

FOR BHF USE							

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0048330</u></p> <p><b>Facility Name:</b> <u>Aperion Care Highwood</u></p> <p><b>Address:</b> <u>50 Pleasant Avenue</u> <u>Highwood</u> <u>60040</u></p> <p style="padding-left: 40px;">Number City Zip Code</p> <p><b>County:</b> <u>Lake</u></p> <p><b>Telephone Number:</b> <u>(847) 432-9142</u> <b>Fax #</b> <u>(847) 432-4740</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/9/2006</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b></p> <p><b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u></p> <p><b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; padding: 5px;"><b>Officer or Administrator of Provider</b></td> <td style="padding: 5px;">(Signed) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) _____</td> </tr> <tr> <td style="padding: 5px;"><b>Paid Preparer</b></td> <td style="padding: 5px;">(Signed) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right" style="font-size: small;"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630     </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____		(Date) _____		(Type or Print Name) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) _____		(Date) _____		(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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Facility Name & ID Number Aperion Care Highwood

# 0048330 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>104</u>	Skilled (SNF)	<u>104</u>	<u>37,960</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>104</u>	TOTALS	<u>104</u>	<u>37,960</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,677</u>	<u>551</u>	<u>5,563</u>	<u>8,791</u>	8
9	SNF/PED					9
10	ICF	<u>15,802</u>	<u>4,418</u>	<u>1,001</u>	<u>21,221</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,479</u>	<u>4,969</u>	<u>6,564</u>	<u>30,012</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.06%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES  NO

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

YES  NO

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

Date started 09/06/06

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

YES  Date 09/06/06 NO

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

YES  NO  If YES, enter number of beds certified 104 and days of care provided 5,446

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	281,419	17,969	27,280	326,668		326,668	(18,663)	308,005		1
2	Food Purchase		205,357		205,357		205,357	(1,540)	203,817		2
3	Housekeeping	142,312	16,767		159,079		159,079		159,079		3
4	Laundry	69,226	15,012		84,238		84,238		84,238		4
5	Heat and Other Utilities			140,495	140,495		140,495	(7,396)	133,099		5
6	Maintenance	50,600	13,584	72,580	136,764		136,764	18,184	154,948		6
7	Other (specify):*							1,857	1,857		7
8	<b>TOTAL General Services</b>	543,557	268,689	240,355	1,052,601		1,052,601	(7,558)	1,045,043		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			69,552	69,552		69,552		69,552		9
10	Nursing and Medical Records	1,749,542	196,032	73,423	2,018,997		2,018,997	(33,718)	1,985,279		10
10a	Therapy	113,954			113,954		113,954		113,954		10a
11	Activities	93,042	4,003	2,240	99,285		99,285		99,285		11
12	Social Services	135,676		2,852	138,528		138,528		138,528		12
13	CNA Training										13
14	Program Transportation			2,861	2,861		2,861	1,987	4,848		14
15	Other (specify):*							3,107	3,107		15
16	<b>TOTAL Health Care and Programs</b>	2,092,214	200,035	150,928	2,443,177		2,443,177	(28,624)	2,414,553		16
	<b>C. General Administration</b>										
17	Administrative	91,958		69,000	160,958		160,958	(24,302)	136,656		17
18	Directors Fees										18
19	Professional Services			314,562	314,562	(204)	314,358	(202,733)	111,625		19
20	Dues, Fees, Subscriptions & Promotions			62,864	62,864		62,864	(41,112)	21,752		20
21	Clerical & General Office Expenses	86,417		306,171	392,588		392,588	(184,346)	208,242		21
22	Employee Benefits & Payroll Taxes			420,256	420,256		420,256		420,256		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,386	1,386		1,386	1,263	2,649		24
25	Other Admin. Staff Transportation			3,080	3,080		3,080	4,173	7,253		25
26	Insurance-Prop.Liab.Malpractice			100,909	100,909		100,909	5,420	106,329		26
27	Other (specify):*							11,083	11,083		27
28	<b>TOTAL General Administration</b>	178,375		1,278,228	1,456,603	(204)	1,456,399	(430,554)	1,025,845		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,814,146	468,724	1,669,511	4,952,381	(204)	4,952,177	(466,736)	4,485,441		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 Highwood

#0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			146,091	146,091		146,091	544,558	690,649			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,440	61,440		61,440	738,641	800,081			32
33	Real Estate Taxes			116,639	116,639	204	116,843	1,698	118,541			33
34	Rent-Facility & Grounds			1,036,000	1,036,000		1,036,000	(1,035,662)	338			34
35	Rent-Equipment & Vehicles			10,006	10,006		10,006	4,105	14,111			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,370,176	1,370,176	204	1,370,380	253,340	1,623,720			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		273,134	742,720	1,015,854		1,015,854	(125,885)	889,969			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,189	206,189		206,189		206,189			42
43	Other (specify):*	55,812		91,326	147,138		147,138	(110,107)	37,031			43
44	<b>TOTAL Special Cost Centers</b>	55,812	273,134	1,040,235	1,369,181		1,369,181	(235,992)	1,133,189			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,869,958	741,858	4,079,922	7,691,738		7,691,738	(449,388)	7,242,350			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 Highwood

# 0048330

Report Period Beginning: 01/01/14

Ending: 12/31/14

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,869)	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	(172,763)	30		9
10	Interest and Other Investment Income	(3,078)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(340)	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	(5,154)	21		19
20	Contributions	(36,967)	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	(226,867)	21		24
25	Fund Raising, Advertising and Promotional	(33,506)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(109,382)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (595,926)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
48		49	50	51	52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	146,538		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 146,538</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (449,388)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

Aperion Care HighwoodID# 0048330Report Period Beginning: 01/01/14Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 15,022	06	1
2	Bank Charges	(10,713)	21	2
3	Non Allowable Dues	(300)	20	3
4	Vending Income	(1,200)	02	4
5	Other Unclassified Income	(201)	21	5
6	Bldg Co. - Bookkeeping	(6,000)	19	6
7	Bldg Co. - Amortization	(10,827)	36	7
8	Bldg Co. - Bank Charges	(398)	21	8
9	Bldg Co. - Home Office Expense	(6,000)	19	9
10	Bldg Co. - Accounting Fees	(4,813)	19	10
11	Bldg Co. - Licences & Fees	(250)	20	11
12	Non Allowable Rent	(4,000)	34	12
13	Marketing	(6,820)	43	13
14	Non Allowable Legal	(1,800)	19	14
15	Non Allowable Expense	(45,000)	43	15
16	PAC Dues	(5,624)	20	16
17	Marketing Salary	(18,781)	43	17
18	Non Allowable Travel	(186)	25	18
19	Website Expense	(1,491)	21	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(109,382)	49

Aperion Care Highwood

ID# 0048330

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32



82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Highwood# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(7,863)	114	(10,914)					(18,663)	1
2	Food Purchase	(1,540)											(1,540)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,869)					216		257				(7,396)	5
6	Maintenance	15,022		2,364		(3,493)	1,869	2,115	307				18,184	6
7	Other (specify):*			155		976	370	356					1,857	7
8	<b>TOTAL General Services</b>	<b>5,613</b>		<b>2,519</b>		<b>(10,380)</b>	<b>2,569</b>	<b>(8,443)</b>	<b>564</b>				<b>(7,558)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			2,048		(27,008)		(8,758)					(33,718)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							1,987					1,987	14
15	Other (specify):*			153		1,992		962					3,107	15
16	<b>TOTAL Health Care and Programs</b>			<b>2,201</b>		<b>(25,016)</b>		<b>(5,809)</b>					<b>(28,624)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(30,866)	1,394		6,737	(1,567)					(24,302)	17
18	Directors Fees													18
19	Professional Services	(18,613)	16,813	(65,844)	(52,925)	68	(73,067)	(6,956)	522		(2,731)		(202,733)	19
20	Fees, Subscriptions & Promotions	(43,141)	250	1,444	20	6	273	12	24				(41,112)	20
21	Clerical & General Office Expenses	(244,824)	398	15,709	19,334	837	17,728	5,819	653				(184,346)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			642	12	190	119	300					1,263	24
25	Other Admin. Staff Transportation	(186)		1,822	20	1,428	816	273					4,173	25
26	Insurance-Prop.Liab.Malpractice			481	4,035		845	59					5,420	26
27	Other (specify):*			3,066		99	7,130	788					11,083	27
28	<b>TOTAL General Administration</b>	<b>(306,764)</b>	<b>17,461</b>	<b>(73,546)</b>	<b>(28,110)</b>	<b>2,628</b>	<b>(39,419)</b>	<b>(1,272)</b>	<b>1,199</b>		<b>(2,731)</b>		<b>(430,554)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(301,151)</b>	<b>17,461</b>	<b>(68,826)</b>	<b>(28,110)</b>	<b>(32,768)</b>	<b>(36,850)</b>	<b>(15,524)</b>	<b>1,763</b>		<b>(2,731)</b>		<b>(466,736)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Highwood# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(172,763)	714,484			9	701		2,127				544,558	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,078)	739,664				320		1,735				738,641	32
33	Real Estate Taxes								1,698				1,698	33
34	Rent-Facility & Grounds	(4,000)	(1,020,000)	664			(440)		(11,886)				(1,035,662)	34
35	Rent-Equipment & Vehicles			1,618	104	518	563	1,054	248				4,105	35
36	Other (specify):*	(10,827)	10,827											36
37	<b>TOTAL Ownership</b>	<b>(190,668)</b>	<b>444,975</b>	<b>2,282</b>	<b>104</b>	<b>527</b>	<b>1,144</b>	<b>1,054</b>	<b>(6,078)</b>				<b>253,340</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(125,885)			(125,885)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(104,107)						(6,000)					(110,107)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(104,107)</b>						<b>(6,000)</b>		<b>(125,885)</b>			<b>(235,992)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(595,926)	462,436	(66,544)	(28,006)	(32,241)	(35,706)	(20,470)	(4,315)	(125,885)	(2,731)		(449,388)	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 Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,020,000	Highland Park NRC Realty, LLC	100.00%	\$	\$ (1,020,000)	1
2	V	33 Real Estate Taxes	116,638	Highland Park NRC Realty, LLC	100.00%	116,638		2
3	V	32 Interest	325	Highland Park NRC Realty, LLC	100.00%	128,411	128,086	3
4	V	19 Bookkeeping		Highland Park NRC Realty, LLC	100.00%	6,000	6,000	4
5	V	36 Amortization - Loan Fees		Highland Park NRC Realty, LLC	100.00%	10,827	10,827	5
6	V	21 Bank Charges		Highland Park NRC Realty, LLC	100.00%	398	398	6
7	V	30 Depreciation		Highland Park NRC Realty, LLC	100.00%	714,484	714,484	7
8	V	32 Interest - Mortgage		Highland Park NRC Realty, LLC	100.00%	611,578	611,578	8
9	V	19 Home Office Expense		Highland Park NRC Realty, LLC	100.00%	6,000	6,000	9
10	V	19 Accounting Fees		Highland Park NRC Realty, LLC	100.00%	4,813	4,813	10
11	V	20 Licenses & Fees		Highland Park NRC Realty, LLC	100.00%	250	250	11
12	V							12
13	V							13
14	Total		\$ 1,136,963			\$ 1,599,399	\$ * 462,436	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS & MAINTENANCE		APERION CARE	50.00%	2,364	\$ 2,364
16	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE	50.00%	155	155
17	V	10 SALARY- NURSE		APERION CARE	50.00%	2,048	2,048
18	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE	50.00%	153	153
19	V	17 ADMINISTRATIVE		APERION CARE	50.00%	29,134	29,134
20	V	19 PROFESSIONAL FEES		APERION CARE	50.00%	3,030	3,030
21	V	20 FEES, SUBSCRIPTIONS		APERION CARE	50.00%	1,444	1,444
22	V	21 CLERICAL & GENERAL		APERION CARE	50.00%	15,709	15,709
23	V	24 SEMINARS		APERION CARE	50.00%	642	642
24	V	25 AUTO AND TRAVEL		APERION CARE	50.00%	1,822	1,822
25	V	26 INSURANCE		APERION CARE	50.00%	481	481
26	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE	50.00%	3,066	3,066
27	V	35 EQUIPMENT RENTAL		APERION CARE	50.00%	21	21
28	V	35 AUTO LEASE		APERION CARE	50.00%	1,597	1,597
29	V	17 MANAGEMENT FEE	60,000	APERION CARE	50.00%		(60,000)
30	V	19 HOME OFFICE	65,378	APERION CARE	50.00%		(65,378)
31	V	34 RENT		APERION CARE	50.00%	664	664
32	V	19 DATA PROCESSING	3,496	APERION CARE	50.00%		(3,496)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 128,874			\$ 62,330	\$ * (66,544)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE		APERION FINANCIAL	50.00%	1,394	\$ 1,394
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL	50.00%	566	566
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL	50.00%	20	20
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL	50.00%	19,334	19,334
19	V	24 SEMINARS		APERION FINANCIAL	50.00%	12	12
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL	50.00%	20	20
21	V	26 INSURANCE		APERION FINANCIAL	50.00%	4,035	4,035
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL	50.00%	104	104
23	V	19 HOME OFFICE EXPENSE	53,491	APERION FINANCIAL	50.00%		(53,491)
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		\$ 53,491			\$ 25,485	\$ * (28,006)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>APERION CONSULTING</u>	50.00%	\$ 4,757	\$ 4,757
16	V	<u>5</u> <u>UTILITIES</u>		<u>APERION CONSULTING</u>	50.00%		
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>APERION CONSULTING</u>	50.00%	1,957	1,957
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>APERION CONSULTING</u>	50.00%	976	976
19	V	<u>10</u> <u>SALARY NURSE</u>		<u>APERION CONSULTING</u>	50.00%	13,703	13,703
20	V	<u>15</u> <u>PAYROLL TAXES/GROUP INSURANCE</u>		<u>APERION CONSULTING</u>	50.00%	1,992	1,992
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>APERION CONSULTING</u>	50.00%		
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>APERION CONSULTING</u>	50.00%	68	68
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APERION CONSULTING</u>	50.00%	6	6
24	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>APERION CONSULTING</u>	50.00%	837	837
25	V	<u>24</u> <u>SEMINARS</u>		<u>APERION CONSULTING</u>	50.00%	190	190
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APERION CONSULTING</u>	50.00%	1,428	1,428
27	V	<u>26</u> <u>INSURANCE</u>		<u>APERION CONSULTING</u>	50.00%		
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>APERION CONSULTING</u>	50.00%	99	99
29	V	<u>35</u> <u>AUTO LEASE</u>		<u>APERION CONSULTING</u>	50.00%	518	518
30	V	<u>10</u> <u>CONSULTING</u>	40,711	<u>APERION CONSULTING</u>	50.00%		(40,711)
31	V	<u>01</u> <u>DIETICIAN</u>	12,620	<u>APERION CONSULTING</u>	50.00%		(12,620)
32	V	<u>06</u> <u>PAINTER</u>	800	<u>APERION CONSULTING</u>	50.00%		(800)
33	V	<u>06</u> <u>PROJECT MANAGER</u>	4,650	<u>APERION CONSULTING</u>	50.00%		(4,650)
34	V	<u>30</u> <u>DEPRECIATION</u>		<u>APERION CONSULTING</u>	100.00%	9	9
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 58,781			\$ 26,540	\$ * (32,241)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>YAM MANAGEMENT, LLC</u>	100.00%	\$ 114	\$	114	15
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	216		216	16
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	1,869		1,869	17
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. &amp; DIETARY</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	370		370	18
19	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	6,737		6,737	19
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	2,145		2,145	20
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	273		273	21
22	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	36,112		36,112	22
23	V	<u>24</u> <u>SEMINARS</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	119		119	23
24	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	816		816	24
25	V	<u>26</u> <u>INSURANCE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	845		845	25
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	7,130		7,130	26
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	701		701	27
28	V	<u>32</u> <u>INTEREST</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	320		320	28
29	V	<u>33</u> <u>REAL ESTATE TAX</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%				29
30	V	<u>34</u> <u>RENT</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	4,375		4,375	30
31	V	<u>34</u> <u>PARKING RENTAL</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	185		185	31
32	V	<u>35</u> <u>AUTO LEASE</u>		<u>YAM MANAGEMENT, LLC</u>	100.00%	563		563	32
33	V								33
34	V	<u>19</u> <u>ACCOUNTING</u>	22,200	<u>YAM MANAGEMENT, LLC</u>	100.00%			(22,200)	34
35	V			<u>YAM MANAGEMENT, LLC</u>	100.00%				35
36	V	<u>19</u> <u>BOOKKEPPING</u>	53,012	<u>YAM MANAGEMENT, LLC</u>	100.00%			(53,012)	36
37	V	<u>21</u> <u>CORPORATE EVENTS</u>	18,384	<u>YAM MANAGEMENT, LLC</u>	100.00%			(18,384)	37
38	V	<u>34</u> <u>RENT</u>	5,000	<u>YAM MANAGEMENT, LLC</u>	100.00%			(5,000)	38
39	Total		\$ 98,596			\$ 62,890	\$ *	(35,706)	39

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 3,746	\$ 3,746
16	V	<u>5</u> <u>UTILITIES</u>		<u>YAM CONSULTING, LLC</u>	100.00%		
17	V	<u>6</u> <u>REPAIRS &amp; MAINTENANCE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,115	2,115
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	356	356
19	V	<u>10</u> <u>NURSE SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	15,842	15,842
20	V	<u>15</u> <u>EMP. BEN.-NURSE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	962	962
21	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	7,433	7,433
22	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,199	2,199
23	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	12	12
24	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	5,819	5,819
25	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	300	300
26	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	273	273
27	V	<u>26</u> <u>INSURANCE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	59	59
28	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	788	788
29	V	<u>14</u> <u>NURSE TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,987	1,987
30	V	<u>32</u> <u>INTEREST</u>		<u>YAM CONSULTING, LLC</u>	100.00%		
31	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,054	1,054
32	V	<u>10</u> <u>NURSE CONSULTING</u>	24,600	<u>YAM CONSULTING, LLC</u>	100.00%		(24,600)
33	V	<u>19</u> <u>DATA PROCESSING</u>	9,155	<u>YAM CONSULTING, LLC</u>	100.00%		(9,155)
34	V	<u>01</u> <u>DIETICIAN</u>	14,660	<u>YAM CONSULTING, LLC</u>	100.00%		(14,660)
35	V	<u>17</u> <u>ADMINISTRATIVE CONSULTANT</u>	9,000	<u>YAM CONSULTING, LLC</u>	100.00%		(9,000)
36	V	<u>43</u> <u>MARKETING</u>	6,000	<u>YAM CONSULTING, LLC</u>	100.00%		(6,000)
37	V						
38	V						
39	<b>Total</b>		\$ 63,415			\$ 42,945	\$ * (20,470)

\* 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%	\$ 257	\$	257	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	307		307	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	522		522	17
18	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	24		24	18
19	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	653		653	19
20	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	2,127		2,127	20
21	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,735		1,735	21
22	V	34 RENT		8131 N. MONTICELLO, LLC	100.00%	338		338	22
23	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	248		248	23
24	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,698		1,698	24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC	100.00%			(7,000)	26
27	V	34 RENT	5,224	8132 N. MONTICELLO, LLC	100.00%			(5,224)	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		\$ 12,224			\$ 7,909	\$ *	(4,315)	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	\$ 740,502	Renewal Rehab	100.00%	\$ 614,617	\$ (125,885)
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		\$ 740,502			\$ 614,617	\$ * (125,885)

\* 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	\$ 13,005	ProPay HR LLC	12.00%	\$ 10,274	\$ (2,731)
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		\$ 13,005			\$ 10,274	\$ * (2,731)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number

Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	YOSEF MEYSEL	0.10%	Aperion Care Amboy	Amboy	Highland Park NRC Realty, LLC	SKOKIE	BUILDING CO.	1
2	NRC INVESTMENT GROUP	99.9%	Aperion Care Jacksonville	Jacksonville	YAM MANAGEMENT (1/1/14-6/30/14)	SKOKIE	MANAGEMENT CO.	2
3			River Crossing Rehab	Galesburg	YAM CONSULTING (1/1/14-6/30/14)	SKOKIE	CONSULTING CO.	3
4			Aperion Care Dolton	Dolton	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING CO.	4
5			Riverwood Rehab	East Moline	PROPAY	EVANSTON	PAYROLL SERVICES	5
6			Aperion Care Bridgeport	Bridgeport	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7			Aperion Care Litchfield	Litchfield	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	7
8			Aperion Care Springfield	Springfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	8
9			Aperion Care Burbank	Burbank	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	9
10			Aperion Care Midlothian	Midlothian	APERION ESTATES PERU	PERU, IN	ALF	10
11			Aperion Care St. Elmo	St. Elmo	APERION CARE COPPERAS HOLLOW	CALDWELL, TX	ALF	11
12			Aperion Care Chicago Heights	Chicago Heights	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	12
13			Aperion Care Forest Park	Forest Park				13
14			Aperion Care Oak Lawn	Oak Lawn				14
15			Aperion Care Evanston	Evanston				15
16			Aperion Care Decatur	Decatur				16
17			Aperion Care International	Chicago				17
18			Aperion Care Plum Grove	Palatine				18
19			Aperion Care Wilmington	Wilmington				19
20			Aperion Care Arbors Michigan City	Michigan City, IN				20
21			Aperion Care Demotte	Demotte, IN				21
22			Aperion Care Kokomo	Kokomo, IN				22
23			Aperion Care Peru	Peru, IN				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Valparaiso	Valparaiso, IN				25
26			Aperion Care Copperas Hollow	Caldwell, TX				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Highwood # 0048330 Report Period Beginning: 01/01/14 Ending: 12/31/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	0.100%	See Attached	1.5	3.75%	Alloc. Salary	\$ 7,013	17-07	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	1,171	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	1,504	17-07	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	770	21-07	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.5	3.75%	Alloc. Salary	1,414	21-07	5
6											6
7											7
8											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	\$ 11,872		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 Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	67,680	59,564	15,079	2,364	1
2	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	431,728	30	4,451		15,079	155	2
3	10	SALARY- NURSE	ACTUAL CENSUS	431,728	30	58,629	58,629	15,079	2,048	3
4	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	4,381		15,079	153	4
5	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30	834,151	758,436	15,079	29,134	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	86,759		15,079	3,030	6
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	41,339		15,079	1,444	7
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	449,771	436,216	15,079	15,709	8
9	24	SEMINARS	ACTUAL CENSUS	431,728	30	18,383		15,079	642	9
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	52,156		15,079	1,822	10
11	26	INSURANCE	ACTUAL CENSUS	431,728	30	13,783		15,079	481	11
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	87,772		15,079	3,066	12
13	34	RENT	ACTUAL CENSUS	431,728	30	19,000		15,079	664	13
14	35	EQUIPMENT RENTAL	ACTUAL CENSUS	431,728	30	601		15,079	21	14
15	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	45,731		15,079	1,597	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,587	\$ 1,312,845		\$ 62,330	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	30	39,916		15,079	1,394	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	30	16,216		15,079	566	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	30	570		15,079	20	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	30	553,558	596,633	15,079	19,334	4
5	24	SEMINARS	ACTUAL CENSUS	30	342		15,079	12	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	30	585		15,079	20	6
7	26	INSURANCE	ACTUAL CENSUS	30	115,531		15,079	4,035	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	30	2,974		15,079	104	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 729,692	\$ 596,633		\$ 25,485	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	431,728	30	\$ 136,198	\$ 136,198	15,079	\$ 4,757	1
2	5	UTILITIES	ACTUAL CENSUS	431,728	30		15,079			2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	431,728	30	56,041	55,918	15,079	1,957	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	431,728	30	27,933		15,079	976	4
5	10	SALARY NURSE	ACTUAL CENSUS	431,728	30	392,341	392,341	15,079	13,703	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	431,728	30	57,045		15,079	1,992	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	431,728	30			15,079		7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	431,728	30	1,960		15,079	68	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	431,728	30	180		15,079	6	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	431,728	30	23,973	19,489	15,079	837	10
11	24	SEMINARS	ACTUAL CENSUS	431,728	30	5,431		15,079	190	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	431,728	30	40,886		15,079	1,428	12
13	26	INSURANCE	ACTUAL CENSUS	431,728	30			15,079		13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	431,728	30	2,834		15,079	99	14
15	30	DEPRECIATION	ACTUAL CENSUS	431,728	30	263		15,079	9	15
16	35	AUTO LEASE	ACTUAL CENSUS	431,728	30	14,818		15,079	518	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 759,903	\$ 603,946		\$ 26,540	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	375,486	26	\$ 2,866	\$ 2,866	14,933	\$ 114	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26	5,432	14,933	216	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	47,002	38,824	14,933	1,869	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	375,486	26	9,302	14,933	370	4	
5	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	169,404	169,404	14,933	6,737	5
6	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	53,925	14,933	2,145	6	
7	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	6,855	14,933	273	7	
8	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	908,031	634,084	14,933	36,112	8
9	24	SEMINARS	ACTUAL CENSUS	375,486	26	3,004	14,933	119	9	
10	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	20,508	14,933	816	10	
11	26	INSURANCE	ACTUAL CENSUS	375,486	26	21,257	14,933	845	11	
12	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	179,286	14,933	7,130	12	
13	30	DEPRECIATION	ACTUAL CENSUS	375,486	26	17,623	14,933	701	13	
14	32	INTEREST	ACTUAL CENSUS	375,486	26	8,053	14,933	320	14	
15	33	REAL ESTATE TAX	ACTUAL CENSUS	375,486	26		14,933		15	
16	34	RENT	ACTUAL CENSUS	375,486	26	110,000	14,933	4,375	16	
17	34	PARKING RENTAL	ACTUAL CENSUS	375,486	26	4,655	14,933	185	17	
18	35	AUTO LEASE	ACTUAL CENSUS	375,486	26	14,167	14,933	563	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,581,370	\$ 845,178	\$ 62,890	25	

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	ACTUAL CENSUS	375,486	26	\$ 94,203	\$ 94,203	14,933	\$ 3,746	1
2	5	UTILITIES	ACTUAL CENSUS	375,486	26			14,933		2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	375,486	26	53,189	53,189	14,933	2,115	3
4	7	EMP. BEN.-GEN. SERV.	ACTUAL CENSUS	375,486	26	8,951		14,933	356	4
5	10	NURSE SALARY	ACTUAL CENSUS	375,486	26	398,330	398,330	14,933	15,842	5
6	15	EMP. BEN.-NURSE	ACTUAL CENSUS	375,486	26	24,191		14,933	962	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	375,486	26	186,891	186,891	14,933	7,433	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	375,486	26	55,290		14,933	2,199	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	375,486	26	291		14,933	12	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	375,486	26	146,322	139,573	14,933	5,819	10
11	24	SEMINARS	ACTUAL CENSUS	375,486	26	7,546		14,933	300	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	375,486	26	6,873		14,933	273	12
13	26	INSURANCE	ACTUAL CENSUS	375,486	26	1,489		14,933	59	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	375,486	26	19,826		14,933	788	14
15	14	NURSE TRAVEL	ACTUAL CENSUS	375,486	26	49,952		14,933	1,987	15
16	32	INTEREST	ACTUAL CENSUS	375,486	26	1		14,933		16
17	35	AUTO RENTAL	ACTUAL CENSUS	375,486	26	26,512		14,933	1,054	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,079,857	\$ 872,186		\$ 42,945	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	807,214	30	\$ 6,925	\$ 30,012	\$ 257	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	807,214	30	8,268	30,012	307	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	807,214	30	14,051	30,012	522	3
4	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	807,214	30	646	30,012	24	4
5	21	OFFICE EXPENSE	ACTUAL CENSUS	807,214	30	17,570	30,012	653	5
6	30	DEPRECIATION	ACTUAL CENSUS	807,214	30	57,207	30,012	2,127	6
7	32	INTEREST EXPENSE	ACTUAL CENSUS	807,214	30	46,653	30,012	1,735	7
8	34	RENT	ACTUAL CENSUS	807,214	30	9,100	30,012	338	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	807,214	30	6,667	30,012	248	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	807,214	30	45,673	30,012	1,698	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 212,760	\$	\$ 7,909	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Sevices	Direct		\$	\$		\$ 614,617	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				\$	\$		\$ 614,617	25



Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 10,274	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 10,274	25

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name &amp; ID Number

Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10	Reporting Period Interest Expense					
		Related**					Monthly Payment Required	Date of Note							Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO												Original	Balance		
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Lake Forest Bank & Trust		X	Mortgage			\$	\$ 9,280,000				\$ 611,578	1					
2	Lake Forest Bank & Trust		X	Loan Payable				936,220				128,411	2					
3													3					
4													4					
5													5					
<b>Working Capital</b>																		
6	Lake Forest Bank & Trust		X	Line of Credit				1,173,591				59,455	6					
7													7					
8													8					
9	<b>TOTAL Facility Related</b>						\$	\$ 11,389,811				\$ 799,444	9					
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X									(3,078)	10					
11	Insurance Interest		X									1,985	11					
12	Interest Income - Bldg Co.		X									(325)	12					
13	See Supplemental Schedule											2,055	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$ 637	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 11,389,811				\$ 800,081	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 Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$	1				
2												2				
3												3				
4												4				
5												5				
6												6				
7	<b>TOTAL Long-Term</b>											7				
	<b>Working Capital</b>															
8							\$	\$			\$	8				
9												9				
10												10				
11												11				
12												12				
13												13				
14	<b>TOTAL Working Capital</b>											14				
	<b>B. Non-Facility Related*</b>															
15	Allocated from 8131 N. Monticello						\$	\$			\$	1,735	15			
16	Allocated from YAM Management											320	16			
17													17			
18													18			
19													19			
20	<b>TOTAL Non-Facility Related</b>											2,055	20			

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>111,063</u>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>115,549</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>4,486</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>113,852</u>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>204</u>	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>118,542</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>47,529</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>49,195</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>55,432</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>111,063</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>113,851</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>2014 Accrual = 2013 Taxes Paid</b>					
<b>Allocated from 8131 N. Monticello \$1,698</b>					

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

# 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Highwood COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-15-427-002</u>	<u>Long Term Care Property</u>	\$ <u>113,850.82</u>	\$ <u>113,850.82</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>64,433.32</u>	\$ <u>2,098.53</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>178,284.14</u></u>	\$ <u><u>115,949.35</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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





4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Aperion Care Highwood

# 0048330 Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,802 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2006</u>	<u>\$ 627,000</u>	<u>1</u>
2	<u>Allocated from 8131 N. Monticello</u>			<u>3,309</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 630,309</b>	<b>3</b>

**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	104	2007	1961	\$ 3,407,107	\$ 714,484	35	\$ 97,346	\$ (617,138)	\$ 784,312	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		2007	104,937		20	10,327	10,327	77,398	9
10	Various		2008	26,276		20	595	595	23,934	10
11	Various		2009	22,285		20	2,074	2,074	12,301	11
12	Various		2010	258,593		20	26,065	26,065	113,832	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	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		9,501,814			475,091	475,091	1,951,529	67
68		41,237		2,823	1,511	(1,312)	6,392	68
69				146,091		(146,091)		69
70		\$ 13,362,249	\$ 863,398		\$ 613,009	\$ (250,389)	\$ 2,969,699	70

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

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 13,362,249	\$ 863,398		\$ 613,009	\$ (250,389)	\$ 2,969,699	1
2	Door Wiring/Releases	2011			20				2
3	Walk-In Combo Freezer/Cooler Installed In Basement Dining Room	2011	26,500		20	1,325	1,325	5,079	3
4	Custom Cabinets Built In And Secured To Wall	2011	25,200		20	1,260	1,260	4,935	4
5	Duro-Last Roofing System	2011	27,577		20	1,379	1,379	5,286	5
6	Low Voltage Systems	2011	99,000		20	4,950	4,950	18,975	6
7	Architects	2011	3,598		20	180	180	690	7
8	Bathroom Fixtures, Flooring, Lighting	2011	18,800		20	940	940	3,212	8
9	Storm Sewer System Updates	2011	9,000		20	450	450	1,575	9
10	Remove Curb & Gutters	2011	3,700		20	185	185	586	10
11	Counter, Wallcovering	2012	4,356		20	436	436	1,270	11
12	Trees	2012	5,200		20	347	347	867	12
13	Dining Room	2012	4,501		20	450	450	1,200	13
14	Mechanical Screens	2012	8,500		20	1,700	1,700	5,100	14
15	Steel Railings	2013	3,630		20	726	726	1,452	15
16	Grading Of Park Area	2013	12,000		20	800	800	1,600	16
17	Security System	2013	4,460		20	892	892	1,635	17
18	Lobby Side Panels, Dining Room Walls, Resident Room Bathroom	2013	18,521		20	926	926	1,158	18
19	Fox Valley Pull Stations, Fire Alarm System	2014	2,950		20	148	148	148	19
20	Fox Valley Fire Alarm System Related Equipment	2014	3,484		20	174	174	174	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	34

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

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1		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 12C, Carried Forward		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	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)		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	34

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

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	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)	\$ 13,643,225	\$ 863,398		\$ 630,276	\$ (233,122)	\$ 3,024,640	34

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



Facility Name & ID Number Aperion Care Highwood# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9	<u>Chandalier, Wallcovering, Flooring, Tile, Handrails</u>	2010	190,983		20	9,549	9,549	47,746	9
10	<u>Walls, Repair Cracks, Floor Prep</u>	2010	5,634		20	282	282	1,408	10
11	<u>Flooring, Chandalier, Cove Base</u>	2010	90,707		20	4,535	4,535	22,677	11
12	<u>Blinds, Ramp, Flooring, Cornice, Painting</u>	2010	113,000		20	5,650	5,650	28,250	12
13	<u>VCT &amp; Cove Base, Flooring, Cabinetry, Painting</u>	2010	270,481		20	13,524	13,524	67,620	13
14	<u>Elevator Floor, Granite Wall Caps, Floor Prep, Window Treatmen</u>	2010	20,443		20	1,022	1,022	5,111	14
15	<u>Porcelain Tile, Wallcovering, Custom Reception Desk</u>	2010	18,851		20	943	943	4,713	15
16	<u>Sink Cabinet, Flooring</u>	2010	7,862		20	393	393	1,965	16
17	<u>Flooring, Wallcovering, Cove Base, Handrails, Room Signage</u>	2010	101,919		20	5,096	5,096	25,480	17
18	<u>Handrails, VCT, Flooring, Cubicle Tracks/Curtains, Painting</u>	2010	203,450		20	10,173	10,173	50,863	18
19	<u>Vinyl Cove Base, Corner Guards</u>	2011	1,850		20	92	92	370	19
20	<u>Corner Guards, VCT, Flooring, Signage</u>	2011	44,933		20	2,247	2,247	8,987	20
21	<u>Flooring, Bathroom Mirrors, Window Treatments, Cubicle Track</u>	2011	53,302		20	2,665	2,665	10,660	21
22	<u>Wall Sconces</u>	2011	2,391		20	120	120	478	22
23	<b>Additional Construction Costs</b>	2011	81,620		20	4,081	4,081	16,324	23
24	<u>General Construction on Building</u>	2011	7,849,388		20	392,469	392,469	1,569,878	24
25	<u>SAS Architect Fees</u>	2011	445,000		20	22,250	22,250	89,000	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 1,951,529	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 1,951,529	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)		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 1,951,529	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>Allocated from 8131 N. Monticello</b>	<b>2010</b>	<b>25,711</b>	<b>765</b>	<b>35</b>	<b>659</b>	<b>(106)</b>	<b>2,939</b>	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<b>Allocated from 8131 N. Monticello</b>	<b>2010</b>	<b>11,517</b>	<b>1,157</b>	<b>20</b>	<b>576</b>	<b>(581)</b>	<b>2,613</b>	9
10	<b>Allocated from 8131 N. Monticello</b>	<b>2013</b>	<b>2,003</b>	<b>200</b>	<b>20</b>	<b>100</b>	<b>(100)</b>	<b>200</b>	10
11	<b>Allocated from YAM Management</b>			<b>701</b>			<b>(701)</b>		11
12	<b>Allocated from Aperion Care</b>	<b>2010</b>	<b>1,151</b>		<b>20</b>	<b>115</b>	<b>115</b>	<b>492</b>	12
13	<b>Allocated from Aperion Care</b>	<b>2012</b>	<b>726</b>		<b>20</b>	<b>48</b>	<b>48</b>	<b>122</b>	13
14	<b>Allocated from Aperion Care</b>	<b>2013</b>	<b>129</b>		<b>20</b>	<b>13</b>	<b>13</b>	<b>26</b>	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		<b>\$ 41,237</b>	<b>\$ 2,823</b>		<b>\$ 1,511</b>	<b>\$ (1,312)</b>	<b>\$ 6,392</b>	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 41,237	\$ 2,823		\$ 1,511	\$ (1,312)	\$ 6,392	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)		\$ 41,237	\$ 2,823		\$ 1,511	\$ (1,312)	\$ 6,392	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 448,115	\$ 5	\$ 52,969	\$ 52,964	10	\$ 239,772	71
72	Current Year Purchases	12,052	9	453	444	10	453	72
73	Fully Depreciated Assets	83,280				10	83,280	73
74								74
75	TOTALS	\$ 543,448	\$ 14	\$ 53,423	\$ 53,409		\$ 323,505	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		2009 GMC Savana	2009	\$ 46,762	\$	\$ 6,712	\$ 6,712	5	\$ 46,762	76
77		Allocated from Aperion Care	2014	1,188		238	238	5	834	77
78										78
79										79
80	TOTALS			\$ 47,950	\$	\$ 6,950	\$ 6,950		\$ 47,596	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)	\$ 14,864,932	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 863,412	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 690,649	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (172,763)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,395,741	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from 8131 N. Monticello</u>				<u>338</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>338</b>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

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

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 10,379 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from YAM Consulting</u>		\$	\$ <u>1,054</u>	17
18	<u>Allocated from YAM Management</u>			<u>563</u>	18
19	<u>Allocated from Aperion Consulting</u>			<u>518</u>	19
20	<u>Allocated from Aperion Care</u>			<u>1,597</u>	20
21	<b>TOTAL</b>		\$	\$ <b>3,732</b>	21

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

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

Facility Name & ID Number Aperion Care Highwood # 0048330 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	285,830	\$		\$	285,830	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				76,179				76,179	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				378,315				378,315	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					246,224			246,224	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>						2,396	26,910			29,306	13
14	TOTAL			\$		\$	742,720	\$	273,134	\$	1,015,854	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 Highwood# 0048330Report Period Beginning: 01/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,246	\$ 88,446	1
2	Cash-Patient Deposits	76,152	76,152	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,176,793	2,176,793	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	143,963	143,963	6
7	Other Prepaid Expenses	10,000	10,000	7
8	Accounts Receivable (owners or related parties)	968,151	833,000	8
9	Other(specify):	138,126	630,002	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,514,431	\$ 3,958,356	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,407,107	14
15	Leasehold Improvements, at Historical Cost	794,117	9,092,611	15
16	Equipment, at Historical Cost	489,687	2,538,310	16
17	Accumulated Depreciation (book methods)	(705,009)	(3,861,805)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		3,609	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 578,795	\$ 11,806,832	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,093,226	\$ 15,765,188	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 979,352	\$ 991,352	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	76,648	76,648	28
29	Short-Term Notes Payable	1,173,591	1,253,454	29
30	Accrued Salaries Payable	181,762	181,762	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,707	2,707	31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,852	113,852	32
33	Accrued Interest Payable	3,048	72,235	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	30,950	1,890,602	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,561,910	\$ 4,582,612	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		10,136,357	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 10,136,357	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,561,910	\$ 14,718,969	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,531,316	\$ 1,046,219	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,093,226	\$ 15,765,188	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,563,773</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>5</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,563,778</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(32,214)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(248)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(32,462)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,531,316</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,965,096	1
2	Discounts and Allowances for all Levels	473,152	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,438,248</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	189,629	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 189,629</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	20,517	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,890	19
20	Radiology and X-Ray	982	20
21	Other Medical Services	1,779	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 27,168</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,078	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 3,078</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,401	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,401</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,659,524</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,052,601	31
32	Health Care	2,443,177	32
33	General Administration	1,456,603	33
<b>B. Capital Expense</b>			
34	Ownership	1,370,176	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,162,992	35
36	Provider Participation Fee	206,189	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,691,738</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(32,214)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (32,214)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,964,936	44
45	Private Pay - Net Inpatient Revenue	1,132,463	45
46	Medicare - Net Inpatient Revenue	2,945,354	46
47	Other-(specify) <u>Insurance</u>	395,495	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 7,438,248</b>	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 Highwood

# 0048330

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,966	2,462	\$ 99,899	\$ 40.58	1
2	Assistant Director of Nursing	1,872	2,088	69,663	33.36	2
3	Registered Nurses	16,477	17,784	547,531	30.79	3
4	Licensed Practical Nurses	12,036	13,096	316,920	24.20	4
5	CNAs & Orderlies	49,908	55,509	685,832	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,030	7,029	113,954	16.21	8
9	Activity Director	1,640	1,929	34,956	18.12	9
10	Activity Assistants	5,296	5,679	58,086	10.23	10
11	Social Service Workers	5,795	6,219	135,676	21.82	11
12	Dietician					12
13	Food Service Supervisor	3,097	3,165	63,986	20.22	13
14	Head Cook	4,177	5,110	64,248	12.57	14
15	Cook Helpers/Assistants	15,014	16,272	153,185	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,160	50,600	23.43	17
18	Housekeepers	11,860	13,068	142,312	10.89	18
19	Laundry	5,763	6,363	69,226	10.88	19
20	Administrator	1,549	1,809	91,958	50.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,448	7,868	86,417	10.98	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	2,147	2,266	29,697	13.11	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	967	1,130	55,812	49.39	33
34	TOTAL (lines 1 - 33)	155,002	171,006	\$ 2,869,958 *	\$ 16.78	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	496	\$ 27,280	01-03	35
36	Medical Director	Monthly	69,552	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	872	65,311	10-03	38
39	Pharmacist Consultant	Monthly	8,112	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	52	2,240	11-03	44
45	Social Service Consultant	40	2,852	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,460	\$ 175,347		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

Facility Name & ID Number Aperion Care Highwood

# 0048330

Report Period Beginning: 01/01/14

Ending: 12/31/14

**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>Sarah Jakoubek 1/26/14-current</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 82,737</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 69,911</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
<u>Heather Levine 1/1/14-1/25/14</u>	<u>Administrator</u>	<u>0.00%</u>	<u>9,220</u>	<u>Unemployment Compensation Insurance</u>	<u>21,929</u>	<u>Advertising: Employee Recruitment</u>	<u>1,632</u>	
				<u>FICA Taxes</u>	<u>219,062</u>	<u>Health Care Worker Background Check</u>	<u>1,760</u>	
				<u>Employee Health Insurance</u>	<u>89,952</u>	<u>(Indicate # of checks performed <u>176</u>)</u>		
				<u>Employee Meals</u>	<u>63</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues &amp; Subscriptions</u>	<u>13,355</u>	
				<u>Union Pension Fund</u>	<u>16,207</u>	<u>Licenses &amp; Permits</u>	<u>1,236</u>	
				<u>401K Expense</u>	<u>1,381</u>	<u>Allocated from YAM Consulting</u>	<u>12</u>	
				<u>Other Employee Benefits</u>	<u>1,591</u>	<u>Allocated from YAM Management</u>	<u>273</u>	
				<u>Employee Physicals</u>	<u>160</u>	<u>See Supplemental Schedule</u>	<u>1,494</u>	
						<u>Less: Public Relations Expense</u>	<u>( )</u>	
						<u>Non-allowable advertising</u>	<u>( )</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 91,957</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 420,256</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 21,752</b>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>YAM Administrative Consultant</u>			<u>\$ 9,000</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Management Fees - Aperion Care</u>			<u>60,000</u>					
							<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 69,000</b>	<b>TOTAL</b>		<b>\$</b>	<u>Seminar Expense</u>	<u>1,386</u>
<b>(Attach a copy of any management service agreement)</b>							<u>Allocated from YAM Consulting</u>	<u>300</u>
							<u>Allocated from YAM Management</u>	<u>119</u>
							<u>See Supplemental Schedule</u>	<u>844</u>
							<u>Entertainment Expense</u>	<u>( )</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
							<b>TOTAL</b>	<b>\$ 2,649</b>
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Frost, Ruttenberg &amp; Rothblatt</u>	<u>Accounting</u>		<u>\$ 12,338</u>					
<u>YAM Management</u>	<u>Accounting</u>		<u>22,200</u>					
<u>YAM Management</u>	<u>Bookkeeping</u>		<u>53,012</u>					
<u>YAM Consulting</u>	<u>Data Processing</u>		<u>9,155</u>					
<u>Pro Payroll Solutions, LLC</u>	<u>Payroll Processing</u>		<u>1,568</u>					
<u>American Data</u>	<u>Data Processing</u>		<u>5,695</u>					
<u>Galaxy Hosted Software</u>	<u>Clinical Software</u>		<u>12,600</u>					
<u>National Data Corporation</u>	<u>Financial Software</u>		<u>1,422</u>					
<u>Wescom Solutions</u>	<u>E.H.R. Software</u>		<u>7,684</u>					
<u>Medifax-EDI</u>	<u>Data Processing</u>		<u>7,073</u>					
<u>E-Health Data Solutions</u>	<u>MDS Software</u>		<u>2,700</u>					
<u>See Supplemental Schedule</u>			<u>179,113</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 314,560</b>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Aperion Care Highwood# 0048330

Report Period Beginning:

01/01/14

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$7,772
- (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. \$ 25,781 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. \$ 206,189  
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. \$ 63 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.