FOR BHF USE

LL1

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.

I. IDPH License ID Number: 0052019

Facility Name: Aria Post Acute Care

Address: 4600 N Frontage Road (Number) Hillside (City) 60162 (Zip Code)

County: Cook

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

HFS ID Number:

Date of Initial License for Current Owners: 9/28/2012

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Aria Post Acute Care # 0052019 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	198	Skilled (SNF)	198	72,270	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	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			14,806	14,806	8
9	SNF/PED					9
10	ICF	42,758	2,041	2,931	47,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,758	2,041	17,737	62,536	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.53%

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)
N/A

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/28/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/28/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 198 and days of care provided 11,023

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2014 Fiscal Year: 21/31/2014

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

Facility Name & ID Number Aria Post Acute Care # 0052019 **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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	348,320	50,092	6,798	405,210		405,210		405,210			1
2	Food Purchase		351,570		351,570		351,570	(115)	351,455			2
3	Housekeeping	302,828	67,192		370,020		370,020		370,020			3
4	Laundry	95,364	9,103	17,358	121,825		121,825		121,825			4
5	Heat and Other Utilities			288,932	288,932		288,932	(3,637)	285,295			5
6	Maintenance	59,771		188,718	248,489		248,489	21,201	269,690			6
7	Other (specify):*							373	373			7
8	**TOTAL General Services**	806,283	477,957	501,806	1,786,046		1,786,046	17,822	1,803,868			8
	B. Health Care and Programs											
9	Medical Director			92,431	92,431		92,431		92,431			9
10	Nursing and Medical Records	4,165,971	308,974	9,966	4,484,911		4,484,911	17,195	4,502,106			10
10a	Therapy	37,487			37,487		37,487		37,487			10a
11	Activities	122,029	19,050	1,933	143,012		143,012		143,012			11
12	Social Services	172,542			172,542		172,542		172,542			12
13	CNA Training											13
14	Program Transportation			13,728	13,728		13,728		13,728			14
15	Other (specify):*							1,557	1,557			15
16	**TOTAL Health Care and Programs**	4,498,029	328,024	118,058	4,944,111		4,944,111	18,752	4,962,863			16
	C. General Administration											
17	Administrative	132,217		665,536	797,753		797,753	(640,016)	157,737			17
18	Directors Fees											18
19	Professional Services			160,480	160,480	(8,538)	151,942	422	152,364			19
20	Dues, Fees, Subscriptions & Promotions			88,411	88,411		88,411	(59,972)	28,439			20
21	Clerical & General Office Expenses	249,692	3,564	494,967	748,223		748,223	(124,754)	623,469			21
22	Employee Benefits & Payroll Taxes			921,762	921,762		921,762		921,762			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,547	5,547		5,547	1,148	6,695			24
25	Other Admin. Staff Transportation			52	52		52	5,196	5,248			25
26	Insurance-Prop.Liab.Malpractice			687,276	687,276		687,276	592	687,868			26
27	Other (specify):*							18,280	18,280			27
28	**TOTAL General Administration**	381,909	3,564	3,024,031	3,409,504	(8,538)	3,400,966	(799,104)	2,601,861			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,686,221	809,545	3,643,895	10,139,661	(8,538)	10,131,123	(762,530)	9,368,593			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 Aria Post Acute Care #0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			190,650	190,650		190,650	408,345	598,995			30
31	Amortization of Pre-Op. & Org.			22,593	22,593		22,593	(22,593)	(0)			31
32	Interest			129,440	129,440		129,440	892,895	1,022,335			32
33	Real Estate Taxes			586,108	586,108	8,538	594,646	(73,108)	521,538			33
34	Rent-Facility & Grounds			1,197,000	1,197,000		1,197,000	(1,196,604)	396			34
35	Rent-Equipment & Vehicles			45,321	45,321		45,321	2,434	47,755			35
36	Other (specify):*											36
37	TOTAL Ownership			2,171,112	2,171,112	8,538	2,179,650	11,369	2,191,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		575,130	1,940,726	2,515,856		2,515,856	(29,743)	2,486,113			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			371,618	371,618		371,618		371,618			42
43	Other (specify):*	187,649			187,649		187,649	(187,649)	0			43
44	TOTAL Special Cost Centers	187,649	575,130	2,312,344	3,075,123		3,075,123	(217,392)	2,857,731			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,873,870	1,384,675	8,127,351	15,385,896		15,385,896	(968,553)	14,417,343			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 Aria Post Acute Care # 0052019 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,237)	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	3,123	30		9
10	Interest and Other Investment Income	(1,421)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	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	(3,702)	21		18
19	Entertainment				19
20	Contributions	(22,349)	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	(165,002)	21		24
25	Fund Raising, Advertising and Promotional	(26,149)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,380)	20		28
29	Other-Attach Schedule	(811,509)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,034,741)		$	30

BHF USE ONLY								
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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	66,188		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 66,188		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (968,553)		37

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

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

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

Aria Post Acute Care

ID# 0052019

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (119,618)	21	1
2	Bank Charges	(19,191)	21	2
3				3
4	Amortization - Goodwill	(22,593)	31	4
5	Building Company - License and Inspection	(250)	20	5
6	Building Company - Legal Fees	(260)	19	6
7	Building Company - Accounting Fees	(5,500)	19	7
8	Building Company - Amortization of Loan Fees	(44,135)	36	8
9	Building Company - Bank Charges	(207)	21	9
10	Building Company - Amortization of Goodwill	(165,800)	31	10
11	Additional R&M	8,914	06	11
12	Medical Records Income	(189)	10	12
13	PAC Dues	(11,435)	20	13
14	Day Care Allocation - Real Estate	(76,598)	33	14
15	Collection Expense	(14,648)	21	15
16	Non-Allowable Fees	(5,934)	21	16
17	Non-Allowable legal Fees	(7,468)	19	17
18	Marketing Salaries	(144,747)	43	18
19	Guest Relations	(42,902)	43	19
20	Day Care Allocation - Mortgage Interest	(84,885)	32	20
21	Day Care Allocation - Depreciation	(54,063)	30	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(811,509)		49

Aria Post Acute Care

ID# 0052019

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aria Post Acute Care # 0052019 **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)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(115)											(115)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,237)		2,600									(3,637)	5
6	Maintenance	8,914		12,287									21,201	6
7	Other (specify):*			373									373	7
8	**TOTAL General Services**	2,562		15,260									17,822	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(189)		17,574			(190)						17,195	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,557									1,557	15
16	**TOTAL Health Care and Programs**	(189)		19,131			(190)						18,752	16
	C. General Administration													
17	Administrative			(640,016)									(640,016)	17
18	Directors Fees													18
19	Professional Services	(13,228)	5,760	7,890									422	19
20	Fees, Subscriptions & Promotions	(61,563)	250	1,341									(59,972)	20
21	Clerical & General Office Expenses	(328,302)	207	203,341									(124,754)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,148									1,148	24
25	Other Admin. Staff Transportation			5,196									5,196	25
26	Insurance-Prop.Liab.Malpractice			592									592	26
27	Other (specify):*			18,280									18,280	27
28	**TOTAL General Administration**	(403,093)	6,217	(402,228)									(799,104)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(400,720)	6,217	(367,837)			(190)						(762,530)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aria Post Acute Care # 0052019 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(50,940)	450,525	8,760									408,345	30
31	Amortization of Pre-Op. & Org.	(188,393)	165,800										(22,593)	31
32	Interest	(86,306)	977,082	2,119									892,895	32
33	Real Estate Taxes	(76,598)		3,490									(73,108)	33
34	Rent-Facility & Grounds		(1,197,000)	396									(1,196,604)	34
35	Rent-Equipment & Vehicles			2,434									2,434	35
36	Other (specify):*	(44,135)	44,135											36
37	**TOTAL Ownership**	(446,372)	440,542	17,199									11,369	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(6,778)	(12,025)	(10,940)						(29,743)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(187,649)											(187,649)	43
44	**TOTAL Special Cost Centers**	(187,649)			(6,778)	(12,025)	(10,940)						(217,392)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,034,741)	446,759	(350,638)	(6,778)	(12,025)	(11,130)						(968,553)	45

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,197,000	Encore Realty Partners LLC		$	$ (1,197,000)	1
2	V	32	Interest	292	Encore Realty Partners LLC		977,374	977,082	2
3	V	20	License and Inspection		Encore Realty Partners LLC		250	250	3
4	V	19	Legal Fees		Encore Realty Partners LLC		260	260	4
5	V	19	Accounting Fees		Encore Realty Partners LLC		5,500	5,500	5
6	V	36	Amortization of Loan Fees		Encore Realty Partners LLC		44,135	44,135	6
7	V	30	Depreciation		Encore Realty Partners LLC		450,525	450,525	7
8	V	21	Bank Charges		Encore Realty Partners LLC		207	207	8
9	V	31	Amortization of Goodwill		Encore Realty Partners LLC		165,800	165,800	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,197,292			$ 1,644,051	$ * 446,759	14

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 2,600	$ 2,600	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	4,215	4,215	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,072	8,072	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	373	373	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	17,574	17,574	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	1,557	1,557	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	25,520	25,520	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	7,890	7,890	22
23	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,341	1,341	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	171,285	171,285	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	32,056	32,056	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,148	1,148	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	5,196	5,196	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	592	592	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	18,280	18,280	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,760	8,760	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,119	2,119	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	3,490	3,490	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	396	396	33
34	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	2,434	2,434	34
35	V								35
36	V	17	BOOKKEEPING FEE	665,536	NUCARE SERVICES CORP.	100.00%		(665,536)	36
37	V								37
38	V								38
39	Total			$ 665,536			$ 314,898	$ * (350,638)	39

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & MEDICAL SUPPLIES	$ 73,398	INTEGRA HEALTHCARE EQUIPMENT		$ 66,620	$ (6,778)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,398			$ 66,620	$ * (6,778)	39

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	RESPIRATORY SERVICES	$ 57,687	INTEGRA RESPIRATORY SERVICES LLC		$ 45,662	$ (12,025)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 57,687			$ 45,662	$ * (12,025)	39

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	AMBULANCE	$ 816	LIFELINE AMBULANCE		$ 626	$ (190)	15
16	V	39	AMBULANCE	47,118	LIFELINE AMBULANCE		36,178	(10,940)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,934			$ 36,804	$ * (11,130)	39

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS COMPENSATION	$ 115,642	MAPLE LEAF INSURANCE		$ 115,642	$	15
16	V	26	LIABILITY INSURANCE	426,335	MAPLE LEAF INSURANCE		426,335		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 541,977			$ 541,977	$ *	39

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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	ARIA HILL, LLC	55.000%	CALIFORNIA GARDENS CORP.	CHICAGO	ENCORE REALTY PARTNERS		BUILDING COMPANY	1
2	TAM1023 CONSULTING, LLC	5.000%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	MAPLE LEAF INSURANCE	GRAND CAYMAN	LIABILITY INSURANCE	2
3	IBEX MANAGEMENT SERVICES, LLC	20.000%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	JMD VENTURES LLC	20.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5			JACKSON CORP.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING	5
6			MONROE CORP.	CHICAGO	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	6
7			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	DRAKE LOUIS ENTERPRISE, LL	LINCOLNWOOD	MANAGEMENT CO.	7
8			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	8
9			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10			RENAISSANCE EAST	MESA, ARIZONA	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV.	10
11			RENAISSANCE PARK SOUTH,LLC	CHICAGO				11
12			RENAISSANCE VILLAGE AL	MESA, ARIZONA				12
13			RENAISSANCE VILLAGE IL	MESA, ARIZONA				13
14			RENAISSANCE WEST	MESA, ARIZONA				14
15			CLAREMONT - HANOVER PARK	HANOVER PARK				15
16			SEVEN OAKS	GLENDALE, WISC.				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 Aria Post Acute Care # 0052019 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 Aria Post Acute Care # 0052019 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											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	$		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 Aria Post Acute Care # 0052019 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 [X]

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

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

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 [X] NO [ ]

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

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,239,904	17	$ 44,608	$	72,270	$ 2,600	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	72,310	72,310	72,270	4,215	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,239,904	17	138,492		72,270	8,072	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,239,904	17	6,405		72,270	373	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	301,506	301,506	72,270	17,574	5
6	15	EMPLOYEE BENEFITS - CLIN	AVAIL. CENSUS DAYS	1,239,904	17	26,708		72,270	1,557	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	1,239,904	17	437,828	437,828	72,270	25,520	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,239,904	17	135,365		72,270	7,890	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,239,904	17	23,010		72,270	1,341	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,239,904	17	2,938,655	2,938,655	72,270	171,285	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,239,904	17	549,976		72,270	32,056	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,239,904	17	19,695		72,270	1,148	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,239,904	17	89,139		72,270	5,196	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,239,904	17	10,164		72,270	592	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,239,904	17	313,624		72,270	18,280	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,239,904	17	150,292		72,270	8,760	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,239,904	17	36,349		72,270	2,119	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,239,904	17	59,877		72,270	3,490	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,239,904	17	6,796		72,270	396	19
20	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,239,904	17	41,766		72,270	2,434	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,402,565	$ 3,750,299		$ 314,898	25

Facility Name & ID Number Aria Post Acute Care # 0052019 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 [X] NO [ ]

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

Name of Related Organization: Integra Healthcare Equipment, LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 66,620	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					$	$		$ 66,620	25

Facility Name & ID Number Aria Post Acute Care # 0052019 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 [X] NO [ ]

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

Name of Related Organization: Integra Respiratory Services LLC
Street Address: 747 Church Road
City / State / Zip Code: Elmhurst, IL 60126
Phone Number: (630) 834-3700
Fax Number: (630) 834-1500

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	RESPIRATORY SERVICES	DIRECT ALLOCATION			$	$		$ 45,662	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					$	$		$ 45,662	25

Facility Name & ID Number Aria Post Acute Care # 0052019 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 [X] NO [ ]

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

Name of Related Organization: Lifeline Ambulance LLC
Street Address: 2424 S. Wabash Avenue
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	AMBULANCE	DIRECT ALLOCATION			$	$		$ 626	1
2	39	AMBULANCE	DIRECT ALLOCATION						36,178	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					$	$		$ 36,804	25

Facility Name & ID Number Aria Post Acute Care # 0052019 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 [X] NO [ ]

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

Name of Related Organization: Maple Leaf Insurance
Street Address: PO Box 69, 720 West Bay Rd
City / State / Zip Code: Grand Cayman, KY1-1102
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	WORKERS COMPENSATION	DIRECT ALLOCATION			$	$		$ 115,642	1
2	26	LIABILITY INSURANCE	DIRECT ALLOCATION						426,335	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					$	$		$ 541,977	25

Facility Name & ID Number Aria Post Acute Care # 0052019 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Loan Payable			$	$ 11,060,000			$ 622,489	1
2	Mezzanine Loan Payable		X	Loan Payable				2,250,000				2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit				3,950,000			129,440	6
7	The Private Bank		X	Line of Credit				1,000,000			270,000	7
8	See Supplemental Schedule										2,119	8
9	TOTAL Facility Related						$	$ 18,260,000			$ 1,024,048	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,421)	10
11	Bldg Co - Interest Income		X								(292)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,713)	14
15	TOTALS (line 9+line14)						$	$ 18,260,000			$ 1,022,335	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** 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 Aria Post Acute Care # 0052019 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from NuCare		X				$	$			$ 2,119	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,119	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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.)

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 521,216	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.)		$ 565,210	2
3. Under or (over) accrual (line 2 minus line 1).		$ 43,994	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 469,006	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 8,538	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 521,538	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	695,013	8
	2010	537,756	9
	2011	584,963	10
	2012	611,161	11
	2013	561,720	12

Beginning Acrual Adjusted
2014 Accrual: $638,319 x 0.83 = $469,006
Allocated from NuCare: $3,490

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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 Aria Post Acute Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052019

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-101-14-0000	Long Term Care Property	$ 638,318.90	$ 561,720.90
2.	10-27-319-028-0000	Home Office Allocation	$ 89,368.57	$ 3,490.03
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 727,687.47	$ 565,210.93

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.

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aria Post Acute Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052019

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

Hillside Montessori School - Child Day Care

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2012	$ 1,200,000	1
2	Allocated from 7257 N. Lincoln Ave.			6,248	2
3	TOTALS			$ 1,206,248	3

Facility Name & ID Number Aria Post Acute Care # 0052019 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198		2012	1997	$ 9,076,289	$ 178,662	35	$ 259,323	$ 80,661	$ 540,533	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aria Post Acute Care # 0052019 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		104,467	4,226		4,044	(182)	36,659	68
69	Financial Statement Depreciation			190,650			(190,650)		69
70	TOTAL (lines 4 thru 69)		$ 9,180,756	$ 373,538		$ 263,367	$ (110,171)	$ 577,192	70

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12A, Carried Forward		$ 9,180,756	$ 373,538		$ 263,367	$ (110,171)	$ 577,192	1
2	Awning	2012	15,960		20	798	798	1,862	2
3	Ceiling Under Awning	2012	3,796		20	190	190	427	3
4	Wi-Fi Wiring	2012	5,500		20	275	275	619	4
5	Fixtures For Awning	2012	6,185		20	309	309	670	5
6	Lightbox	2012	4,639		20	232	232	503	6
7	4 Cctv Cameras	2013	3,400		20	680	680	1,190	7
8	Outlets For Tvs, Installed Wall Mounts, Overhead Lights	2013	4,000		20	800	800	1,400	8
9	15 Cctvs	2013	7,490		20	1,498	1,498	2,247	9
10	Fire Alarm Work. Upgrade Motherboard, Intellignet Loop Interfa	2013	17,895		20	895	895	1,118	10
11	Chiller Unit Repairs	2013	4,310		20	216	216	305	11
12	Resident Rms,Bathrms,Hallways-Roofing,Painting,Wiring,Floorin	2013	698,212		20	34,911	34,911	69,821	12
13	Asphalt Curbs, Landscaping	2013	92,444		20	4,622	4,622	9,244	13
14	Coffee Station & Dining Room Bistro	2014	9,300		20	465	465	465	14
15	2 Boiler Pump Replacements	2014	4,084		20	204	204	204	15
16	Stained Concrete Sidewalk Installation	2014	4,760		20	185	185	185	16
17	Trane Chiller	2014	12,249		20	255	255	255	17
18	Card Reader Replacement Panel	2014	3,325		20	97	97	97	18
19	Electrical Work - Fire Alarm System	2014	5,250		20	66	66	66	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)		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12B, Carried Forward		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	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
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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)		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12C, Carried Forward		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	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
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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)		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12D, Carried Forward		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	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
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18									18
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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)		$ 10,083,556	$ 373,538		$ 310,064	$ (63,474)	$ 667,871	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12F, Carried Forward		$	$		$	$	$	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Ave.	2004	56,235	1,442	20	1,607	165	17,875	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Nucare	2003	683	45	20	34	(11)	380	9
10	Allocated from Nucare	2004	13,861	907	20	694	(213)	7,432	10
11	Allocated from Nucare	2005	822	54	20	41	(13)	405	11
12	Allocated from Nucare	2006	1,114	73	20	56	(17)	466	12
13	Allocated from Nucare	2008	1,174	77	20	59	(18)	367	13
14	Allocated from Nucare	2009	18,910	1,238	20	945	(293)	5,304	14
15	Allocated from Nucare	2010	2,906	190	20	145	(45)	655	15
16	Allocated from Nucare	2011	157	10	20	8	(2)	31	16
17	Allocated from Nucare	2012	175	11	20	9	(2)	24	17
18		2014	2,186	143	20	66	(77)	66	18
19									19
20	Allocated from 7257 N. Lincoln Ave.	2005	5,126	36	20	324	288	3,067	20
21	Allocated from 7257 N. Lincoln Ave.	2004	1,118		20	56	56	587	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)		$ 104,467	$ 4,226		$ 4,044	$ (182)	$ 36,659	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 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 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	Totals from Page 12H, Carried Forward		$ 104,467	$ 4,226		$ 4,044	$ (182)	$ 36,659	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 104,467	$ 4,226		$ 4,044	$ (182)	$ 36,659	34

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,458,235	$ 221,733	$ 277,489	$ 55,756	10	$ 618,154	71
72	Current Year Purchases	54,947	567	5,000	4,433	10	5,000	72
73	Fully Depreciated Assets	22,580		66	66	10	22,578	73
74								74
75	TOTALS	$ 1,535,762	$ 222,300	$ 282,555	$ 60,255		$ 645,731	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		Alloc. From Nucare	2014	$ 516	$ 34	$ 6,376	$ 6,342	5	$ 456	76
77										77
78										78
79										79
80	TOTALS			$ 516	$ 34	$ 6,376	$ 6,342		$ 456	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)	$ 12,826,082	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 595,872	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 598,995	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,123	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,314,058	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.

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Allocated from NuCare (Parking Lot)				396			5
6								6
7	TOTAL				$ 396 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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: $ 29,575 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	Facility	2012 Ford Bus	$	$ 15,746	17
18	Allocated from Nucare			2,434	18
19					19
20					20
21	TOTAL		$	$ 18,180	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 Aria Post Acute Care # 0052019 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 772,933	$		$ 772,933	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			231,520			231,520	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			826,292			826,292	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 prescrpts				478,039		478,039	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					109,981	97,091		207,072	13
14	TOTAL			$		$ 1,940,726	$ 575,130		$ 2,515,856	14

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

STATE OF ILLINOIS

Facility Name & ID Number Aria Post Acute Care # 0052019 Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 70,078	$ 1,482,287	1
2	Cash-Patient Deposits	2,181	2,181	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,676,903	6,676,903	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,917	8,917	6
7	Other Prepaid Expenses	24,076	24,076	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		173,250	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,782,155	$ 8,367,614	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,200,000	13
14	Buildings, at Historical Cost		9,076,289	14
15	Leasehold Improvements, at Historical Cost	801,142	801,142	15
16	Equipment, at Historical Cost	460,351	1,549,351	16
17	Accumulated Depreciation (book methods)	(240,216)	(1,244,200)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,105	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(61,335)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,132,408	3,238,052	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,153,685	$ 14,721,404	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,935,840	$ 23,089,018	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 933,886	$ 933,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,950,000	3,950,000	29
30	Accrued Salaries Payable	182,837	182,837	30
31	Accrued Taxes Payable (excluding real estate taxes)	306,178	306,178	31
32	Accrued Real Estate Taxes(Sch.IX-B)	421,727	469,006	32
33	Accrued Interest Payable		103,071	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	753,034	913,046	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,547,662	$ 6,858,024	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		14,310,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	196,837	196,837	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 196,837	$ 14,506,837	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,744,499	$ 21,364,861	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,191,341	$ 1,724,157	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,935,840	$ 23,089,018	48

***(See instructions.)**

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 999,967	1
2	Restatements (describe):		2
3	**Amortization of Goodwill**	(22,593)	3
4	**Bad Debts**	(23,040)	4
5	**Workers' Comp Ins.**	8,708	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 963,042	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,228,299	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,228,299	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,191,341	24 *

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

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,047,323	1
2	Discounts and Allowances for all Levels	(5,759,053)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,288,270	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,940,541	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,940,541	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	973,908	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	260,974	19
20	Radiology and X-Ray	59,558	20
21	Other Medical Services	89,334	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,383,774	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,421	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,421	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	189	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 189	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,614,195	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,786,046	31
32	Health Care	4,944,111	32
33	General Administration	3,409,504	33
	B. Capital Expense		
34	Ownership	2,171,112	34
	C. Ancillary Expense		
35	Special Cost Centers	2,703,505	35
36	Provider Participation Fee	371,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,385,896	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,228,299	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,228,299	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,398,627	44
45	Private Pay - Net Inpatient Revenue	343,135	45
46	Medicare - Net Inpatient Revenue	1,702,635	46
47	Other-(specify) Managed Care	360,984	47
48	Other-(specify) Hospice	482,889	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,288,270	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 Aria Post Acute Care # 0052019 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,834	2,086	$ 113,819	$ 54.56	1
2	Assistant Director of Nursing	1,997	2,117	94,754	44.76	2
3	Registered Nurses	40,957	44,743	1,520,097	33.97	3
4	Licensed Practical Nurses	37,770	42,463	1,213,868	28.59	4
5	CNAs & Orderlies	96,901	107,806	1,166,247	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,141	3,450	37,487	10.87	8
9	Activity Director	1,542	1,738	46,546	26.78	9
10	Activity Assistants	7,199	7,774	75,483	9.71	10
11	Social Service Workers	5,378	6,267	162,870	25.99	11
12	Dietician					12
13	Food Service Supervisor	2,558	2,807	70,959	25.28	13
14	Head Cook	5,261	5,897	69,062	11.71	14
15	Cook Helpers/Assistants	18,126	20,134	208,299	10.35	15
16	Dishwashers					16
17	Maintenance Workers	2,544	2,809	59,771	21.28	17
18	Housekeepers	23,448	26,494	302,828	11.43	18
19	Laundry	7,234	8,249	95,364	11.56	19
20	Administrator	1,829	2,086	110,316	52.88	20
21	Assistant Administrator					21
22	Other Administrative	250	250	21,901	87.60	22
23	Office Manager	3,730	4,234	107,465	25.38	23
24	Clerical	8,578	9,386	142,227	15.15	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	2,370	2,842	57,186	20.12	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,215	6,535	197,320	30.19	33
34	TOTAL (lines 1 - 33)	278,862	310,167	$ 5,873,869 *	$ 18.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,798	01-03	35
36	Medical Director	Monthly	92,431	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,966	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	35	1,933	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	35	$ 111,128		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Moshe Polstein	Administrator	0	$ 99,342
Eitan Y. Zeffren	Administrator	0	10,974
Marilyn Flaherty	VP Medicare Reimb	0	8,791
Sondra Mixdorf	VP Clinical	0	13,109
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 132,217

B. Administrative - Other

Description	Amount
NuCare Services Corp - Bookkeeping Fees	$ 665,536
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 665,536

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 34,998
Frost, Ruttenberg, & Rothblatt	Accounting	26,003
McGladrey LLP	Accounting	548
Personal Planners	Unemployment Consultant	3,234
Ability Network Inc.	Computer Services	2,563
CDW Government Inc.	Computer Services	1,875
Creative Technology Solutions	Computer Services	15,139
Curaspan Health Group	Computer Services	4,500
EBS Master	Computer Services	1,153
E-Health Data Solutions	Computer Services	5,112
Formation Healthcare Group	Computer Services	1,005
See Supplemental Schedule		59,210
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 160,480

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 135,993
Unemployment Compensation Insurance	64,075
FICA Taxes	448,154
Employee Health Insurance	250,088
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	12,841
Other Employee Benefits	10,611
TOTAL (agree to Schedule V, line 22, col.8)	$ 921,762

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	9,897
License and Permits	17,201
Allocated from NuCare	1,341
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,439

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,547
Allocated from NuCare	1,148
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,695

**See instructions.

Facility Name & ID Number Aria Post Acute Care # 0052019 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Aria Post Acute Care # 0052019 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 $14,657; Alliance of HC Council $1,080**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **76** 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. $ **371,618**
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? **Yes** 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. $ Has any meal income been offset against related costs? **N/A** 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 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.