

Facility Name & ID Number Aperion Care Decatur, Llc

0051482 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	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	27,959	1,261	3,703	32,923	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,959	1,261	3,703	32,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.43%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 140 and days of care provided 1,965

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Aperion Care Decatur, Llc

0051482

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
	A. General Services										
1	Dietary	172,148	14,853	14,396	201,397		201,397	7,630	209,027		1
2	Food Purchase		171,422		171,422		171,422	121	171,543		2
3	Housekeeping	104,120	23,925	116	128,161		128,161		128,161		3
4	Laundry	71,027	11,756		82,783		82,783		82,783		4
5	Heat and Other Utilities			129,010	129,010		129,010	(16,118)	112,892		5
6	Maintenance	63,064	27,022	33,562	123,648		123,648	18,404	142,052		6
7	Other (specify):*							1,929	1,929		7
8	TOTAL General Services	410,359	248,978	177,084	836,421		836,421	11,967	848,388		8
	B. Health Care and Programs										
9	Medical Director			67,000	67,000		67,000		67,000		9
10	Nursing and Medical Records	1,655,322	112,699	69,070	1,837,091		1,837,091	(10,416)	1,826,675		10
10a	Therapy	4,070	3,055		7,125		7,125		7,125		10a
11	Activities	70,248	2,352	1,313	73,913		73,913		73,913		11
12	Social Services	120,764		264	121,028		121,028		121,028		12
13	CNA Training										13
14	Program Transportation			6,730	6,730		6,730		6,730		14
15	Other (specify):*							4,433	4,433		15
16	TOTAL Health Care and Programs	1,850,404	118,106	144,377	2,112,887		2,112,887	(5,983)	2,106,904		16
	C. General Administration										
17	Administrative	92,473			92,473		92,473	59,418	151,891		17
18	Directors Fees										18
19	Professional Services			263,014	263,014		263,014	(152,388)	110,626		19
20	Dues, Fees, Subscriptions & Promotions			105,257	105,257		105,257	(47,212)	58,045		20
21	Clerical & General Office Expenses	85,789		453,008	538,797		538,797	(310,916)	227,881		21
22	Employee Benefits & Payroll Taxes			413,081	413,081		413,081		413,081		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,179	2,179		2,179	4,869	7,048		24
25	Other Admin. Staff Transportation			4,444	4,444		4,444	9,015	13,459		25
26	Insurance-Prop.Liab.Malpractice			139,138	139,138		139,138	8,677	147,815		26
27	Other (specify):*							5,357	5,357		27
28	TOTAL General Administration	178,262		1,380,121	1,558,383		1,558,383	(423,179)	1,135,204		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,439,025	367,084	1,701,582	4,507,691		4,507,691	(417,196)	4,090,495		29

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

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

Facility Name & ID Number

Aperion Care Decatur, Llc

#0051482

Report Period Beginning:

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Ending:

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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			83,451	83,451		83,451	(25,614)	57,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,001	38,001		38,001	2,982	40,983			32
33	Real Estate Taxes			51,421	51,421		51,421	2,014	53,435			33
34	Rent-Facility & Grounds			739,180	739,180		739,180	(33,445)	705,735			34
35	Rent-Equipment & Vehicles			17,769	17,769		17,769	4,148	21,917			35
36	Other (specify):*			11,591	11,591		11,591	(11,591)				36
37	TOTAL Ownership			941,413	941,413		941,413	(61,507)	879,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,289	360,899	474,188		474,188	(49,922)	424,266			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			280,752	280,752		280,752		280,752			42
43	Other (specify):*			31,985	31,985		31,985	(31,985)				43
44	TOTAL Special Cost Centers		113,289	673,636	786,925		786,925	(81,907)	705,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,439,025	480,373	3,316,631	6,236,029		6,236,029	(560,609)	5,675,420			45

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

Aperion Care Decatur, Llc

ID# 0051482

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (28,008)	43	1
2	Promotional Products	(3,977)	43	2
3	Bank Charges	(13,232)	21	3
4	Theft & Damage Loss	(2,469)	21	4
5	Amortization	(11,591)	36	5
6	Additional R&M	11,692	06	6
7	Legal Settlement	(10,000)	21	7
8	PAC Dues	(13,916)	20	8
9	Non Allowable Legal Fees	(681)	19	9
10	Website Fee	(85)	21	10
11	Non Allowable Rent	(22,000)	34	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	Total	(94,267)		49

Aperion Care Decatur, Llc

Report Period Beginning: ID# 0051482
 Ending: 01/01/15
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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 Decatur, Llc# 0051482

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				7,630								7,630	1
2	Food Purchase	(66)		187									121	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,642)		6			518						(16,118)	5
6	Maintenance	11,692		4,445	1,486	16	765						18,404	6
7	Other (specify):*			286	1,643								1,929	7
8	TOTAL General Services	(5,016)		4,924	10,759	16	1,283						11,967	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			4,028	(14,444)								(10,416)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			287	4,146								4,433	15
16	TOTAL Health Care and Programs			4,315	(10,298)								(5,983)	16
	C. General Administration													
17	Administrative			56,525		2,894							59,418	17
18	Directors Fees													18
19	Professional Services	(681)		(79,756)	744	(69,146)	175		(3,723)				(152,388)	19
20	Fees, Subscriptions & Promotions	(50,416)		1,869	1,275	49	11						(47,212)	20
21	Clerical & General Office Expenses	(396,052)		31,996	1,339	50,776	1,025						(310,916)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,515	259	95							4,869	24
25	Other Admin. Staff Transportation			5,344	2,980	691							9,015	25
26	Insurance-Prop.Liab.Malpractice			1,465		7,212							8,677	26
27	Other (specify):*			5,237	120								5,357	27
28	TOTAL General Administration	(447,149)		27,195	6,717	(7,430)	1,212		(3,723)				(423,179)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(452,165)		36,434	7,178	(7,414)	2,495		(3,723)				(417,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Decatur, Llc# 0051482

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)	
30	D. Ownership													
	Depreciation	(28,283)		551	62		2,056						(25,614)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,671)		4,059	18		1,576						2,982	32
33	Real Estate Taxes						2,014						2,014	33
34	Rent-Facility & Grounds	(22,000)		287			(11,732)						(33,445)	34
35	Rent-Equipment & Vehicles			2,796	447	325	580						4,148	35
36	Other (specify):*	(11,591)											(11,591)	36
37	TOTAL Ownership	(64,545)		7,692	527	325	(5,506)						(61,507)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(49,922)					(49,922)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(31,985)											(31,985)	43
44	TOTAL Special Cost Centers	(31,985)						(49,922)					(81,907)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(548,695)		44,126	7,705	(7,089)	(3,011)	(49,922)	(3,723)				(560,609)	45

Facility Name & ID Number

Aperion Care Decatur, Llc

0051482

Report Period Beginning:

01/01/15

Ending:

12/31/15

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	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%	\$ 187	\$	187	15
16	V	5	UTILITIES	APERION CARE	100.00%	6		6	16
17	V	6	REPAIRS & MAINTENANCE	APERION CARE	100.00%	4,445		4,445	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY	APERION CARE	100.00%	286		286	18
19	V	10	SALARY- NURSE	APERION CARE	100.00%	4,028		4,028	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE	APERION CARE	100.00%	287		287	20
21	V	17	ADMINISTRATIVE	APERION CARE	100.00%	56,525		56,525	21
22	V	19	PROFESSIONAL FEES	APERION CARE	100.00%	11,251		11,251	22
23	V	20	FEES, SUBSCRIPTIONS	APERION CARE	100.00%	1,869		1,869	23
24	V	21	CLERICAL & GENERAL	APERION CARE	100.00%	31,996		31,996	24
25	V	24	SEMINARS	APERION CARE	100.00%	4,515		4,515	25
26	V	25	AUTO AND TRAVEL	APERION CARE	100.00%	5,344		5,344	26
27	V	26	INSURANCE	APERION CARE	100.00%	1,465		1,465	27
28	V	27	EMP. BEN.-GEN. ADMIN.	APERION CARE	100.00%	5,237		5,237	28
29	V	30	DEPRECIATION	APERION CARE	100.00%	551		551	29
30	V	32	INTEREST	APERION CARE	100.00%	4,059		4,059	30
31	V	33	REAL ESTATE TAX	APERION CARE	100.00%				31
32	V	34	RENT	APERION CARE	100.00%	287		287	32
33	V	35	EQUIPMENT RENTAL	APERION CARE	100.00%	88		88	33
34	V	35	AUTO LEASE	APERION CARE	100.00%	2,707		2,707	34
35	V	17	MANAGEMENT FEE	APERION CARE	100.00%				35
36	V	19	HOME OFFICE	APERION CARE	100.00%			(85,519)	36
37	V	19	DATA PROCESSING	APERION CARE	100.00%			(5,488)	37
38	V								38
39	Total		\$ 91,007			\$ 135,133	\$ *	44,126	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%	\$ 7,630	\$ 7,630
16	V	<u>5</u> <u>UTILITIES</u>		<u>APERION CONSULTING</u>	100.00%		
17	V	<u>6</u> <u>REPAIRS & MAINTENANCE</u>		<u>APERION CONSULTING</u>	100.00%	4,986	4,986
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. & DIETARY</u>		<u>APERION CONSULTING</u>	100.00%	1,643	1,643
19	V	<u>10</u> <u>SALARY NURSE</u>		<u>APERION CONSULTING</u>	100.00%	31,706	31,706
20	V	<u>15</u> <u>PAYROLL TAXES/GROUP INSURANCE</u>		<u>APERION CONSULTING</u>	100.00%	4,146	4,146
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%	744	744
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APERION CONSULTING</u>	100.00%	1,275	1,275
24	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>APERION CONSULTING</u>	100.00%	1,339	1,339
25	V	<u>24</u> <u>SEMINARS</u>		<u>APERION CONSULTING</u>	100.00%	259	259
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APERION CONSULTING</u>	100.00%	2,980	2,980
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%	120	120
29	V	<u>30</u> <u>DEPRECIATION</u>		<u>APERION CONSULTING</u>	100.00%	62	62
30	V	<u>32</u> <u>INTEREST</u>		<u>APERION CONSULTING</u>	100.00%	18	18
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%	447	447
34	V	<u>10</u> <u>CONSULTING</u>	46,150	<u>APERION CONSULTING</u>	100.00%		(46,150)
35	V	<u>01</u> <u>DIETICIAN</u>		<u>APERION CONSULTING</u>	100.00%		
36	V	<u>06</u> <u>PAINTER</u>		<u>APERION CONSULTING</u>	100.00%		
37	V	<u>06</u> <u>PROJECT MANAGER</u>	3,500	<u>APERION CONSULTING</u>	100.00%		(3,500)
38	V						
39	Total		\$ 49,650			\$ 57,355	\$ * 7,705

* 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%	16	\$	16	15
16	V	17 ADMINISTRATIVE		APERION FINANCIAL	100.00%	2,894		2,894	16
17	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	824		824	17
18	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	49		49	18
19	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	50,776		50,776	19
20	V	24 SEMINARS		APERION FINANCIAL	100.00%	95		95	20
21	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	691		691	21
22	V	26 INSURANCE		APERION FINANCIAL	100.00%	7,212		7,212	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	325		325	23
24	V	19 HOME OFFICE EXPENSE	69,970	APERION FINANCIAL	100.00%			(69,970)	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		\$ 69,970			\$ 62,882	\$ *	(7,089)	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%	\$ 518	\$	518	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		765		765	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		175		175	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		11		11	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		1,025		1,025	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		2,056		2,056	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,576		1,576	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		555		555	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		580		580	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,014		2,014	24
25	V								25
26	V	34 RENT	12,000	8131 N. MONTICELLO, LLC				(12,000)	26
27	V	34 RENT	287	8132 N. MONTICELLO, LLC				(287)	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		\$ 12,287			\$ 9,276	\$ *	(3,011)	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	\$ 346,684	Renewal Rehab	100.00%	\$ 296,762	\$ (49,922)
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		\$ 346,684			\$ 296,762	\$ * (49,922)

* 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	\$ 14,320	ProPay HR LLC	24.00%	\$ 10,597	\$ (3,723)
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		\$ 14,320			\$ 10,597	\$ * (3,723)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

Table with 8 columns: Line Item, Name, Ownership %, Name, City, Name, City, Type of Business, and a final column with numbers 1-30. It lists various owners and related nursing homes and business entities.

Facility Name & ID Number

Aperion Care Decatur, Llc

#

0051482

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	Jay Meystel	Relative	Administrative	0	See Attached	0.70	1.75%	Alloc. Salary	\$ 1,103	17-7	1	
2	Joel Meystel	Relative	Administrative	0	See Attached	0.70	3.50%	Alloc. Salary	2,084	17-7	2	
3	Cynthia Meystel	Relative	Clerical	0	See Attached	0.10	3.03%	Alloc. Salary	839	21-7	3	
4	Fred Frankel	Owner	Administrative	0.50%	See Attached	1.40	3.50%	Alloc. Salary	5,206	17-7	4	
5	Steve Turofsky	Owner	Administrative	0.50%	See Attached	1.40	3.50%	Alloc. Salary	5,152	17-7	5	
6	Christina Inofre	Owner	Nursing	0.50%	See Attached	1.40	3.50%	Alloc. Salary	4,075	10-7	6	
7	Shimon Meystel	Relative	Clerical	0	See Attached	1.40	3.50%	Alloc. Salary	150	21-7	7	
8	Yosef Meystel	Relative	Administrative	0	See Attached	1.40	3.50%	Alloc. Salary	7,118	17-7	8	
9	David Berkowitz	Relative	Administrative	0	See Attached	1.40	3.50%	Alloc. Salary	7,118	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	\$ 32,845		13	

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

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

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	\$ 32,923	\$ 187	1	
2	5	UTILITIES	ACTUAL CENSUS	925,063	39	179	32,923	6	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	124,883	112,788	32,923	4,445	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	8,040	32,923	286	4	
5	10	SALARY- NURSE	ACTUAL CENSUS	925,063	39	113,170	113,170	32,923	4,028	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	8,067	32,923	287	6	
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	1,588,216	1,274,084	32,923	56,525	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	316,131	32,923	11,251	8	
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	52,521	32,923	1,869	9	
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	899,005	810,120	32,923	31,996	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	126,855	32,923	4,515	11	
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	150,166	32,923	5,344	12	
13	26	INSURANCE	ACTUAL CENSUS	925,063	39	41,165	32,923	1,465	13	
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	147,150	32,923	5,237	14	
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	15,480	32,923	551	15	
16	32	INTEREST	ACTUAL CENSUS	925,063	39	114,048	32,923	4,059	16	
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39		32,923		17	
18	34	RENT	ACTUAL CENSUS	925,063	39	8,054	32,923	287	18	
19	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	2,485	32,923	88	19	
20	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	76,069	32,923	2,707	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,796,942	\$ 2,310,162	\$ 135,133	25	

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	32,923	\$ 7,630	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39			32,923		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	140,088	138,625	32,923	4,986	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	46,162		32,923	1,643	4
5	10	SALARY NURSE	ACTUAL CENSUS	925,063	39	890,856	890,856	32,923	31,706	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	116,493		32,923	4,146	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39			32,923		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	20,901		32,923	744	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	35,826		32,923	1,275	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	37,620	25,723	32,923	1,339	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	7,289		32,923	259	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	83,735		32,923	2,980	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39			32,923		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	3,364		32,923	120	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	1,739		32,923	62	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	508		32,923	18	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			32,923		17
18	34	RENT	ACTUAL CENSUS	925,063	39			32,923		18
19	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	12,556		32,923	447	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,611,525	\$ 1,269,593		\$ 57,355	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	32,923	16	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	81,303	81,303	2,894	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	23,144	32,923	824	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	1,382	32,923	49	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	1,426,697	1,383,575	50,776	5
6	24	SEMINARS	ACTUAL CENSUS	925,063	39	2,672	32,923	95	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	19,412	32,923	691	7
8	26	INSURANCE	ACTUAL CENSUS	925,063	39	202,628	32,923	7,212	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	9,143	32,923	325	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	\$ 62,882	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	\$ 32,923	\$ 518	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	21,508	32,923	765	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	4,910	32,923	175	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	320	32,923	11	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	925,063	39	28,813	32,923	1,025	5
6	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	57,774	32,923	2,056	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	925,063	39	44,281	32,923	1,576	7
8	34	RENT	ACTUAL CENSUS	925,063	39	15,600	32,923	555	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	16,285	32,923	580	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	925,063	39	56,595	32,923	2,014	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	\$	\$ 9,276	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	37	\$	\$		\$ 296,762	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				\$	\$		\$ 296,762	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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		\$	\$		\$ 10,597	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				\$	\$		\$ 10,597	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Aperion Care Decatur, Llc

0051482

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	The Private Bank	X	Line of Credit			751,131			35,134	6									
7	Assurance	X	Insurance Financing						2,867	7									
8										8									
9	TOTAL Facility Related					\$ 751,131			\$ 38,001	9									
B. Non-Facility Related*																			
10	Interest Income	X							(2,671)	10									
11	Allocated from Aperion Care	X							4,059	11									
12	Allocated from Aperion Consult	X							18	12									
13	See Supplemental Schedule								1,576	13									
14	TOTAL Non-Facility Related					\$			\$ 2,982	14									
15	TOTALS (line 9+line14)					\$ 751,131			\$ 40,983	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 Decatur, Llc

0051482

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			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15	Allocated from 8131 N. Montice	X								1,576										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									1,576										

* 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 2014 report.		\$	53,666		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.)		\$	54,558		2
3. Under or (over) accrual (line 2 minus line 1).		\$	892		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	52,543		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.)		\$			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.		\$	53,435		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>55,326</u>	8	FOR BHF USE ONLY	
	2011	<u>54,541</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>54,625</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>53,466</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>52,544</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2015 Accrual = 2014 Tax					
Allocated from 8131 N. Monticello = \$2,014					

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Decatur, Llc COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0051482

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>04-12-03-251-002</u>	<u>Long Term Care Property</u>	\$ <u>52,543.94</u>	\$ <u>52,543.94</u>
2. <u>Allocated from 8131 N. Monticello</u>	<u>Home Office Allocation</u>	\$ <u>64,606.75</u>	\$ <u>2,019.27</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>117,150.69</u>	\$ <u>54,563.21</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 Decatur, Llc

0051482

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,340 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>			\$ <u>3,168</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 3,168	3

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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
	Improvement Type**										
9	Various		2011		33,399		20	3,964	3,964	17,451	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			39,043		2,146	1,352	(794)	7,182
69					83,451		(83,451)	
70			\$ 72,442		\$ 85,597	\$ 5,316	\$ (80,281)	\$ 24,633

**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		\$ 72,442	\$ 85,597		\$ 5,316	\$ (80,281)	\$ 24,633	1
2	Tpo Roofing System On Flat Roof	2012	98,800		20	9,880	9,880	39,520	2
3	Stainless Steel Fire Shutter Door	2012	3,865		20	387	387	1,353	3
4	Digital Watchdog/ Camera	2012	12,560		20	2,512	2,512	9,001	4
5	Therapy Room Flooring & Painting	2012	14,526		20	726	726	2,724	5
6	Lobby Flooring & Wallcovering	2012	12,753		20	638	638	2,391	6
7	Medicare Corridor Wallcovering	2012	60,266		20	3,013	3,013	11,300	7
8	Activity Room Floor & Blinds	2012	7,195		20	360	360	1,349	8
9	Dining Room Flooring, Railings, Wallcovering & Fans	2012	37,514		20	1,876	1,876	7,034	9
10	Light Fixtures In Lobby, Reception, Smoke Lounge, Medicare Corridor	2012	21,188		20	1,059	1,059	3,973	10
11	Wallpaper In Lobby, Corridors, Large Dining Room	2012	61,394		20	3,070	3,070	11,511	11
12	Signage	2012	13,012		20	651	651	2,440	12
13	Installed Wiring In Dialysis Room	2013	2,740		20	274	274	617	13
14	New Voip And Data Lines	2014	3,600		20	720	720	1,080	14
15	Install Front Name Sign & 2 Face Panels	2014	6,358		20	424	424	600	15
16	New Voip And Data Lines	2014	3,600		20	720	720	1,020	16
17	Replace Tile In 10 Resident Rms In Hall 5	2015	6,267		20	418	418	418	17
18	4 Ton Ac Unit	2015	4,830		20	403	403	403	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)		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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		\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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)	\$ 442,909	\$ 85,597		\$ 32,445	\$ (53,152)	\$ 121,365	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 Building Company		\$	\$		\$	\$	\$	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	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.

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	24,611	732	35	631	(101)	3,444	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	11,025	1,310	20	551	(759)	3,053	9
10	Allocated from 8131 N. Monticello	2013	1,918		20	96	96	288	10
11									11
12	Allocated from Aperion Care	2010	1,060	85	20	53	(32)	318	12
13	Allocated from Aperion Care	2012	301	12	20	15	3	60	13
14	Allocated from Aperion Care	2013	128	7	20	6	(1)	19	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 39,043	\$ 2,146		\$ 1,352	\$ (794)	\$ 7,182	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		\$ 39,043	\$ 2,146		\$ 1,352	\$ (794)	\$ 7,182	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)	\$ 39,043	\$ 2,146		\$ 1,352	\$ (794)	\$ 7,182	34

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

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	\$ 143,837	\$ 152	\$ 24,322	\$ 24,170	10	\$ 80,702	71
72	Current Year Purchases	6,166	171	681	510	10	681	72
73	Fully Depreciated Assets	43,931				10	43,931	73
74								74
75	TOTALS	\$ 193,934	\$ 323	\$ 25,003	\$ 24,680		\$ 125,314	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	\$ 1,122	\$ 148	\$ 224	\$ 76	5	\$ 376	76
77		Allocated from Aperion Consultir	2015	825	53	165	112	5	165	77
78										78
79										79
80	TOTALS			\$ 1,947	\$ 201	\$ 389	\$ 188		\$ 541	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 641,958	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,121	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,838	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,283)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 247,220	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? 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>1975</u>	<u>140</u>	<u>5/1/2011</u>	\$ <u>705,180</u>			3
4	Additions						4
5	<u>Allocated from 8131 N. Monticello</u>			<u>555</u>			5
6							6
7	TOTAL	<u>140</u>		\$ <u>705,735</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: \$ 18,762 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>2,707</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>447</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,154</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	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	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	\$		\$ 158,636	\$		\$ 158,636	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			45,266			45,266	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			142,782			142,782	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				110,916		110,916	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>					14,215	2,373		16,588	13
14	TOTAL			\$		\$ 360,899	\$ 113,289		\$ 474,188	14

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

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,271,014		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,965		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	65,492		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,445,471	\$	10
B. Long-Term Assets				
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	361,899		15
16	Equipment, at Historical Cost	298,876		16
17	Accumulated Depreciation (book methods)	(330,556)		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):	234,254		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 564,473	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,009,944	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 575,242	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	751,131		29
30	Accrued Salaries Payable	118,431		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,137		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,543		32
33	Accrued Interest Payable	(373)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	6,268		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,509,379	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	3,093,910		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,093,910	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,603,289	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,593,345)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,009,944	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,389,141)	1
2	Restatements (describe):		2
3	Bad Debt	(50,000)	3
4	Rounding	6	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,439,135)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,044,210)	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	(110,000)	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)	\$ (1,154,210)	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)	\$ (2,593,345)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Decatur, Llc# 0051482Report Period Beginning: 01/01/15

Ending:

12/31/15**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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,716,908	1
2	Discounts and Allowances for all Levels	(682,011)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,034,897	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,462	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 63,462	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,750	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,152	19
20	Radiology and X-Ray	270	20
21	Other Medical Services	4,617	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 90,789	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,671	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,671	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,191,819	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	836,421	31
32	Health Care	2,112,887	32
33	General Administration	1,558,383	33
B. Capital Expense			
34	Ownership	941,413	34
C. Ancillary Expense			
35	Special Cost Centers	506,173	35
36	Provider Participation Fee	280,752	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,236,029	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,044,210)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,044,210)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,693,184	44
45	Private Pay - Net Inpatient Revenue	188,677	45
46	Medicare - Net Inpatient Revenue	808,843	46
47	Other-(specify) <u>Insurance</u>	344,193	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,034,897	49

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

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

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

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

Facility Name & ID Number Aperion Care Decatur, Llc

0051482

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	1,920	2,127	\$ 75,191	\$ 35.35	1
2	Assistant Director of Nursing	1,128	1,152	31,637	27.46	2
3	Registered Nurses	3,442	3,795	103,258	27.21	3
4	Licensed Practical Nurses	23,972	25,409	580,213	22.83	4
5	CNAs & Orderlies	65,785	71,025	850,701	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	88	143	4,070	28.46	8
9	Activity Director	1,856	1,980	24,028	12.14	9
10	Activity Assistants	4,278	4,453	39,582	8.89	10
11	Social Service Workers	5,069	5,453	120,764	22.15	11
12	Dietician					12
13	Food Service Supervisor	2,469	2,767	35,485	12.82	13
14	Head Cook	4,274	4,750	56,090	11.81	14
15	Cook Helpers/Assistants	7,810	8,359	80,573	9.64	15
16	Dishwashers					16
17	Maintenance Workers	3,766	3,962	63,064	15.92	17
18	Housekeepers	10,483	11,356	104,120	9.17	18
19	Laundry	6,198	6,833	71,027	10.39	19
20	Administrator	1,864	2,131	92,473	43.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,450	2,736	50,577	18.49	23
24	Clerical	3,907	4,176	35,212	8.43	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	1,059	1,168	14,322	12.26	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	705	747	6,638	8.89	33
34	TOTAL (lines 1 - 33)	152,523	164,522	\$ 2,439,025 *	\$ 14.82	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	262	\$ 14,396	01-03	35
36	Medical Director	Monthly	67,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	615	46,150	10-03	38
39	Pharmacist Consultant	Monthly	10,920	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	22	1,313	11-03	44
45	Social Service Consultant	5	264	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	904	\$ 152,043		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Teri Rebstock (1/1 - 6/11)	Administrator	0	\$ 50,009	Workers' Compensation Insurance	\$ 68,429	IDPH License Fee	\$ 1,990	
Deborah Vege (6/12 - 10/29)	Administrator	0	39,065	Unemployment Compensation Insurance	124,896	Advertising: Employee Recruitment	13,095	
Brenda Reed (Nov-Dec)	Administrator	0	3,399	FICA Taxes	184,127	Health Care Worker Background Check		
				Employee Health Insurance	30,046	(Indicate # of checks performed <u>365</u>)	3,648	
				Employee Meals	95	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	34,844	
				401K Expense	712	Licenses & Fees	1,264	
				Employee Physicals	720	Allocated from Aperion Care	1,869	
				Other Employee Benefits	4,056	Allocated from Aperion Consulting	1,275	
						See Supplemental Schedule	60	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 92,473					
(List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 413,081	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 58,045	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,179
							Allocated from Aperion Care	4,515
							Allocated from Aperion Consulting	259
							See Supplemental Schedule	95
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 7,048
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
FR&R/Marcum LLP	Accounting		\$ 24,760					
See Attached	Legal		4,071					
Aperion Care	Home Office Expense		85,519					
Aperion Financial	Home Office Expense		69,971					
ProPay HR	Payroll Processing		14,320					
Personnel Planners	Unemployment Consult		3,927					
Aperion Care	Data Processing		5,488					
Creative Technology Solutions	Data Processing		12,483					
E-Health Data Solutions	MDS Software		5,400					
Galaxy Hosted Software	Data Processing		11,150					
National Datacare Corporation	Data Processing		4,420					
See Supplemental Schedule			21,505					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 263,013					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Decatur, Llc# 0051482

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$42,170
- (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. \$ 8,380 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. \$ 280,752
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. \$ 95 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.