

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,050	398		22,448	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,050	398		22,448	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.62%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Aperion Care Litchfield, Llc

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Report Period Beginning:

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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	168,314	17,159	4,972	190,445		190,445	5,202	195,647		1
2	Food Purchase		100,631		100,631		100,631	110	100,741		2
3	Housekeeping	71,649	9,833		81,482		81,482		81,482		3
4	Laundry	28,449	6,319		34,768		34,768		34,768		4
5	Heat and Other Utilities			59,283	59,283		59,283	110	59,393		5
6	Maintenance	34,255	8,903	17,746	60,904		60,904	9,912	70,816		6
7	Other (specify):*							1,315	1,315		7
8	TOTAL General Services	302,667	142,845	82,001	527,513		527,513	16,649	544,162		8
	B. Health Care and Programs										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	624,306	26,854	37,604	688,764		688,764	(3,136)	685,628		10
10a	Therapy		1,231		1,231		1,231		1,231		10a
11	Activities	55,861	3,257	942	60,060		60,060		60,060		11
12	Social Services	90,777		1,083	91,860		91,860		91,860		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,023	3,023		15
16	TOTAL Health Care and Programs	770,944	31,342	45,129	847,415		847,415	(113)	847,302		16
	C. General Administration										
17	Administrative	92,401		72,941	165,342		165,342	(32,428)	132,914		17
18	Directors Fees										18
19	Professional Services			140,893	140,893		140,893	(76,722)	64,171		19
20	Dues, Fees, Subscriptions & Promotions			58,630	58,630		58,630	(37,103)	21,527		20
21	Clerical & General Office Expenses	16,436		65,824	82,260		82,260	29,581	111,841		21
22	Employee Benefits & Payroll Taxes			152,456	152,456		152,456		152,456		22
23	Inservice Training & Education										23
24	Travel and Seminar			825	825		825	3,320	4,145		24
25	Other Admin. Staff Transportation			4,219	4,219		4,219	6,147	10,366		25
26	Insurance-Prop.Liab.Malpractice			27,466	27,466		27,466	11,598	39,064		26
27	Other (specify):*							3,653	3,653		27
28	TOTAL General Administration	108,837		523,254	632,091		632,091	(91,955)	540,136		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,182,448	174,187	650,384	2,007,019		2,007,019	(75,419)	1,931,600		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.

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Report Period Beginning:

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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			42,173	42,173		42,173	26,110	68,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,570	9,570		9,570	49,839	59,409			32
33	Real Estate Taxes							24,885	24,885			33
34	Rent-Facility & Grounds			187,090	187,090		187,090	(186,711)	379			34
35	Rent-Equipment & Vehicles			6,906	6,906		6,906	2,828	9,734			35
36	Other (specify):*			13,522	13,522		13,522	(4,642)	8,880			36
37	TOTAL Ownership			259,261	259,261		259,261	(87,691)	171,570			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,075	171,075		171,075		171,075			42
43	Other (specify):*			9,499	9,499		9,499	(9,499)	(0)			43
44	TOTAL Special Cost Centers			180,574	180,574		180,574	(9,499)	171,075			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,182,448	174,187	1,090,219	2,446,854		2,446,854	(172,608)	2,274,246			45

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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(247)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,303)	30		9
10	Interest and Other Investment Income	(263)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,795)	21		18
19	Entertainment	(1,312)	21		19
20	Contributions	(33,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,868)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(95,068)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,373)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(19,235)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,235)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (172,608)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Aperion Care Litchfield, Llc

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising / Marketing	\$ (9,499)	43	1
2	Bank Charges	(6,529)	21	2
3	Theft & Damage Loss	(1,516)	21	3
4	Amortization	(13,522)	36	4
5	Bldg Co. Amortization	(3,508)	36	5
6	Bldg. Co. Bank Charges	(150)	21	6
7	Bldg. Co. Accounting Fees	(9,000)	19	7
8	Bldg. Co. Bookkeeping Fees	(10,000)	19	8
9	Bldg. Co. Professional Fees	(175)	19	9
10	Additional R&M	5,249	06	10
11	PAC Dues	(5,788)	20	11
12	Non-allowable Legal Fees	(181)	19	12
13	Other Income	(8,449)	21	13
14	Non-Allowable Building Rent	(32,000)	34	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(95,068)		49

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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 Litchfield, Llc# 0051102

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				5,202								5,202	1
2	Food Purchase	(18)		128									110	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(247)		4			353						110	5
6	Maintenance	5,249		3,030	1,100	11	522						9,912	6
7	Other (specify):*			195	1,120								1,315	7
8	TOTAL General Services	4,984		3,357	7,422	11	875						16,649	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,746	(5,882)								(3,136)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			196	2,827								3,023	15
16	TOTAL Health Care and Programs			2,942	(3,055)								(113)	16
	C. General Administration													
17	Administrative			(34,400)		1,973							(32,428)	17
18	Directors Fees													18
19	Professional Services	(19,356)	19,175	(40,543)	507	(34,949)	119	(1,676)					(76,722)	19
20	Fees, Subscriptions & Promotions	(39,288)		1,274	869	34	8						(37,103)	20
21	Clerical & General Office Expenses	(28,619)	150	21,816	913	34,621	699						29,581	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			3,078	177	65							3,320	24
25	Other Admin. Staff Transportation			3,644	2,032	471							6,147	25
26	Insurance-Prop.Liab.Malpractice		5,682	999		4,917							11,598	26
27	Other (specify):*			3,571	82								3,653	27
28	TOTAL General Administration	(87,263)	25,007	(40,561)	4,580	7,132	826	(1,676)					(91,955)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,279)	25,007	(34,262)	8,947	7,143	1,701	(1,676)					(75,419)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102

Report Period Beginning:

01/01/15

Ending:

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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)	
	D. Ownership													
30	Depreciation	(12,303)	36,593	376	42		1,402						26,110	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(263)	46,247	2,768	12		1,075						49,839	32
33	Real Estate Taxes		23,512				1,373						24,885	33
34	Rent-Facility & Grounds	(32,000)	(143,090)	195			(11,816)						(186,711)	34
35	Rent-Equipment & Vehicles			1,906	305	222	395						2,828	35
36	Other (specify):*	(17,030)	12,388										(4,642)	36
37	TOTAL Ownership	(61,595)	(24,350)	5,246	359	222	(7,571)						(87,691)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,499)											(9,499)	43
44	TOTAL Special Cost Centers	(9,499)											(9,499)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(153,373)	657	(29,017)	9,305	7,365	(5,870)	(1,676)					(172,608)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 143,090	1024 East Tyler, LLC	100.00%	\$	(143,090)	1
2	V	32 Interest	25	1024 East Tyler, LLC	100.00%	46,272	46,247	2
3	V	36 Amortization		1024 East Tyler, LLC	100.00%	3,508	3,508	3
4	V	21 Bank Charges		1024 East Tyler, LLC	100.00%	150	150	4
5	V	30 Depreciation		1024 East Tyler, LLC	100.00%	36,593	36,593	5
6	V	36 Insurance Expense - MIP		1024 East Tyler, LLC	100.00%	8,880	8,880	6
7	V	26 Insurance Expense		1024 East Tyler, LLC	100.00%	5,682	5,682	7
8	V	33 Real Estate Taxes	491	1024 East Tyler, LLC	100.00%	24,003	23,512	8
9	V	19 Accounting Fees		1024 East Tyler, LLC	100.00%	9,000	9,000	9
10	V	19 Bookeeping Fees		1024 East Tyler, LLC	100.00%	10,000	10,000	10
11	V	19 Professional Fees		1024 East Tyler, LLC	100.00%	175	175	11
12	V							12
13	V							13
14	Total		\$ 143,606			\$ 144,263	\$ * 657	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%	\$ 128	\$ 128
16	V	5 UTILITIES		APERION CARE	100.00%	4	4
17	V	6 REPAIRS & MAINTENANCE		APERION CARE	100.00%	3,030	3,030
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	195	195
19	V	10 SALARY- NURSE		APERION CARE	100.00%	2,746	2,746
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	196	196
21	V	17 ADMINISTRATIVE		APERION CARE	100.00%	38,540	38,540
22	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	7,671	7,671
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	1,274	1,274
24	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	21,816	21,816
25	V	24 SEMINARS		APERION CARE	100.00%	3,078	3,078
26	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	3,644	3,644
27	V	26 INSURANCE		APERION CARE	100.00%	999	999
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	3,571	3,571
29	V	30 DEPRECIATION		APERION CARE	100.00%	376	376
30	V	32 INTEREST		APERION CARE	100.00%	2,768	2,768
31	V	33 REAL ESTATE TAX		APERION CARE	100.00%		
32	V	34 RENT		APERION CARE	100.00%	195	195
33	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	60	60
34	V	35 AUTO LEASE		APERION CARE	100.00%	1,846	1,846
35	V	17 MANAGEMENT FEE	72,941	APERION CARE	100.00%		(72,941)
36	V	19 HOME OFFICE	43,402	APERION CARE	100.00%		(43,402)
37	V	19 DATA PROCESSING	4,812				(4,812)
38	V						
39	Total		\$ 121,155			\$ 92,138	\$ * (29,017)

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

Facility Name & ID Number

Aperion Care Litchfield, Llc

0051102

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:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIETARY	\$	APERION CONSULTING	100.00%	\$ 5,202	\$	5,202	15
16	V	5 UTILITIES		APERION CONSULTING	100.00%				16
17	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	3,399		3,399	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	1,120		1,120	18
19	V	10 SALARY NURSE		APERION CONSULTING	100.00%	21,618		21,618	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	2,827		2,827	20
21	V	17 ADMINISTRATIVE		APERION CONSULTING	100.00%				21
22	V	19 PROFESSIONAL FEES		APERION CONSULTING	100.00%	507		507	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	869		869	23
24	V	21 CLERICAL & GENERAL		APERION CONSULTING	100.00%	913		913	24
25	V	24 SEMINARS		APERION CONSULTING	100.00%	177		177	25
26	V	25 AUTO AND TRAVEL		APERION CONSULTING	100.00%	2,032		2,032	26
27	V	26 INSURANCE		APERION CONSULTING	100.00%				27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	82		82	28
29	V	30 DEPRECIATION		APERION CONSULTING	100.00%	42		42	29
30	V	32 INTEREST		APERION CONSULTING	100.00%	12		12	30
31	V	33 REAL ESTATE TAX		APERION CONSULTING	100.00%				31
32	V	34 RENT		APERION CONSULTING	100.00%				32
33	V	35 AUTO LEASE		APERION CONSULTING	100.00%	305		305	33
34	V	10 CONSULTING	27,500	APERION CONSULTING	100.00%			(27,500)	34
35	V	01 DIETICIAN		APERION CONSULTING	100.00%				35
36	V	06 PAINTER		APERION CONSULTING	100.00%				36
37	V	06 PROJECT MANAGER	2,299	APERION CONSULTING	100.00%			(2,299)	37
38	V								38
39	Total		\$ 29,799			\$ 39,104	\$ *	9,305	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	6 REPAIRS & MAINTENANCE		APERION FINANCIAL	100.00%	11	\$	11	15
16	V	17 ADMINISTRATIVE		APERION FINANCIAL	100.00%	1,973		1,973	16
17	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	562		562	17
18	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	34		34	18
19	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	34,621		34,621	19
20	V	24 SEMINARS		APERION FINANCIAL	100.00%	65		65	20
21	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	471		471	21
22	V	26 INSURANCE		APERION FINANCIAL	100.00%	4,917		4,917	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	222		222	23
24	V	19 HOME OFFICE EXPENSE	35,511	APERION FINANCIAL	100.00%			(35,511)	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		\$ 35,511			\$ 42,876	\$ *	7,365	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%	\$ 353	\$	353	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		522		522	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		119		119	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		8		8	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		699		699	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,402		1,402	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,075		1,075	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		379		379	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		395		395	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,373		1,373	24
25	V								25
26	V	34 RENT	12,000	8131 N. MONTICELLO, LLC				(12,000)	26
27	V	34 RENT	195	8131 N. MONTICELLO, LLC				(195)	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		\$ 12,195			\$ 6,325	\$ *	(5,870)	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	\$ 6,446	ProPay HR LLC	24.00%	\$ 4,770	\$ (1,676)
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		\$ 6,446			\$ 4,770	\$ * (1,676)

* 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: 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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ML EQUITY PARTNERS LLC	5.00%	Aperion Care Amboy	Amboy	1024 EAST TYLER, LLC	LITCHFIELD	BUILDING COMPANY	1
2	MARTIN LOEB	2.00%	Aperion Care Midlothian	Midlothian	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	HOWARD SUSS	5.00%	River Crossing Rehab	Galesburg	PROPAY	EVANSTON	PAYROLL SERVICES	3
4	DAVID BERKOWITZ	36.50%	Aperion Care Dolton	Dolton	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	4
5	DECLARATION OF TRUST OF YOSEF MEYSTEL	34.50%	Riverwood Rehab	East Moline	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	5
6	JAY MEYSTEL TRUST	4.00%	Apetion Care Bridgeport	Bridgeport	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	6
7	STEVEN TUROFSKY	1.00%	Aperion Care Springfield	Springfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	7
8	FREDERICK S. FRANKEL	1.00%	Aperion Care Jacksonville	Jacksonville	APERION ESTATES PERU	PERU, IN	ALF	8
9	CHRISTINE INOFRE	1.00%	Aperion Care Evanston	Evanston	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	9
10	42170 LIMITED PARTNERSHIP	2.50%	Aperion Care St. Elmo	St. Elmo	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	10
11	1219 LIMITED PARTNERSHIP	2.50%	Aperion Care Burbank	Burbank	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	11
12	257 LTD. PARTNERSHIP	2.50%	Aperion Care Chicago Heights	Chicago Heights	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	12
13	417A, LLC	2.50%	Aperion Care Forest Park	Forest Park				13
14			Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Spring Valley	Spring Valley				20
21			The Arbors at Michigan City	Michigan City, IN				21
22			Aperion Care Demotte	Demotte, IN				22
23			Aperion Care Kokomo	Kokomo, IN				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Tolleston Park	Gary, IN				25
26			Aperion Care Valparaiso	Valparaiso, IN				26
27			Aperion Care Hidden Lake	St. Louis, MO				27
28			Aperion Care Elgin	Elgin				28
29			Aperion Care Toluca	Toluca				29
30			Aperion Care Colfax	Colfax				30

Facility Name & ID Number

Aperion Care Litchfield, Llc

#

0051102

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	Yosef Meystel	Relative	Administrative	0%	See Attached	1.00	2.50%	Alloc. Salary	\$ 4,853	17-7	1	
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.50	1.25%	Alloc. Salary	752	17-7	2	
3	Joel Meystel	Relative	Administrative	0%	See Attached	0.50	2.50%	Alloc. Salary	1,421	17-7	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.10	3.03%	Alloc. Salary	572	21-7	4	
5	Shimon Meystel	Relative	Clerical	0%	See Attached	1.00	2.50%	Alloc. Salary	102	21-7	5	
6	David Berkowitz	Owner	Administrative	36.50%	See Attached	1.00	2.50%	Alloc. Salary	4,853	17-7	6	
7	Fred Frankel	Owner	Administrative	1.00%	See Attached	1.00	2.50%	Alloc. Salary	3,550	17-7	7	
8	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.00	2.50%	Alloc. Salary	3,513	17-7	8	
9	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.00	2.50%	Alloc. Salary	2,778	10-7	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 22,394		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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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	\$ 22,448	\$ 128	1	
2	5	UTILITIES	ACTUAL CENSUS	925,063	39	179	22,448	4	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	124,883	112,788	22,448	3,030	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	8,040	22,448	195	4	
5	10	SALARY- NURSE	ACTUAL CENSUS	925,063	39	113,170	113,170	22,448	2,746	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	8,067	22,448	196	6	
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	1,588,216	1,274,084	22,448	38,540	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	316,131	22,448	7,671	8	
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	52,521	22,448	1,274	9	
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	899,005	810,120	22,448	21,816	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	126,855	22,448	3,078	11	
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	150,166	22,448	3,644	12	
13	26	INSURANCE	ACTUAL CENSUS	925,063	39	41,165	22,448	999	13	
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	147,150	22,448	3,571	14	
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	15,480	22,448	376	15	
16	32	INTEREST	ACTUAL CENSUS	925,063	39	114,048	22,448	2,768	16	
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39		22,448		17	
18	34	RENT	ACTUAL CENSUS	925,063	39	8,054	22,448	195	18	
19	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	2,485	22,448	60	19	
20	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	76,069	22,448	1,846	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,796,942	\$ 2,310,162	\$ 92,138	25	

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	22,448	\$ 5,202	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39			22,448		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	140,088	138,625	22,448	3,399	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	46,162		22,448	1,120	4
5	10	SALARY NURSE	ACTUAL CENSUS	925,063	39	890,856	890,856	22,448	21,618	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	116,493		22,448	2,827	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39			22,448		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	20,901		22,448	507	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	35,826		22,448	869	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	37,620	25,723	22,448	913	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	7,289		22,448	177	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	83,735		22,448	2,032	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39			22,448		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	3,364		22,448	82	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	1,739		22,448	42	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	508		22,448	12	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			22,448		17
18	34	RENT	ACTUAL CENSUS	925,063	39			22,448		18
19	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	12,556		22,448	305	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,611,525	\$ 1,269,593		\$ 39,104	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	22,448	11	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	81,303	22,448	1,973	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	23,144	22,448	562	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	1,382	22,448	34	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	1,426,697	22,448	34,621	5
6	24	SEMINARS	ACTUAL CENSUS	925,063	39	2,672	22,448	65	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	19,412	22,448	471	7
8	26	INSURANCE	ACTUAL CENSUS	925,063	39	202,628	22,448	4,917	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	9,143	22,448	222	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	\$ 42,876	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 22,448	\$ 353	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	21,508	22,448	522	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	4,910	22,448	119	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	320	22,448	8	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	925,063	39	28,813	22,448	699	5
6	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	57,774	22,448	1,402	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	925,063	39	44,281	22,448	1,075	7
8	34	RENT	ACTUAL CENSUS	925,063	39	15,600	22,448	379	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	16,285	22,448	395	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	925,063	39	56,595	22,448	1,373	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	\$	\$ 6,325	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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	19	Payroll Services	Direct		\$	\$		\$ 4,770	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				\$	\$		\$ 4,770	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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			
A. Directly Facility Related																				
Long-Term																				
1	Red Capital		X	Mortgage			\$	\$ 1,076,540		\$ 46,272	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	First Midwest Bank		X	Line of Credit				185,839	12.11.16	3.7340	9,204	6								
7	Assurance		X	Insurance Financing							366	7								
8												8								
9	TOTAL Facility Related						\$	\$ 1,262,379			\$ 55,841	9								
B. Non-Facility Related*																				
10	Interest Income		X								(263)	10								
11	Interest Income - Bldg. Co		X								(25)	11								
12	Allocated from Aperion Care	X									2,768	12								
13	See Supplemental Schedule										1,087	13								
14	TOTAL Non-Facility Related						\$	\$			\$ 3,567	14								
15	TOTALS (line 9+line14)						\$	\$ 1,262,379			\$ 59,408	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,880 Line # 36

* 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 Litchfield, Llc

0051102

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 - Aperion Consulting	X								12										
16	Allocated - 8131 N Monticello	X								1,075										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									1,087										

* 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.		\$	23,351	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.)		\$	24,233	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	882	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	24,003	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.		\$	24,885	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>21,891</u>	<u>8</u>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>22,440</u>	<u>9</u>																
	2012	<u>22,135</u>	<u>10</u>																
	2013	<u>22,240</u>	<u>11</u>																
	2014	<u>22,860</u>	<u>12</u>																
2015 Accrual = \$22,860 x 1.05 = \$24,003																			
Beginning Accrual Adjusted																			
Allocated from 8131 N. Monticello = \$1,373																			

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Litchfield, Llc COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0051102

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 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>2010</u>	\$ <u>8,241</u>	<u>1</u>
2	<u>Allocated from 8131 N Monticello</u>		<u>2010</u>	<u>2,160</u>	<u>2</u>
3	TOTALS			\$ 10,401	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		2010	1971	\$ 666,776	\$ 36,593	35	\$ 19,051	\$ (17,542)	\$ 101,605	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2011		197,162		20	11,223	11,223	54,834	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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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					
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			26,621	1,463	921	(542)	4,897	68				
69				42,173		(42,173)		69				
70		\$	890,559	\$	80,229	\$	31,195	\$	(49,034)	\$	161,336	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		\$ 890,559	\$ 80,229		\$ 31,195	\$ (49,034)	\$ 161,336	1
2	Electrical For Light Fixtures And Thermoplastic Insulation	2012	21,095		20	2,110	2,110	7,735	2
3	Modify Doors, & Dining Room Cabinets, Cleaned Drains	2012	15,020		20	1,502	1,502	6,008	3
4	Parking Lot	2012	41,734		20	2,784	2,784	9,741	4
5	Replaced 58 Sprinkler Heads	2013	3,250		20	325	325	975	5
6	New Sign Display Set In Concrete	2014	5,351		20	357	357	535	6
7	Install New Hot Water Heater	2014	5,936		20	297	297	544	7
8	Replace Heating Panel Wires In East Wing	2014	4,876		20	244	244	427	8
9	Electrical Upgrade Of Heating Panel	2014	5,147		20	257	257	493	9
10	Installed Phone System And Cableing	2015	4,650		20	465	465	465	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)		\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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		\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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)	\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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		\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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)	\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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		\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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)	\$ 997,617	\$ 80,229		\$ 39,535	\$ (40,694)	\$ 188,259	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	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		\$	\$		\$	\$	\$	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

**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	16,781	499	35	430	(69)	2,349	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	723	58	20	36	(22)	217	9
10	Allocated from Aperion Care	2012	205	8	20	10	2	41	10
11	Allocated from Aperion Care	2013	87	5	20	4	(1)	13	11
12									12
13	Allocated from 8131 N Monticello	2010	7,517	893	20	376	(517)	2,081	13
14	Allocated from 8131 N Monticello	2013	1,308		20	65	65	196	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)		\$ 26,621	\$ 1,463		\$ 921	\$ (542)	\$ 4,897	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		\$ 26,621	\$ 1,463		\$ 921	\$ (542)	\$ 4,897	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)	\$ 26,621	\$ 1,463		\$ 921	\$ (542)	\$ 4,897	34

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 214,053	\$ 104	\$ 23,667	\$ 23,563	10	\$ 99,409	71
72	Current Year Purchases	13,488	116	987	871	10	987	72
73	Fully Depreciated Assets	20,320				10	20,320	73
74								74
75	TOTALS	\$ 247,861	\$ 220	\$ 24,654	\$ 24,434		\$ 120,716	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		2007 Ford E350- Purchased New	2011	\$ 16,615	\$	\$ 2,035	\$ 2,035	5	\$ 11,527	76
77		2006 DODGE GRAND CARAVA	2014	7,031		1,793	1,793	5	2,848	77
78		Allocated from Aperion Care	2014	765	101	153	52	5	256	78
79		Allocated from Aperion Consultir	2015	563	36	113	77	5	113	79
80	TOTALS			\$ 24,974	\$ 137	\$ 4,094	\$ 3,957		\$ 14,744	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,280,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,586	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,283	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,303)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 323,719	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from 8131 N Monticello</u>				<u>379</u>			5
6								6
7	TOTAL				\$ <u>379</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: \$ 7,583 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>1,846</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>305</u>	18
19					19
20					20
21	TOTAL		\$	<u>2,151</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	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 13,117	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	261,751	266,302	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,125	53,367	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	357	101,529	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 310,233	\$ 434,315	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	281,839	311,254	15
16	Equipment, at Historical Cost	112,890	301,715	16
17	Accumulated Depreciation (book methods)	(183,935)	(433,204)	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):	499,536	581,392	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 710,330	\$ 1,274,591	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,020,563	\$ 1,708,906	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 70,622	\$ 70,622	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	185,839	213,429	29
30	Accrued Salaries Payable	60,093	60,093	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,756	1,756	31
32	Accrued Real Estate Taxes(Sch.IX-B)		24,003	32
33	Accrued Interest Payable	(607)	3,206	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	41,758	41,758	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 359,461	\$ 414,867	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,048,950	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	351,214	351,214	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 351,214	\$ 1,400,164	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 710,675	\$ 1,815,031	46
47	TOTAL EQUITY(page 18, line 24)	\$ 309,888	\$ (106,125)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,020,563	\$ 1,708,906	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 263,033	1
2	Restatements (describe):		2
3	<u>Rounding</u>	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 263,036	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	155,843	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	(108,991)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 46,852	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)	\$ 309,888	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperia Care Litchfield, Llc

0051102

Report 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	\$ 3,819,149	1
2	Discounts and Allowances for all Levels	(1,217,417)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,601,732	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	702	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 702	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	263	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 263	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,602,697	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	527,513	31
32	Health Care	847,415	32
33	General Administration	632,091	33
B. Capital Expense			
34	Ownership	259,261	34
C. Ancillary Expense			
35	Special Cost Centers	9,499	35
36	Provider Participation Fee	171,075	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,446,854	40
41	Income before Income Taxes (line 30 minus line 40)**	155,843	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 155,843	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,533,976	44
45	Private Pay - Net Inpatient Revenue	67,660	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Insurance</u>	96	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,601,732	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 Litchfield, Llc**

0051102

Report Period Beginning:

01/01/15

Ending:

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,080	\$ 82,923	\$ 39.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,520	6,071	153,278	25.25	3
4	Licensed Practical Nurses	6,160	6,485	111,764	17.23	4
5	CNAs & Orderlies	23,018	25,044	276,341	11.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,822	2,082	34,277	16.46	9
10	Activity Assistants	124	124	1,569	12.65	10
11	Social Service Workers	3,656	4,107	90,777	22.10	11
12	Dietician					12
13	Food Service Supervisor	1,737	2,043	30,010	14.69	13
14	Head Cook	4,009	4,449			14
15	Cook Helpers/Assistants	6,477	7,038	138,304	19.65	15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,226	34,255	15.39	17
18	Housekeepers	5,411	6,194	71,649	11.57	18
19	Laundry	2,178	2,412	28,449	11.79	19
20	Administrator	2,584	3,218	92,401	28.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,319	1,432	16,436	11.48	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,279	1,378	20,015	14.52	33
34	TOTAL (lines 1 - 33)	69,205	76,383	\$ 1,182,448 *	\$ 15.48	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	86	\$ 4,972	01-03	35
36	Medical Director	Monthly	5,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	27,500	10-03	38
39	Pharmacist Consultant	Monthly	4,104	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	17	942	11-03	44
45	Social Service Consultant	21	1,083	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	Monthly	6,000	10 - 03	47
48					48
49	TOTAL (lines 35 - 48)	124	\$ 50,101		49

C. CONTRACT NURSES

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

XIX. 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	
<u>Andy Kindernay</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 92,401</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 22,267</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>22,391</u>	<u>Advertising: Employee Recruitment</u>	<u>2,453</u>	
				<u>FICA Taxes</u>	<u>87,418</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>19,517</u>	<u>(Indicate # of checks performed <u>56</u>)</u>	<u>562</u>	
				<u>Employee Meals</u>	<u>281</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>13,521</u>	
				<u>Employee Physicals</u>	<u>160</u>	<u>License & Permits</u>	<u>817</u>	
				<u>Employee Benefits Other</u>	<u>422</u>	<u>Allocated from Aperion Care</u>	<u>1,274</u>	
						<u>Allocated from Aperion Consulting</u>	<u>869</u>	
						<u>See Supplemental Schedule</u>	<u>42</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 92,401			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,526	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
					\$ 152,456			
Description			Amount					
<u>Management Fees - Aperion Care, Inc.</u>			<u>\$ 72,941</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 72,941					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Aperion Care, Inc.</u>	<u>Data Processing</u>		<u>\$ 4,812</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Creative Technology Solutions</u>	<u>Data Processing</u>		<u>6,885</u>					
<u>E-Health Data Solutions</u>	<u>MDS Software</u>		<u>5,400</u>					
<u>Galaxy Hosted Software</u>	<u>Clinical Software</u>		<u>11,150</u>				<u>In-State Travel</u>	
<u>National Datacare Corp</u>	<u>Pharmacy Software</u>		<u>1,740</u>					
<u>Wescom Solutions</u>	<u>E.H.R. Software</u>		<u>10,854</u>					
<u>Aperion Care, Inc.</u>	<u>Home Office Expense</u>		<u>43,402</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>35,511</u>				<u>Seminar Expense</u>	<u>824</u>
<u>Propay HR</u>	<u>Payroll Processing</u>		<u>6,446</u>				<u>Allocated from Aperion Care</u>	<u>3,078</u>
<u>FRR / Marcum</u>	<u>Accounting</u>		<u>12,710</u>				<u>Allocated from Aperion Consulting</u>	<u>177</u>
<u>Personnel Planners</u>	<u>Unemployment Consultant</u>		<u>404</u>				<u>See Supplemental Schedule</u>	<u>65</u>
<u>See Supplemental Schedule</u>			<u>1,581</u>				<u>Entertainment Expense</u>	<u>()</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 140,894	TOTAL		\$	TOTAL	\$ 4,144
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102

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 \$17,540
- (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. \$ 838 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. \$ 171,075
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. \$ 281 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? No
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.