Monticello- \$902															

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 St Elmo COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0052696

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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-12-27-237-002</u>	<u>Long Term Care Facility</u>	\$ <u>75.40</u>	\$ <u>75.40</u>
2. <u>01-12-27-237-003</u>	<u>Long Term Care Facility</u>	\$ <u>21,112.45</u>	\$ <u>21,112.45</u>
3. <u>01-12-27-237-004</u>	<u>Long Term Care Facility</u>	\$ <u>1,685.27</u>	\$ <u>1,685.27</u>
4. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>64,433.32</u>	\$ <u>1,115.20</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>87,306.44</u></u>	\$ <u><u>23,988.32</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 St Elmo

0052696 Report Period Beginning:

02/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,076 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>51,830</u>	<u>2014</u>	<u>\$ 90,000</u>	<u>1</u>
2	<u>Allocated from 8131 N. Monticello</u>			<u>1,758</u>	<u>2</u>
3	TOTALS	51,830		\$ 91,758	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		2014	1968	\$ 1,108,000	\$	39	\$ 28,410	\$ 28,410	\$ 28,410	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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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											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F & 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>			21,987	1,474	808	(666)	3,417	68
69	<u>Financial Statement Depreciation</u>				8,175		(8,175)		69
70	TOTAL (lines 4 thru 69)			\$ 1,129,987	\$ 9,649	\$ 29,218	\$ 19,569	\$ 31,827	70

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

Facility Name & ID Number **Aperion Care St Elmo**

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 1,129,987	\$ 9,649		\$ 29,218	\$ 19,569	\$ 31,827	1
2	Labor & Materials To Install New Light Fixtures & Exit Signs	2014	20,758		20	519	519	519	2
3	Furnish & Install New Sign With Lexan Face Panels	2014	3,220		20	107	107	107	3
4	New Ceiling In Kitchen & Replace Front Roof Area	2014	9,000		20	375	375	375	4
5	New Cat5E Lines For New & Existing Computers	2014	4,800		20	720	720	720	5
6	Computer Back Up On Generator	2014	4,025		20	268	268	268	6
7	Light Fixtures	2014	2,818		20	47	47	47	7
8	New Architectural 30 Year Shingle Roof	2014	86,290		20	1,079	1,079	1,079	8
9	Soffit Fascia	2014	9,200		20	77	77	77	9
10	Cabling For Vip System	2014	4,000		20	133	133	133	10
11	New Windows,Paint 28 Rooms,New Vct Tiles In 5 Rooms, 25 New	2014	116,700		20	486	486	486	11
12	Electrical Work For 28 New Ptac Units- Includes New 400 Amp M	2014	33,460		20	139	139	139	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)		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	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)		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	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		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	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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16									16
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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)		\$ 1,424,258	\$ 9,649		\$ 33,169	\$ 23,520	\$ 35,778	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
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29									
30									
31									
32									
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	13,663	406	35	350	(56)	1,562	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from 8131 N. Monticello	2010	6,120	615	20	306	(309)	1,389	9
10	Allocated from 8131 N. Monticello	2013	1,065	106	20	53	(53)	103	10
11	Allocated from YAM Management			347			(347)		11
12	Allocated from Aperion Care	2010	653		20	65	65	279	12
13	Allocated from Aperion Care	2012	413		20	27	27	69	13
14	Allocated from Aperion Care	2013	73		20	7	7	15	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)		\$ 21,987	\$ 1,474		\$ 808	\$ (666)	\$ 3,417	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 12H, Carried Forward		\$ 21,987	\$ 1,474		\$ 808	\$ (666)	\$ 3,417	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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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)		\$ 21,987	\$ 1,474		\$ 808	\$ (666)	\$ 3,417	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	\$ 2,856	\$	\$ 448	\$ 448	10	\$ 1,329	71
72	Current Year Purchases	148,254	8	14,790	14,782	10	14,790	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 151,110	\$ 8	\$ 15,238	\$ 15,230		\$ 16,119	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2014	\$ 675	\$	\$ 135	\$ 135	5	\$ 474	76
77										77
78										78
79										79
80	TOTALS			\$ 675	\$	\$ 135	\$ 135		\$ 474	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)	\$ 1,667,801	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,542	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 38,885	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 52,371	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning: 02/01/14

Ending: 12/31/14

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>180</u>			5
6								6
7	TOTAL				\$ <u>180</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,911

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>521</u>	17
18	<u>Allocated from YAM Management</u>			<u>279</u>	18
19	<u>Allocated from Aperion Care</u>			<u>907</u>	19
20	<u>Allocated from Aperion Consulting</u>			<u>294</u>	20
21	TOTAL		\$	\$ <u>2,001</u>	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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>
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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	39 - 03	hrs	\$		\$	105,802	\$		\$	105,802	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				10,641				10,641	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				103,208				103,208	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 03	# of prescripts				51,833				51,833	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						931	5,946			6,877	13
14	TOTAL			\$		\$	272,415	\$	5,946	\$	278,361	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.

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	\$ 500	\$ 65,821	1
2	Cash-Patient Deposits	3,004	3,004	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	574,702	574,702	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,542	25,542	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	712	712	8
9	Other(specify):	4,719	5,719	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 609,179	\$ 675,500	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,000	13
14	Buildings, at Historical Cost		1,108,000	14
15	Leasehold Improvements, at Historical Cost	292,051	292,051	15
16	Equipment, at Historical Cost	15,565	157,565	16
17	Accumulated Depreciation (book methods)	(8,175)	(8,175)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,563)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	600,000	1,653,172	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 899,441	\$ 3,290,050	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,508,620	\$ 3,965,550	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 343,718	\$ 355,718	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,737	2,737	28
29	Short-Term Notes Payable	472,000	472,000	29
30	Accrued Salaries Payable	82,148	82,148	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,011	4,011	31
32	Accrued Real Estate Taxes(Sch.IX-B)		22,873	32
33	Accrued Interest Payable	1,616	7,667	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	42,652	42,652	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 948,882	\$ 989,806	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,530,313	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	526,063	1,366,063	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 526,063	\$ 2,896,376	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,474,945	\$ 3,886,182	46
47	TOTAL EQUITY(page 18, line 24)	\$ 33,675	\$ 79,368	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,508,620	\$ 3,965,550	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	122,175	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	(88,500)	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)	\$ 33,675	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)	\$ 33,675	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	\$ 2,405,235	1
2	Discounts and Allowances for all Levels	299,736	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,704,971	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	11,096	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 11,096	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	979	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	42,336	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,421	19
20	Radiology and X-Ray	1,828	20
21	Other Medical Services	16,612	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,176	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)		26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	20,792	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,792	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,801,035	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	419,635	31
32	Health Care	929,816	32
33	General Administration	703,391	33
B. Capital Expense			
34	Ownership	196,974	34
C. Ancillary Expense			
35	Special Cost Centers	311,535	35
36	Provider Participation Fee	117,509	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,678,860	40
41	Income before Income Taxes (line 30 minus line 40)**	122,175	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 122,175	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,322,990	44
45	Private Pay - Net Inpatient Revenue	604,864	45
46	Medicare - Net Inpatient Revenue	752,181	46
47	Other-(specify) <u>Insurance</u>	24,936	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,704,971	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 St Elmo

0052696

Report Period Beginning:

02/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,184	1,350	\$ 44,632	\$ 33.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,441	4,929	96,474	19.57	3
4	Licensed Practical Nurses	11,986	12,745	224,489	17.61	4
5	CNAs & Orderlies	34,293	36,754	353,363	9.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,754	1,904	21,585	11.34	9
10	Activity Assistants	1,352	1,539	16,403	10.66	10
11	Social Service Workers	1,930	2,090	22,795	10.91	11
12	Dietician					12
13	Food Service Supervisor	1,381	1,485	21,834	14.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,068	8,891	83,509	9.39	15
16	Dishwashers					16
17	Maintenance Workers	1,503	1,768	19,008	10.75	17
18	Housekeepers	6,361	6,831	65,631	9.61	18
19	Laundry	2,947	3,146	28,851	9.17	19
20	Administrator	1,840	1,840	99,383	54.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,078	1,203	11,868	9.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,453	1,570	32,652	20.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,407	1,630	18,027	11.06	33
34	TOTAL (lines 1 - 33)	82,978	89,675	\$ 1,160,504 *	\$ 12.94	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	84	\$ 4,602	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	288	21,822	10-03	38
39	Pharmacist Consultant	Monthly	3,276	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	40	2,200	11-03	44
45	Social Service Consultant	40	2,201	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	452	\$ 44,101		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-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 St Elmo# 0052696

Report Period Beginning:

02/01/14

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$2,753
- (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. \$ 9,035 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 117,509
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? Yes Indicate the amount. \$ 979
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.