

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696 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	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,570	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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	635		1,778	2,413	8	
9	SNF/PED					9	
10	ICF	9,373	3,793		13,166	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,008	3,793	1,778	15,579	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.14%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2014 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 42 and days of care provided 1,650

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	108,855	12,630	4,637	126,122		126,122	3,611	129,733		1
2	Food Purchase		98,402		98,402		98,402	(1,907)	96,495		2
3	Housekeeping	56,812	12,169		68,981		68,981		68,981		3
4	Laundry	37,121	4,713		41,834		41,834		41,834		4
5	Heat and Other Utilities			50,911	50,911		50,911	(2,793)	48,118		5
6	Maintenance	25,247	17,730	27,767	70,744		70,744	11,730	82,474		6
7	Other (specify):*							912	912		7
8	TOTAL General Services	228,035	145,644	83,315	456,994		456,994	11,554	468,548		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	855,590	57,179	6,440	919,209		919,209	12,409	931,618		10
10a	Therapy		537		537		537		537		10a
11	Activities	39,905	2,522	3,106	45,533		45,533		45,533		11
12	Social Services	48,464		4,210	52,674		52,674		52,674		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,098	2,098		15
16	TOTAL Health Care and Programs	943,959	60,238	16,756	1,020,953		1,020,953	14,507	1,035,460		16
	C. General Administration										
17	Administrative	107,942		130,488	238,430		238,430	(102,372)	136,058		17
18	Directors Fees										18
19	Professional Services			165,391	165,391		165,391	(94,528)	70,863		19
20	Dues, Fees, Subscriptions & Promotions			57,616	57,616		57,616	(39,126)	18,490		20
21	Clerical & General Office Expenses	14,559		125,106	139,665		139,665	(40,047)	99,618		21
22	Employee Benefits & Payroll Taxes			162,347	162,347		162,347		162,347		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,189	1,189		1,189	2,304	3,493		24
25	Other Admin. Staff Transportation			401	401		401	4,266	4,667		25
26	Insurance-Prop.Liab.Malpractice			46,288	46,288		46,288	4,105	50,393		26
27	Other (specify):*							2,535	2,535		27
28	TOTAL General Administration	122,501		688,826	811,327		811,327	(262,862)	548,465		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,294,495	205,882	788,897	2,289,274		2,289,274	(236,802)	2,052,472		29

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

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

Facility Name & ID Number Aperion Care St. Elmo, Llc #0052696 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			35,935	35,935		35,935	26,640	62,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,994	27,994		27,994	76,063	104,057			32
33	Real Estate Taxes							24,455	24,455			33
34	Rent-Facility & Grounds			206,200	206,200		206,200	(205,938)	262			34
35	Rent-Equipment & Vehicles			9,683	9,683		9,683	1,963	11,646			35
36	Other (specify):*							0	0			36
37	TOTAL Ownership			279,812	279,812		279,812	(76,817)	202,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,313	266,535	269,848		269,848	(30,968)	238,880			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,991	119,991		119,991		119,991			42
43	Other (specify):*			13,318	13,318		13,318	(13,318)	0			43
44	TOTAL Special Cost Centers		3,313	399,844	403,157		403,157	(44,286)	358,871			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,294,495	209,195	1,468,553	2,972,243		2,972,243	(357,905)	2,614,338			45

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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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	(1,500)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,041)	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	(31,433)	30		9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(240)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,341)	21		19
20	Contributions	(35,500)	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	(66,286)	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	(65,202)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (204,556)		\$	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)	(153,349)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (153,349)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (357,905)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (9,718)	43	1
2	Promotional Products	(3,600)	43	2
3	Bank Charges	(12,439)	21	3
4	Theft & Damage Loss	(267)	21	4
5	Meals on Wheels	(256)	02	5
6	Bldg Co - Amortization	(2,796)	36	6
7	Bldg Co - Bank Fees	(4,808)	21	7
8	Bldg Co - State Replacement Tax	(347)	21	8
9	Bldg Co - Professional Fees	(1,575)	19	9
10	Bldg Co - Rent Expense	(10,000)	34	10
11	Additional R&M	8,698	06	11
12	PAC Dues	(5,142)	20	12
13	Non Allowable Legal Fees	(953)	19	13
14	Non Allowable Rent	(22,000)	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	(65,202)		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 St. Elmo, Llc# 0052696

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				3,611								3,611	1
2	Food Purchase	(1,996)		89									(1,907)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,041)		3			245						(2,793)	5
6	Maintenance	8,698		2,103	559	8	362						11,730	6
7	Other (specify):*			135	777								912	7
8	TOTAL General Services	3,661		2,330	4,947	8	607						11,554	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			1,906	10,503								12,409	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			136	1,962								2,098	15
16	TOTAL Health Care and Programs			2,042	12,465								14,507	16
	C. General Administration													
17	Administrative			(103,741)		1,369							(102,372)	17
18	Directors Fees													18
19	Professional Services	(2,528)	1,575	(51,552)	352	(40,052)	83		(2,406)				(94,528)	19
20	Fees, Subscriptions & Promotions	(40,642)		885	603	23	5						(39,126)	20
21	Clerical & General Office Expenses	(85,488)	5,155	15,140	634	24,027	485						(40,047)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,136	123	45							2,304	24
25	Other Admin. Staff Transportation			2,529	1,410	327							4,266	25
26	Insurance-Prop.Liab.Malpractice			693		3,412							4,105	26
27	Other (specify):*			2,478	57								2,535	27
28	TOTAL General Administration	(128,657)	6,730	(131,432)	3,179	(10,849)	573		(2,406)				(262,862)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,996)	6,730	(127,060)	20,591	(10,841)	1,181		(2,406)				(236,802)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(31,433)	56,810	261	29		973						26,640	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13)	73,400	1,921	9		746						76,063	32
33	Real Estate Taxes		23,502				953						24,455	33
34	Rent-Facility & Grounds	(32,000)	(162,200)	136			(11,873)						(205,938)	34
35	Rent-Equipment & Vehicles			1,323	211	154	274						1,963	35
36	Other (specify):*	(2,796)	2,796										0	36
37	TOTAL Ownership	(66,242)	(5,692)	3,641	249	154	(8,927)						(76,817)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(30,968)					(30,968)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(13,318)											(13,318)	43
44	TOTAL Special Cost Centers	(13,318)						(30,968)					(44,286)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(204,556)	1,038	(123,420)	20,840	(10,687)	(7,747)	(30,968)	(2,406)				(357,905)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rental Income	\$ 172,200	221 East Cumberland, LLC	100.00%	\$	(172,200)	1	
2	V	36 Amortization		221 East Cumberland, LLC	100.00%	2,796	2,796	2	
3	V	21 Bank Fees		221 East Cumberland, LLC	100.00%	4,808	4,808	3	
4	V	33 Real Estate Taxes		221 East Cumberland, LLC	100.00%	23,502	23,502	4	
5	V	21 State Replacement Tax		221 East Cumberland, LLC	100.00%	347	347	5	
6	V	30 Depreciation		221 East Cumberland, LLC	100.00%	56,810	56,810	6	
7	V	32 Interest Expense		221 East Cumberland, LLC	100.00%	73,400	73,400	7	
8	V	19 Professional Fees		221 East Cumberland, LLC	100.00%	1,575	1,575	8	
9	V	34 Rent Expense		221 East Cumberland, LLC	100.00%	10,000	10,000	9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 172,200			\$ 173,238	\$ *	1,038	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%	\$ 89	\$	89	15
16	V	5 UTILITIES		APERION CARE	100.00%	3		3	16
17	V	6 REPAIRS & MAINTENANCE		APERION CARE	100.00%	2,103		2,103	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	100.00%	135		135	18
19	V	10 SALARY- NURSE		APERION CARE	100.00%	1,906		1,906	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	100.00%	136		136	20
21	V	17 ADMINISTRATIVE		APERION CARE	100.00%	26,747		26,747	21
22	V	19 PROFESSIONAL FEES		APERION CARE	100.00%	5,324		5,324	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE	100.00%	885		885	23
24	V	21 CLERICAL & GENERAL		APERION CARE	100.00%	15,140		15,140	24
25	V	24 SEMINARS		APERION CARE	100.00%	2,136		2,136	25
26	V	25 AUTO AND TRAVEL		APERION CARE	100.00%	2,529		2,529	26
27	V	26 INSURANCE		APERION CARE	100.00%	693		693	27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	100.00%	2,478		2,478	28
29	V	30 DEPRECIATION		APERION CARE	100.00%	261		261	29
30	V	32 INTEREST		APERION CARE	100.00%	1,921		1,921	30
31	V	33 REAL ESTATE TAX		APERION CARE	100.00%				31
32	V	34 RENT		APERION CARE	100.00%	136		136	32
33	V	35 EQUIPMENT RENTAL		APERION CARE	100.00%	42		42	33
34	V	35 AUTO LEASE		APERION CARE	100.00%	1,281		1,281	34
35	V	17 MANAGEMENT FEE	130,488	APERION CARE	100.00%			(130,488)	35
36	V	19 HOME OFFICE	49,429	APERION CARE	100.00%			(49,429)	36
37	V	19 DATA PROCESSING	7,447	APERION CARE	100.00%			(7,447)	37
38	V								38
39	Total		\$ 187,364			\$ 63,945	\$ *	(123,420)	39

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

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>1</u> DIETARY	\$	APERION CONSULTING	100.00%	\$ 3,611	\$	3,611	15
16	V	<u>5</u> UTILITIES		APERION CONSULTING	100.00%				16
17	V	<u>6</u> REPAIRS & MAINTENANCE		APERION CONSULTING	100.00%	2,359		2,359	17
18	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING	100.00%	777		777	18
19	V	<u>10</u> SALARY NURSE		APERION CONSULTING	100.00%	15,003		15,003	19
20	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING	100.00%	1,962		1,962	20
21	V	<u>17</u> ADMINISTRATIVE		APERION CONSULTING	100.00%				21
22	V	<u>19</u> PROFESSIONAL FEES		APERION CONSULTING	100.00%	352		352	22
23	V	<u>20</u> FEES, SUBSCRIPTIONS		APERION CONSULTING	100.00%	603		603	23
24	V	<u>21</u> CLERICAL & GENERAL		APERION CONSULTING	100.00%	634		634	24
25	V	<u>24</u> SEMINARS		APERION CONSULTING	100.00%	123		123	25
26	V	<u>25</u> AUTO AND TRAVEL		APERION CONSULTING	100.00%	1,410		1,410	26
27	V	<u>26</u> INSURANCE		APERION CONSULTING	100.00%				27
28	V	<u>27</u> EMP. BEN.-GEN. ADMIN.		APERION CONSULTING	100.00%	57		57	28
29	V	<u>30</u> DEPRECIATION		APERION CONSULTING	100.00%	29		29	29
30	V	<u>32</u> INTEREST		APERION CONSULTING	100.00%	9		9	30
31	V	<u>33</u> REAL ESTATE TAX		APERION CONSULTING	100.00%				31
32	V	<u>34</u> RENT		APERION CONSULTING	100.00%				32
33	V	<u>35</u> AUTO LEASE		APERION CONSULTING	100.00%	211		211	33
34	V	<u>10</u> CONSULTING	4,500	APERION CONSULTING	100.00%			(4,500)	34
35	V	<u>01</u> DIETICIAN		APERION CONSULTING	100.00%				35
36	V	<u>06</u> PAINTER		APERION CONSULTING	100.00%				36
37	V	<u>06</u> PROJECT MANAGER	1,800	APERION CONSULTING	100.00%			(1,800)	37
38	V								38
39	Total		\$ 6,300			\$ 27,140	\$ *	20,840	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%	8	\$ 8
16	V	17 ADMINISTRATIVE		APERION FINANCIAL	100.00%	1,369	1,369
17	V	19 PROFESSIONAL FEES		APERION FINANCIAL	100.00%	390	390
18	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	100.00%	23	23
19	V	21 CLERICAL & GENERAL		APERION FINANCIAL	100.00%	24,027	24,027
20	V	24 SEMINARS		APERION FINANCIAL	100.00%	45	45
21	V	25 AUTO AND TRAVEL		APERION FINANCIAL	100.00%	327	327
22	V	26 INSURANCE		APERION FINANCIAL	100.00%	3,412	3,412
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	100.00%	154	154
24	V	19 HOME OFFICE EXPENSE	40,442	APERION FINANCIAL	100.00%		(40,442)
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		\$ 40,442			\$ 29,755	\$ * (10,687)

* 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%	\$ 245	\$	245	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		362		362	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		83		83	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		5		5	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		485		485	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		973		973	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		746		746	21
22	V	34 RENT		8131 N. MONTICELLO, LLC		263		263	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		274		274	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		953		953	24
25	V								25
26	V	34 RENT	12,000	8131 N. MONTICELLO, LLC				(12,000)	26
27	V	34 RENT	136	8131 N. MONTICELLO, LLC				(136)	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		\$ 12,136			\$ 4,389	\$ *	(7,747)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 215,056	Renewal Rehab	100.00%	\$ 184,088	\$ (30,968)
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		\$ 215,056			\$ 184,088	\$ * (30,968)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 9,252	ProPay HR LLC	24.00%	\$ 6,846	\$ (2,406)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,252			\$ 6,846	\$ * (2,406)

* 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	BM EQUITIES	51.00%	Aperion Care Amboy	Amboy	221 EAST CUMBERLAND	SKOKIE	BUILDING CO.	1
2	MORRIS ESFORMES	10.00%	Aperion Care Jacksonville	Jacksonville	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	DELICIA WIRTEBERG REVOCABLE TRUST	10.00%	River Crossing Rehab	Galesburg	PROPAY	EVANSTON	PAYROLL SERVICES	3
4	JACK AND MARY YOLINSKY	10.00%	Aperion Care Dolton	Dolton	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	4
5	SYLVIA YOLINSKY TRUST	10.00%	Riverwood Rehab	East Moline	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	5
6	257 LTD PARTNERSHIP	2.00%	Aperion Care Bridgeport	Bridgeport	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	6
7	1219 LTD PARTNERSHIP	2.00%	Aperion Care Litchfield	Litchfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	7
8	42170 LTD PARTNERSHIP	2.00%	Aperion Care Springfield	Springfield	APERION ESTATES PERU	PERU, IN	ALF	8
9	FREDRICK S. FRANKEL	1.50%	Aperion Care Evanston	Evanston	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	9
10	STEVEN TUROFSKY	1.50%	Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	10
11			Aperion Care Burbank	Burbank	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	11
12			Aperion Care Chicago Heights	Chicago Heights	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	12
13			Aperion Care Forest Park	Forest Park	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	13
14			Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Highwood	Highwood				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Spring Valley	Spring Valley				20
21			Aperion Care Elgin	Elgin				21
22			Aperion Care Toluca	Toluca				22
23			Aperion Care Colfax	Colfax				23
24			Aperion Care Bloomington	Bloomington				24
25			The Arbors at Michigan City	Michigan City, IN				25
26			Aperion Care Demotte	Demotte, IN				26
27			Aperion Care Kokomo	Kokomo, IN				27
28			Aperion Care Tolleston Park	Gary, IN				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Peru	Peru, IN				30

Facility Name & ID Number

Aperion Care St. Elmo, Llc

#

0052696

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	0.00%	See Attached	0.70	1.75%	Alloc. Salary	\$ 3,368	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.30	0.75%	Alloc. Salary	522	17-7	2	
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.30	1.50%	Alloc. Salary	986	17-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.10	3.03%	Alloc. Salary	397	21-7	4	
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	0.70	1.75%	Alloc. Salary	71	21-7	5	
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.70	1.75%	Alloc. Salary	3,368	17-7	6	
7	Fredrick Frankel	Owner	Administrative	1.50%	See Attached	0.70	1.75%	Alloc. Salary	2,464	17-7	7	
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.70	1.75%	Alloc. Salary	2,438	17-7	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 13,614		13	

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

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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 St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	FOOD	ACTUAL CENSUS	925,063	39	\$ 5,257	\$ 15,579	\$ 89	1	
2	5	UTILITIES	ACTUAL CENSUS	925,063	39	179	15,579	3	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	124,883	112,788	15,579	2,103	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	8,040		15,579	135	4
5	10	SALARY- NURSE	ACTUAL CENSUS	925,063	39	113,170	113,170	15,579	1,906	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	8,067		15,579	136	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	1,588,216	1,274,084	15,579	26,747	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	316,131		15,579	5,324	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	52,521		15,579	885	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	899,005	810,120	15,579	15,140	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	126,855		15,579	2,136	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	150,166		15,579	2,529	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39	41,165		15,579	693	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	147,150		15,579	2,478	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	15,480		15,579	261	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	114,048		15,579	1,921	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			15,579		17
18	34	RENT	ACTUAL CENSUS	925,063	39	8,054		15,579	136	18
19	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	2,485		15,579	42	19
20	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	76,069		15,579	1,281	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,796,942	\$ 2,310,162	\$ 63,945		25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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	15,579	\$ 3,611	1
2	5	UTILITIES	ACTUAL CENSUS	925,063	39			15,579		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	140,088	138,625	15,579	2,359	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	925,063	39	46,162		15,579	777	4
5	10	SALARY NURSE	ACTUAL CENSUS	925,063	39	890,856	890,856	15,579	15,003	5
6	15	PAYROLL TAXES/GROUP INST	ACTUAL CENSUS	925,063	39	116,493		15,579	1,962	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39			15,579		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	20,901		15,579	352	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	35,826		15,579	603	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	37,620	25,723	15,579	634	10
11	24	SEMINARS	ACTUAL CENSUS	925,063	39	7,289		15,579	123	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	83,735		15,579	1,410	12
13	26	INSURANCE	ACTUAL CENSUS	925,063	39			15,579		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	925,063	39	3,364		15,579	57	14
15	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	1,739		15,579	29	15
16	32	INTEREST	ACTUAL CENSUS	925,063	39	508		15,579	9	16
17	33	REAL ESTATE TAX	ACTUAL CENSUS	925,063	39			15,579		17
18	34	RENT	ACTUAL CENSUS	925,063	39			15,579		18
19	35	AUTO LEASE	ACTUAL CENSUS	925,063	39	12,556		15,579	211	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,611,525	\$ 1,269,593		\$ 27,140	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	457	15,579	8	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	925,063	39	81,303	15,579	1,369	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	23,144	15,579	390	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	1,382	15,579	23	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	925,063	39	1,426,697	15,579	24,027	5
6	24	SEMINARS	ACTUAL CENSUS	925,063	39	2,672	15,579	45	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	925,063	39	19,412	15,579	327	7
8	26	INSURANCE	ACTUAL CENSUS	925,063	39	202,628	15,579	3,412	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	9,143	15,579	154	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	\$ 29,755	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	925,063	39	\$ 14,551	\$ 15,579	\$ 245	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	925,063	39	21,508	15,579	362	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	925,063	39	4,910	15,579	83	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	925,063	39	320	15,579	5	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	925,063	39	28,813	15,579	485	5
6	30	DEPRECIATION	ACTUAL CENSUS	925,063	39	57,774	15,579	973	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	925,063	39	44,281	15,579	746	7
8	34	RENT	ACTUAL CENSUS	925,063	39	15,600	15,579	263	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	925,063	39	16,285	15,579	274	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	925,063	39	56,595	15,579	953	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	\$	\$ 4,389	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Renewal Rehab

Street Address

8131 N. Monticello

City / State / Zip Code

Skokie, Illinois 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	37	\$	\$		\$ 184,088	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				\$	\$		\$ 184,088	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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		\$	\$		\$ 6,846	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 6,846	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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 St. Elmo, Llc

0052696

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 St. Elmo, Llc

0052696

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 St. Elmo, Llc

0052696

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	Bank Leumi		X	Mortgage				\$	\$ 1,361,505		\$ 73,400	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Bank Leumi		X	Line of Credit					\$ 517,870		\$ 27,294	6								
7	Insurance Policies		X								\$ 700	7								
8												8								
9	TOTAL Facility Related							\$	\$ 1,879,375		\$ 101,395	9								
B. Non-Facility Related*																				
10	Interest Income		X								\$ (13)	10								
11	Allocated from Aperion Care	X									\$ 1,921	11								
12	Allocated from Aperion Consult	X									\$ 9	12								
13	See Supplemental Schedule										\$ 746	13								
14	TOTAL Non-Facility Related							\$	\$		\$ 2,663	14								
15	TOTALS (line 9+line14)							\$	\$ 1,879,375		\$ 104,058	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number

Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15	Allocated from 8131 N. Montice	X								746										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related									746										

* 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.		\$	22,873	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.)		\$	24,141	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,268	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	23,188	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.		\$	24,456	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	19,364	8	FOR BHF USE ONLY	
	2011	19,940	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012		10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	22,873	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	23,188	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2015 Accrual = 2014 Tax					
Allocated from 8131 N. Monticello = \$953					

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.

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>51,830</u>	<u>2014</u>	<u>\$ 90,000</u>	<u>1</u>
2	<u>Allocated from 8131 N. Monticello</u>			<u>1,499</u>	<u>2</u>
3	TOTALS	51,830		\$ 91,499	3

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		2014	1968	\$ 1,108,000	\$ 56,810	39	\$ 28,410	\$ (28,400)	\$ 56,821	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68			18,475	1,014	640	(374)	3,399	68		
69				35,935		(35,935)		69		
70		\$	1,126,475	\$	29,050	\$	(64,709)	\$	60,220	70

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,126,475	\$ 93,759		\$ 29,050	\$ (64,709)	\$ 60,220	1
2	Labor & Materials To Install New Light Fixtures & Exit Signs	2014	20,758		20	1,038	1,038	1,557	2
3	Furnish & Install New Sign With Lexan Face Panels	2014	3,220		20	215	215	322	3
4	New Ceiling In Kitchen & Replace Front Roof Area	2014	9,000		20	450	450	825	4
5	New Cat5E Lines For New & Existing Computers	2014	4,800		20	960	960	1,680	5
6	Computer Back Up On Generator	2014	4,025		20	805	805	1,073	6
7	Light Fixtures	2014	2,818		20	141	141	188	7
8	New Architectural 30 Year Shingle Roof	2014	86,290		20	4,315	4,315	5,393	8
9	Soffit & Fascia	2014	9,200		20	460	460	537	9
10	Cabling For Vip System	2014	4,000		20	800	800	933	10
11	New Windows, Paint 28 Rms, New Vct Tile In 5 Rms, 25 Ptac Unit	2014	116,700		20	5,835	5,835	6,321	11
12	Electrical Work For 28 New Ptac Units; Includes New 400 Amp M	2014	33,460		20	1,673	1,673	1,812	12
13	Don Office Flr Tile, 4 Resident Rms:Remove Wallpaper New Pain	2015	10,507		20	306	306	306	13
14	Corridor Handrails,End Caps, Bumper Guards & End Caps	2015	8,756		20	292	292	292	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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		\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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)	\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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		\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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)	\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	34

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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)	\$ 1,440,009	\$ 93,759		\$ 46,340	\$ (47,419)	\$ 81,460	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated from 8131 N. Monticello</u>	<u>2010</u>	<u>11,646</u>	<u>346</u>	<u>35</u>	<u>299</u>	<u>(47)</u>	<u>1,630</u>	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from 8131 N. Monticello</u>	<u>2010</u>	<u>5,217</u>	<u>620</u>	<u>20</u>	<u>261</u>	<u>(359)</u>	<u>1,445</u>	9
10	<u>Allocated from 8131 N. Monticello</u>	<u>2013</u>	<u>907</u>		<u>20</u>	<u>45</u>	<u>45</u>	<u>136</u>	10
11									11
12	<u>Allocated from Aperion Care</u>	<u>2010</u>	<u>502</u>	<u>40</u>	<u>20</u>	<u>25</u>	<u>(15)</u>	<u>151</u>	12
13	<u>Allocated from Aperion Care</u>	<u>2012</u>	<u>142</u>	<u>5</u>	<u>20</u>	<u>7</u>	<u>2</u>	<u>28</u>	13
14	<u>Allocated from Aperion Care</u>	<u>2013</u>	<u>61</u>	<u>3</u>	<u>20</u>	<u>3</u>		<u>9</u>	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)		\$ 18,475	\$ 1,014		\$ 640	\$ (374)	\$ 3,399	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		\$ 18,475	\$ 1,014		\$ 640	\$ (374)	\$ 3,399	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)	\$ 18,475	\$ 1,014		\$ 640	\$ (374)	\$ 3,399	34

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

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	\$ 148,576	\$ 72	\$ 15,472	\$ 15,400	10	\$ 30,315	71
72	Current Year Purchases	3,644	81	579	498	10	579	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 152,220	\$ 153	\$ 16,050	\$ 15,897		\$ 30,894	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2015	\$ 531	\$ 70	\$ 106	\$ 36	5	\$ 178	76
77		Allocated from Aperion Consultir	2015	390	25	78	53	5	78	77
78										78
79										79
80	TOTALS			\$ 921	\$ 95	\$ 184	\$ 89		\$ 256	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)	\$ 1,684,649	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,007	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,574	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,433)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 112,609	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? YES NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	<u>Allocated from 8131 N. Monticello</u>			<u>263</u>			5
6							6
7	TOTAL			\$ <u>263</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: \$ 10,153 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>1,281</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>211</u>	18
19					19
20					20
21	TOTAL		\$	<u>1,492</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 100,308	\$		\$ 100,308	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			15,776			15,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			98,973			98,973	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			48,569			48,569	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>					2,909	3,313		6,222	13
14	TOTAL			\$		\$ 266,535	\$ 3,313		\$ 269,848	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 St. Elmo, Llc# 0052696Report Period Beginning: 01/01/15Ending: 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	\$ 11,236	\$ 49,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	544,752	544,752	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,329	26,329	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	7,192	8,192	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 589,509	\$ 628,716	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,000	13
14	Buildings, at Historical Cost		1,108,000	14
15	Leasehold Improvements, at Historical Cost	315,484	315,484	15
16	Equipment, at Historical Cost	22,665	164,665	16
17	Accumulated Depreciation (book methods)	(44,110)	(151,812)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,359)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	560,000	1,232,109	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 854,039	\$ 2,753,087	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,443,548	\$ 3,381,803	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 125,456	\$ 125,456	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	517,870	517,870	29
30	Accrued Salaries Payable	90,911	90,911	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,535	3,535	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,188	32
33	Accrued Interest Payable	2,347	8,209	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	26,233	26,233	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 766,352	\$ 795,402	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,361,505	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	699,063	1,253,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 699,063	\$ 2,614,505	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,465,415	\$ 3,409,907	46
47	TOTAL EQUITY(page 18, line 24)	\$ (21,867)	\$ (28,104)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,443,548	\$ 3,381,803	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 33,675	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)	\$ 33,678	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,092	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	(84,637)	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)	\$ (55,545)	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)	\$ (21,867)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperia Care St. Elmo, Llc

0052696

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	\$ 2,362,321	1
2	Discounts and Allowances for all Levels	567,090	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,929,411	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	66,827	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 66,827	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	1,500	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	113	19
20	Radiology and X-Ray	29	20
21	Other Medical Services	2,286	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,828	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	256	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 256	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,001,335	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	456,994	31
32	Health Care	1,020,953	32
33	General Administration	811,327	33
B. Capital Expense			
34	Ownership	279,812	34
C. Ancillary Expense			
35	Special Cost Centers	283,166	35
36	Provider Participation Fee	119,991	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,972,243	40
41	Income before Income Taxes (line 30 minus line 40)**	29,092	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,092	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,464,865	44
45	Private Pay - Net Inpatient Revenue	610,675	45
46	Medicare - Net Inpatient Revenue	794,806	46
47	Other-(specify) <u>Insurance</u>	59,065	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,929,411	49

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

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

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

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

0052696

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,896	2,080	\$ 67,429	\$ 32.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,802	5,209	122,811	23.58	3
4	Licensed Practical Nurses	13,106	14,067	248,532	17.67	4
5	CNAs & Orderlies	38,724	41,540	398,477	9.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,999	2,155	25,172	11.68	9
10	Activity Assistants	1,261	1,582	14,733	9.31	10
11	Social Service Workers	2,788	3,016	29,168	9.67	11
12	Dietician					12
13	Food Service Supervisor	1,477	1,694	26,011	15.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,654	9,430	82,844	8.79	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,020	25,247	12.50	17
18	Housekeepers	5,999	6,350	56,812	8.95	18
19	Laundry	4,025	4,201	37,121	8.84	19
20	Administrator	1,912	2,080	107,942	51.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,302	1,423	14,559	10.23	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	753	828	18,341	22.15	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,357	1,569	19,296	12.30	33
34	TOTAL (lines 1 - 33)	91,979	99,244	\$ 1,294,495 *	\$ 13.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	84	\$ 4,637	01-03	35
36	Medical Director	Monthly	3,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	60	4,500	10-03	38
39	Pharmacist Consultant	Monthly	1,940	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	56	3,106	11-03	44
45	Social Service Consultant	22	1,210	12-03	45
46	Other(specify) <u>Psychiatric MD</u>	Monthly	3,000	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	223	\$ 21,393		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>Charles Hutson</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 107,942</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 17,346</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>32,919</u>	<u>Advertising: Employee Recruitment</u>	<u>1,203</u>	
				<u>FICA Taxes</u>	<u>96,210</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>12,044</u>	<u>(Indicate # of checks performed <u>77</u>)</u>	<u>770</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>12,460</u>	
				<u>Employee Physicals</u>	<u>1,200</u>	<u>Licenses & Fees</u>	<u>551</u>	
				<u>Other Employee Benefits</u>	<u>2,628</u>	<u>Allocated from Aperion Care</u>	<u>885</u>	
						<u>Allocated from Aperion Consulting</u>	<u>603</u>	
						<u>See Supplemental Schedule</u>	<u>28</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)			\$ 107,942			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,490	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
					\$ 162,346			
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
<u>Management Fees- Aperion Care</u>			<u>\$ 130,488</u>	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
							Description	Amount
							<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 130,488				<u>Seminar Expense</u>	<u>1,189</u>
(Attach a copy of any management service agreement)							<u>Allocated from Aperion Care</u>	<u>2,136</u>
C. Professional Services							<u>Allocated from Aperion Consulting</u>	<u>123</u>
Vendor/Payee	Type		Amount				<u>See Supplemental Schedule</u>	<u>45</u>
<u>FR&R/Marcum LLP</u>	<u>Accounting</u>		<u>\$ 23,385</u>				<u>Entertainment Expense</u>	<u>()</u>
<u>Propay HR</u>	<u>Payroll Processing</u>		<u>9,252</u>				<u>(agree to Sch. V, line 24, col. 8)</u>	
<u>Pendulum LLC</u>	<u>Risk Management</u>		<u>1,184</u>				TOTAL	\$ 3,493
<u>Adj on Pg 5a</u>	<u>Legal</u>		<u>953</u>					
<u>Aperion Care</u>	<u>Home Office Expense</u>		<u>49,429</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>40,442</u>					
<u>Aperion Care</u>	<u>Data Processing</u>		<u>7,447</u>					
<u>Creative Technology Solutions</u>	<u>Data Processing</u>		<u>5,281</u>					
<u>E-Health Data Solutions</u>	<u>Data Processing</u>		<u>5,400</u>					
<u>Galaxy Hosted Software</u>	<u>Data Processing</u>		<u>11,150</u>					
<u>National Datacare Corporation</u>	<u>Data Processing</u>		<u>1,456</u>					
<u>See Supplemental Schedule</u>			<u>10,010</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 165,390	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696

Report Period Beginning:

01/01/15

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$15,583
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,533 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. \$ 119,991
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,500
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.