



Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,405</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	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	Other	Total	
8	SNF	<u>10,335</u>	<u>5,519</u>	<u>2,336</u>	<u>18,190</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,335</u>	<u>5,519</u>	<u>2,336</u>	<u>18,190</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.38%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/1/2014

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/2014 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 97 and days of care provided 1,742

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	136,897	13,853	5,786	156,536		156,536	2,676	159,212		1
2	Food Purchase		105,849		105,849		105,849	(218)	105,631		2
3	Housekeeping	48,245	11,392		59,637		59,637		59,637		3
4	Laundry	52,155	4,947	1,847	58,949		58,949		58,949		4
5	Heat and Other Utilities			78,283	78,283		78,283	(8,200)	70,083		5
6	Maintenance	61,033	13,699	50,355	125,087		125,087	7,812	132,899		6
7	Other (specify):*							1,066	1,066		7
8	<b>TOTAL General Services</b>	<b>298,330</b>	<b>149,740</b>	<b>136,271</b>	<b>584,341</b>		<b>584,341</b>	<b>3,136</b>	<b>587,477</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,800	7,800		7,800		7,800		9
10	Nursing and Medical Records	1,053,843	93,928	38,649	1,186,420		1,186,420	(8,558)	1,177,862		10
10a	Therapy	54,242	135	260	54,637		54,637		54,637		10a
11	Activities	40,174	1,304	687	42,165		42,165		42,165		11
12	Social Services	67,263		6,875	74,138		74,138		74,138		12
13	CNA Training										13
14	Program Transportation			90	90		90		90		14
15	Other (specify):*							2,450	2,450		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,215,522</b>	<b>95,367</b>	<b>54,361</b>	<b>1,365,250</b>		<b>1,365,250</b>	<b>(6,108)</b>	<b>1,359,142</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	79,221		143,753	222,974		222,974	(110,925)	112,049		17
18	Directors Fees										18
19	Professional Services			181,406	181,406		181,406	(102,791)	78,615		19
20	Dues, Fees, Subscriptions & Promotions			66,153	66,153		66,153	(41,369)	24,784		20
21	Clerical & General Office Expenses	51,334		121,901	173,235		173,235	(33,325)	139,910		21
22	Employee Benefits & Payroll Taxes			223,722	223,722		223,722		223,722		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,054	1,054		1,054	2,690	3,744		24
25	Other Admin. Staff Transportation			3,817	3,817		3,817	4,981	8,798		25
26	Insurance-Prop.Liab.Malpractice			69,973	69,973		69,973	4,793	74,766		26
27	Other (specify):*							2,959	2,959		27
28	<b>TOTAL General Administration</b>	<b>130,555</b>		<b>811,779</b>	<b>942,334</b>		<b>942,334</b>	<b>(272,987)</b>	<b>669,347</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,644,407</b>	<b>245,107</b>	<b>1,002,411</b>	<b>2,891,925</b>		<b>2,891,925</b>	<b>(275,959)</b>	<b>2,615,966</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Aperion Care Amboy, Llc

#0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			3,621	3,621		3,621	(928)	2,693			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,083	16,083		16,083	3,097	19,180			32
33	Real Estate Taxes			31,978	31,978		31,978	1,113	33,091			33
34	Rent-Facility & Grounds			397,150	397,150		397,150	(61,693)	335,457			34
35	Rent-Equipment & Vehicles			7,754	7,754		7,754	2,292	10,046			35
36	Other (specify):*			3,371	3,371		3,371	(3,371)				36
37	<b>TOTAL Ownership</b>			459,957	459,957		459,957	(59,491)	400,466			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,628	326,228	381,856		381,856		381,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,753	151,753		151,753		151,753			42
43	Other (specify):*			16,948	16,948		16,948	(16,948)				43
44	<b>TOTAL Special Cost Centers</b>		55,628	494,929	550,557		550,557	(16,948)	533,609			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,644,407	300,735	1,957,297	3,902,439		3,902,439	(352,397)	3,550,042			45

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



Aperion Care Amboy, Llc

ID# 0053215

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 6,719	06	1
2	Advertising/Marketing	(14,981)	43	2
3	Promotional Products	(1,967)	43	3
4	Bank Charges	(6,537)	21	4
5	Amortization	(3,371)	36	5
6	PAC Dues	(6,889)	20	6
7	Non Allowable Rent	(51,000)	34	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(78,026)		49

Aperion Care Amboy, Llc

ID# 0053215

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Amboy, Llc# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	<b>Operating Expenses</b>	<b>PAGES</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>SUMMARY</b>	
	<b>A. General Services</b>	<b>5 &amp; 5A</b>	<b>6</b>	<b>6A</b>	<b>6B</b>	<b>6C</b>	<b>6D</b>	<b>6E</b>	<b>6F</b>	<b>6G</b>	<b>6H</b>	<b>6I</b>	<b>TOTALS</b>	
													<b>(to Sch V, col.7)</b>	
1	Dietary				2,676								2,676	1
2	Food Purchase	(321)		103									(218)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,490)		4			286						(8,200)	5
6	Maintenance	6,719		2,456	(1,795)	9	423						7,812	6
7	Other (specify):*			158	908								1,066	7
8	<b>TOTAL General Services</b>	<b>(2,092)</b>		<b>2,721</b>	<b>1,789</b>	<b>9</b>	<b>709</b>						<b>3,136</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			2,225	(10,783)								(8,558)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			159	2,291								2,450	15
16	<b>TOTAL Health Care and Programs</b>			<b>2,384</b>	<b>(8,492)</b>								<b>(6,108)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(112,523)		1,599							(110,925)	17
18	Directors Fees													18
19	Professional Services			(55,563)	411	(45,372)	97	(2,364)					(102,791)	19
20	Fees, Subscriptions & Promotions	(43,139)		1,033	704	27	6						(41,369)	20
21	Clerical & General Office Expenses	(80,364)		17,678	740	28,054	567						(33,325)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,494	143	53							2,690	24
25	Other Admin. Staff Transportation			2,953	1,647	382							4,981	25
26	Insurance-Prop.Liab.Malpractice			809		3,984							4,793	26
27	Other (specify):*			2,893	66								2,959	27
28	<b>TOTAL General Administration</b>	<b>(123,503)</b>		<b>(140,226)</b>	<b>3,711</b>	<b>(11,273)</b>	<b>669</b>	<b>(2,364)</b>					<b>(272,987)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(125,595)</b>		<b>(135,121)</b>	<b>(2,992)</b>	<b>(11,264)</b>	<b>1,378</b>	<b>(2,364)</b>					<b>(275,959)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Amboy, Llc# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
<b>30</b>	<b>D. Ownership</b>													
	Depreciation	(2,402)		304	34		1,136						(928)	30
<b>31</b>	Amortization of Pre-Op. & Org.													31
<b>32</b>	Interest	(27)		2,243	10		871						3,097	32
<b>33</b>	Real Estate Taxes						1,113						1,113	33
<b>34</b>	Rent-Facility & Grounds	(51,000)		158			(10,851)						(61,693)	34
<b>35</b>	Rent-Equipment & Vehicles			1,545	247	180	320						2,292	35
<b>36</b>	Other (specify):*	(3,371)											(3,371)	36
<b>37</b>	<b>TOTAL Ownership</b>	<b>(56,800)</b>		<b>4,250</b>	<b>291</b>	<b>180</b>	<b>(7,411)</b>						<b>(59,491)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
<b>38</b>	Medically Necessary Transportation													38
<b>39</b>	Ancillary Service Centers													39
<b>40</b>	Barber and Beauty Shops													40
<b>41</b>	Coffee and Gift Shops													41
<b>42</b>	Provider Participation Fee													42
<b>43</b>	Other (specify):*	(16,948)											(16,948)	43
<b>44</b>	<b>TOTAL Special Cost Centers</b>	<b>(16,948)</b>											<b>(16,948)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
<b>45</b>	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(199,343)</b>		<b>(130,871)</b>	<b>(2,702)</b>	<b>(11,085)</b>	<b>(6,033)</b>	<b>(2,364)</b>					<b>(352,397)</b>	<b>45</b>

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	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	2 FOOD	\$	APERION CARE	100.00%	\$ 103	\$	103	15
16	V	5 UTILITIES		APERION CARE	100.00%	4		4	16
17	V	6 REPAIRS & MAINTENANCE		APERION CARE	100.00%	2,456		2,456	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	158		158	18
19	V	10 SALARY- NURSE		APERION CARE	100.00%	2,225		2,225	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	159		159	20
21	V	17 ADMINISTRATIVE		APERION CARE	100.00%	31,230		31,230	21
22	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	6,216		6,216	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,033		1,033	23
24	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	17,678		17,678	24
25	V	24 SEMINARS		APERION CARE	100.00%	2,494		2,494	25
26	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	2,953		2,953	26
27	V	26 INSURANCE		APERION CARE	100.00%	809		809	27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	2,893		2,893	28
29	V	30 DEPRECIATION		APERION CARE	100.00%	304		304	29
30	V	32 INTEREST		APERION CARE	100.00%	2,243		2,243	30
31	V	33 REAL ESTATE TAX		APERION CARE	100.00%				31
32	V	34 RENT		APERION CARE	100.00%	158		158	32
33	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	49		49	33
34	V	35 AUTO LEASE		APERION CARE	100.00%	1,496		1,496	34
35	V	17 MANAGEMENT FEE	143,753	APERION CARE	100.00%			(143,753)	35
36	V	19 HOME OFFICE	56,011	APERION CARE	100.00%			(56,011)	36
37	V	19 DATA PROCESSING	5,768	APERION CARE	100.00%			(5,768)	37
38	V								38
39	Total		\$ 205,532			\$ 74,661	\$ *	(130,871)	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>APERION CONSULTING</u>	100.00%	\$ 4,216	\$ 4,216
16	V	<u>5</u> <u>UTILITIES</u>		<u>APERION CONSULTING</u>	100.00%		
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>APERION CONSULTING</u>	100.00%	2,755	2,755
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>APERION CONSULTING</u>	100.00%	908	908
19	V	<u>10</u> <u>SALARY NURSE</u>		<u>APERION CONSULTING</u>	100.00%	17,517	17,517
20	V	<u>15</u> <u>PAYROLL TAXES/GROUP INSURANCE</u>		<u>APERION CONSULTING</u>	100.00%	2,291	2,291
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>APERION CONSULTING</u>	100.00%		
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>APERION CONSULTING</u>	100.00%	411	411
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APERION CONSULTING</u>	100.00%	704	704
24	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>APERION CONSULTING</u>	100.00%	740	740
25	V	<u>24</u> <u>SEMINARS</u>		<u>APERION CONSULTING</u>	100.00%	143	143
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APERION CONSULTING</u>	100.00%	1,647	1,647
27	V	<u>26</u> <u>INSURANCE</u>		<u>APERION CONSULTING</u>	100.00%		
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>APERION CONSULTING</u>	100.00%	66	66
29	V	<u>30</u> <u>DEPRECIATION</u>		<u>APERION CONSULTING</u>	100.00%	34	34
30	V	<u>32</u> <u>INTEREST</u>		<u>APERION CONSULTING</u>	100.00%	10	10
31	V	<u>33</u> <u>REAL ESTATE TAX</u>		<u>APERION CONSULTING</u>	100.00%		
32	V	<u>34</u> <u>RENT</u>		<u>APERION CONSULTING</u>	100.00%		
33	V	<u>35</u> <u>AUTO LEASE</u>		<u>APERION CONSULTING</u>	100.00%	247	247
34	V	<u>10</u> <u>CONSULTING</u>	28,300	<u>APERION CONSULTING</u>	100.00%		(28,300)
35	V	<u>01</u> <u>DIETICIAN</u>	1,540	<u>APERION CONSULTING</u>	100.00%		(1,540)
36	V	<u>06</u> <u>PAINTER</u>		<u>APERION CONSULTING</u>	100.00%		
37	V	<u>06</u> <u>PROJECT MANAGER</u>	4,550	<u>APERION CONSULTING</u>	100.00%		(4,550)
38	V						
39	Total		\$ 34,390			\$ 31,688	\$ * (2,702)

\* 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 FINANCIAL	100.00%	9	\$ 9
16	V	17 ADMINISTRATIVE		APERION FINANCIAL	100.00%	1,599	1,599
17	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	455	455
18	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	27	27
19	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	28,054	28,054
20	V	24 SEMINARS		APERION FINANCIAL	100.00%	53	53
21	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	382	382
22	V	26 INSURANCE		APERION FINANCIAL	100.00%	3,984	3,984
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	180	180
24	V	19 HOME OFFICE EXPENSE	45,827	APERION FINANCIAL	100.00%		(45,827)
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		\$ 45,827			\$ 34,742	\$ * (11,085)

\* 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%	\$ 286	\$	286	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		423		423	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		97		97	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		6		6	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		567		567	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,136		1,136	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		871		871	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		307		307	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		320		320	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,113		1,113	24
25	V								25
26	V	34 RENT	11,000	8131 N. MONTICELLO, LLC				(11,000)	26
27	V	34 RENT	158	8132 N. MONTICELLO, LLC				(158)	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		\$ 11,158			\$ 5,125	\$ *	(6,033)	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	19 Payroll Services	\$ 9,092	ProPay HR LLC	24.00%	\$ 6,728	\$ (2,364)
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		\$ 9,092			\$ 6,728	\$ * (2,364)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning: 01/01/15

Ending: 12/31/15

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MICHAEL ROSEN	49.00%	Aperion Care St. Elmo	St. Elmo	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	1
2	YOSEF MEYSEL TRUST	10.00%	Aperion Care Jacksonville	Jacksonville	PROPAY	EVANSTON	PAYROLL SERVICES	2
3	DAVID BERKOWITZ DELTA TRUST	10.00%	River Crossing Rehab	Galesburg	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	3
4	DAVID BERKOWITZ TRUST	10.00%	Aperion Care Dolton	Dolton	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	4
5	YOSEF MEYSEL DELTA TRUST	10.00%	Riverwood Rehab	East Moline	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	5
6	FREDERICK S. FRANKEL	2.00%	Aperion Care Bridgeport	Bridgeport	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	6
7	STEVEN TUROFSKY	2.00%	Aperion Care Litchfield	Litchfield	APERION ESTATES PERU	PERU, IN	ALF	7
8	JEREMY BOSHES	2.00%	Aperion Care Springfield	Springfield	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	8
9	MICHELLE KODER	2.00%	Aperion Care Evanston	Evanston	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	9
10	42170 LIMITED PARTNERSHIP	1.00%	Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	10
11	257 LIMITED PARTNERSHIP	1.00%	Aperion Care Burbank	Burbank	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	11
12	1219 LIMITED PARTNERSHIP	1.00%	Aperion Care Chicago Heights	Chicago Heights	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	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 Spring Valley	Spring Valley				20
21			Aperion Care Elgin	Elgin				21
22			Aperion Care Toluca	Toluca				22
23			Aperion Care Colfax	Colfax				23
24			Aperion Care Bloomington	Bloomington				24
25			The Arbors at Michigan City	Michigan City, IN				25
26			Aperion Care Demotte	Demotte, IN				26
27			Aperion Care Kokomo	Kokomo, IN				27
28			Aperion Care Tolleston Park	Gary, IN				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Peru	Peru, IN				30



Facility Name &amp; ID Number

Aperion Care Amboy, Llc

#

0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

## 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	Michael Rosen	Shareholder	Administrative	49.00%	See Attached	0.80	2.00%	Alloc. Fee	\$ 3,933	17-7	1	
2	David Berkowitz	Relative	Administrative	0	See Attached	0.80	2.00%	Alloc. Salary	3,933	17-7	2	
3	Yosef Meystel	Relative	Administrative	0	See Attached	0.80	2.00%	Alloc. Salary	3,933	17-7	3	
4	Jay Meystel	Relative	Administrative	0	See Attached	0.40	1.00%	Alloc. Salary	610	17-7	4	
5	Joel Meystel	Relative	Administrative	0	See Attached	0.40	2.00%	Alloc. Salary	1,151	17-7	5	
6	Cynthia Meystel	Relative	Clerical	0	See Attached	0.10	3.03%	Alloc. Salary	464	21-7	6	
7	Shimon Meystel	Relative	Clerical	0	See Attached	0.80	2.00%	Alloc. Salary	83	21-7	7	
8	Fred Frankel	Shareholder	Administrative	2.00%	See Attached	0.80	2.00%	Alloc. Salary	2,877	17-7	8	
9	Steve Turofsky	Shareholder	Administrative	2.00%	See Attached	0.80	2.00%	Alloc. Salary	2,846	17-7	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 19,830		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 Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

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**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	FOOD	ACTUAL CENSUS	925,063	39	\$ 5,257	\$ 18,190	\$ 103	1	
2	5	UTILITIES	ACTUAL CENSUS	925,063	39	179	18,190	4	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	124,883	112,788	18,190	2,456	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	8,040		18,190	158	4
5	10	SALARY- NURSE	ACTUAL CENSUS	925,063	39	113,170	113,170	18,190	2,225	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	8,067		18,190	159	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	1,588,216	1,274,084	18,190	31,230	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	316,131		18,190	6,216	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	52,521		18,190	1,033	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	899,005	810,120	18,190	17,678	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	126,855		18,190	2,494	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	150,166		18,190	2,953	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39	41,165		18,190	809	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	147,150		18,190	2,893	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	15,480		18,190	304	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	114,048		18,190	2,243	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			18,190		17
18	34	RENT	ACTUAL CENSUS	925,063	39	8,054		18,190	158	18
19	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	2,485		18,190	49	19
20	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	76,069		18,190	1,496	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,796,942	\$ 2,310,162	\$ 74,661		25

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	925,063	39	\$ 214,389	\$ 214,389	18,190	\$ 4,216	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39		18,190			2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	140,088	138,625	18,190	2,755	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	46,162		18,190	908	4
5	10	SALARY NURSE	ACTUAL CENSUS	925,063	39	890,856	890,856	18,190	17,517	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	116,493		18,190	2,291	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39			18,190		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	20,901		18,190	411	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	35,826		18,190	704	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	37,620	25,723	18,190	740	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	7,289		18,190	143	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	83,735		18,190	1,647	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39			18,190		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	3,364		18,190	66	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	1,739		18,190	34	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	508		18,190	10	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			18,190		17
18	34	RENT	ACTUAL CENSUS	925,063	39			18,190		18
19	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	12,556		18,190	247	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,611,525	\$ 1,269,593		\$ 31,688	25

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	457	18,190	9	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	81,303	18,190	1,599	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	23,144	18,190	455	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	1,382	18,190	27	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	1,426,697	18,190	28,054	5
6	24	SEMINARS	ACTUAL CENSUS	925,063	39	2,672	18,190	53	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	19,412	18,190	382	7
8	26	INSURANCE	ACTUAL CENSUS	925,063	39	202,628	18,190	3,984	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	9,143	18,190	180	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					\$ 1,766,837	\$ 1,464,878	\$ 34,742	25

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 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

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	925,063	39	\$ 14,551	\$ 18,190	\$ 286	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	21,508	18,190	423	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	4,910	18,190	97	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	320	18,190	6	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	925,063	39	28,813	18,190	567	5
6	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	57,774	18,190	1,136	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	925,063	39	44,281	18,190	871	7
8	34	RENT	ACTUAL CENSUS	925,063	39	15,600	18,190	307	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	16,285	18,190	320	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	925,063	39	56,595	18,190	1,113	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					\$ 260,637	\$	\$ 5,125	25

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

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 ProPay HR LLC  
 Street Address 2201 W. MAIN ST  
 City / State / Zip Code EVANSTON, ILLINOIS 60202  
 Phone Number ( 847) 905-3268  
 Fax Number ( )

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		\$	\$		\$ 6,728	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				\$	\$		\$ 6,728	25

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending: 12/31/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	First Midwest Bank		X	Line of Credit				523,143		14,894	6									
7	Insurance Policies		X							1,189	7									
8											8									
9	<b>TOTAL Facility Related</b>							\$ 523,143		\$ 16,083	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(27)	10									
11	Allocated from Aperion Care	X								2,243	11									
12	Allocated from Aperion Consult	X								10	12									
13	See Supplemental Schedule									871	13									
14	<b>TOTAL Non-Facility Related</b>							\$		\$ 3,097	14									
15	<b>TOTALS (line 9+line14)</b>							\$ 523,143		\$ 19,180	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 Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15	Allocated from 8131 N. Montice	X								871										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									871										

\* 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.)



**2014 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Aperion Care Amboy, Llc COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0053215

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 2014 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 2014.

(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>02-15-15-328-002</u>	<u>Long Term Care Property</u>	\$ <u>36,314.86</u>	\$ <u>36,314.86</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>64,606.75</u>	\$ <u>1,115.65</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>100,921.61</u>	\$ <u>37,430.51</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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



Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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

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

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

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>			\$ <u>1,750</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>1,750</b>	<b>3</b>

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			21,571	1,185	748	(437)	3,969	68
69				3,621		(3,621)		69
70			\$ 21,571	\$ 4,806		\$ 748	\$ (4,058)	\$ 3,969 70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 21,571	\$ 4,806		\$ 748	\$ (4,058)	\$ 3,969	1
2	Thatcher Oaks Awnings	2014	6,200		20	310	310	310	2
3	Installation Of Cable For Voice & Data	2015	6,850		20	343	343	343	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	34

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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		\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	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		\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	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		\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 34,621	\$ 4,806		\$ 1,401	\$ (3,406)	\$ 4,622	34

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

**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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	13,598	404	35	349	(55)	1,903	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	586	47	20	29	(18)	176	9
10	Allocated from Aperion Care	2012	166	6	20	8	2	33	10
11	Allocated from Aperion Care	2013	71	4	20	4		11	11
12									12
13	Allocated from 8131 N. Monticello	2010	6,091	724	20	305	(419)	1,687	13
14	Allocated from 8131 N. Monticello	2013	1,059		20	53	53	159	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)		\$ 21,571	\$ 1,185		\$ 748	\$ (437)	\$ 3,969	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		\$ 21,571	\$ 1,185		\$ 748	\$ (437)	\$ 3,969	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 21,571	\$ 1,185		\$ 748	\$ (437)	\$ 3,969	34

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 861	\$ 84	\$ 122	\$ 38	10	\$ 242	71
72	Current Year Purchases	9,555	94	956	862	10	956	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 10,416	\$ 178	\$ 1,078	\$ 900		\$ 1,198	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	2015	\$ 620	\$ 82	\$ 124	\$ 42	5	\$ 208	76
77		Allocated from Aperion Consultir	2015	456	29	91	62	5	91	77
78										78
79										79
80	TOTALS			\$ 1,076	\$ 111	\$ 215	\$ 104		\$ 299	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)	\$ 47,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,095	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,693	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,402)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,118	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Green Acres Property

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>97</u>		\$ <u>334,400</u>			3
4	Additions						4
5	Storage Unit			<u>750</u>			5
6	<u>Allocated from 8131 N. Monticello</u>			<u>307</u>			6
7	TOTAL	<u>97</u>		\$ <u>335,457</u>			7

\*\*

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: \$ 8,303 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 Aperion Care</u>		\$ _____	\$ <u>1,496</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>247</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>1,743</u>	21

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

13. /2017 \$ \_\_\_\_\_

14. /2018 \$ \_\_\_\_\_

\* 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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 109,565	\$		\$ 109,565	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,292			21,292	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			181,345			181,345	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				50,004		50,004	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>					14,026	5,624		19,650	13
14	TOTAL			\$		\$ 326,228	\$ 55,628		\$ 381,856	14

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

Facility Name & ID Number Aperion Care Amboy, Llc

# 0053215

Report Period Beginning: 01/01/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 750	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	821,673		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,189		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	39,159		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 899,771	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,050		15
16	Equipment, at Historical Cost	15,023		16
17	Accumulated Depreciation (book methods)	(3,776)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	153,614		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 177,911	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,077,682	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 287,523	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	523,143		29
30	Accrued Salaries Payable	86,357		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,595		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,211		32
33	Accrued Interest Payable	1,279		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	See Attached Schedule	3,897		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 944,005	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	See Attached Schedule	752,494		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 752,494	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,696,499	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (618,817)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,077,682	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Restatement</b>	<b>(120,546)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(120,546)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(498,271)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(498,271)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(618,817)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,359,417	1
2	Discounts and Allowances for all Levels	(112,917)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,246,500	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,218	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 101,218	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,857	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,269	19
20	Radiology and X-Ray	1,558	20
21	Other Medical Services	5,739	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 56,423	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 27	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,404,168	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	584,341	31
32	Health Care	1,365,250	32
33	General Administration	942,334	33
<b>B. Capital Expense</b>			
34	Ownership	459,957	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	398,804	35
36	Provider Participation Fee	151,753	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,902,439	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(498,271)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (498,271)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,375,285	44
45	Private Pay - Net Inpatient Revenue	874,628	45
46	Medicare - Net Inpatient Revenue	802,443	46
47	Other-(specify) <u>Insurance</u>	194,144	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,246,500	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 Amboy, Llc

# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	1,216	1,264	\$ 36,945	\$ 29.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,493	9,069	251,299	27.71	3
4	Licensed Practical Nurses	11,086	11,999	304,270	25.36	4
5	CNAs & Orderlies	36,946	40,011	451,664	11.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,851	3,287	54,242	16.50	8
9	Activity Director	2,048	2,251	28,761	12.78	9
10	Activity Assistants	1,102	1,114	9,920	8.90	10
11	Social Service Workers	3,910	4,104	67,263	16.39	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	26,576	12.78	13
14	Head Cook	5,190	5,674	60,087	10.59	14
15	Cook Helpers/Assistants	5,254	5,459	50,234	9.20	15
16	Dishwashers					16
17	Maintenance Workers	4,322	4,836	61,033	12.62	17
18	Housekeepers	5,018	5,446	48,245	8.86	18
19	Laundry	5,552	5,778	52,155	9.03	19
20	Administrator	2,066	2,377	79,221	33.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,204	33,580	15.24	23
24	Clerical	1,290	1,306	17,754	13.59	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	900	978	9,665	9.88	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	146	146	1,493	10.23	33
34	TOTAL (lines 1 - 33)	101,374	109,383	\$ 1,644,407 *	\$ 15.03	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	Monthly	\$ 5,786	01-03	35
36	Medical Director	Monthly	7,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	377	28,300	10-03	38
39	Pharmacist Consultant	Monthly	5,104	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	260	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	687	11-03	44
45	Social Service Consultant	Monthly	1,625	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	Monthly	5,250	12-03	47
48					48
49	TOTAL (lines 35 - 48)	377	\$ 54,812		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	105	\$ 5,245	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	105	\$ 5,245		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Bernadean McCoy (1/1 - 7/20)	Administrator	0	\$ 37,588	Workers' Compensation Insurance	\$ 45,535	IDPH License Fee	\$ 1,658	
Florencia Rocha (1/1 - 12/31)	Administrator	0	11,108	Unemployment Compensation Insurance	44,420	Advertising: Employee Recruitment	2,644	
Angela Ince (5/4 - 10/9)	Administrator	0	30,525	FICA Taxes	124,131	Health Care Worker Background Check		
				Employee Health Insurance	8,727	(Indicate # of checks performed <u>115</u> )	1,145	
				Employee Meals	27	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	17,067	
				Employee Physicals	80	Licenses & Fees	500	
				Other Employee Benefits	802	Allocated from Aperion Care	1,033	
						Allocated from Aperion Consulting	704	
						See Supplemental Schedule	33	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,221			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,784	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Aperion Care - Management Fees			\$ 143,753				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 143,753				Seminar Expense	1,054
							Allocated from Aperion Care	2,494
							Allocated from Aperion Consulting	143
							See Supplemental Schedule	53
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 181,406	TOTAL		\$	TOTAL	\$ 3,744

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Aperion Care Amboy, Llc# 0053215

Report Period Beginning:

01/01/15

Ending:

12/31/15**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. ICLTC \$20,875
- (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. \$ 7,503 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 151,753  
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. \$ 27 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? 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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.