FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 0053710

Facility Name: Aria Post Acute Care

Address: 4600 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 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			16,116	16,116	8
9	SNF/PED					9
10	ICF	43,018	1,744	2,494	47,256	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,018	1,744	18,610	63,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.69%

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 11,036

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

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

Facility Name & ID Number Aria Post Acute Care # 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	334,077	32,836	34,079	400,992		400,992		400,992			1
2	Food Purchase		352,396		352,396		352,396	(97)	352,299			2
3	Housekeeping	313,004	50,637		363,641		363,641		363,641			3
4	Laundry	18,119	9,623	30,707	58,449		58,449		58,449			4
5	Heat and Other Utilities			295,376	295,376		295,376	(4,525)	290,851			5
6	Maintenance	42,445		178,242	220,687		220,687	21,593	242,280			6
7	Other (specify):*							3,444	3,444			7
8	**TOTAL General Services**	707,645	445,492	538,404	1,691,541		1,691,541	20,416	1,711,957			8
	B. Health Care and Programs											
9	Medical Director			58,400	58,400		58,400		58,400			9
10	Nursing and Medical Records	3,939,848	305,393	48,371	4,293,612		4,293,612	228,725	4,522,337			10
10a	Therapy	68,130		39,582	107,712		107,712	(4,695)	103,017			10a
11	Activities	127,916	16,628	1,980	146,524		146,524		146,524			11
12	Social Services	264,724			264,724		264,724		264,724			12
13	CNA Training											13
14	Program Transportation			43,710	43,710		43,710	(1,543)	42,167			14
15	Other (specify):*							45,434	45,434			15
16	**TOTAL Health Care and Programs**	4,400,618	322,021	192,043	4,914,682		4,914,682	267,921	5,182,603			16
	C. General Administration											
17	Administrative	103,382		920,228	1,023,610		1,023,610	(870,362)	153,248			17
18	Directors Fees											18
19	Professional Services			179,027	179,027	(52,283)	126,744	73,168	199,912			19
20	Dues, Fees, Subscriptions & Promotions			84,055	84,055		84,055	(20,000)	64,055			20
21	Clerical & General Office Expenses	230,208	151	503,039	733,398		733,398	(147,730)	585,668			21
22	Employee Benefits & Payroll Taxes			1,111,986	1,111,986		1,111,986		1,111,986			22
23	Inservice Training & Education											23
24	Travel and Seminar			899	899		899	2,584	3,483			24
25	Other Admin. Staff Transportation			14,123	14,123		14,123	11,516	25,639			25
26	Insurance-Prop.Liab.Malpractice			585,541	585,541		585,541	357,909	943,450			26
27	Other (specify):*							55,474	55,474			27
28	**TOTAL General Administration**	333,590	151	3,398,898	3,732,639	(52,283)	3,680,356	(537,440)	3,142,916			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,441,853	767,664	4,129,345	10,338,862	(52,283)	10,286,579	(249,103)	10,037,476			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 #0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			156,684	156,684		156,684	428,165	584,849			30
31	Amortization of Pre-Op. & Org.			22,593	22,593		22,593	(22,593)	(0)			31
32	Interest			149,024	149,024		149,024	772,313	921,337			32
33	Real Estate Taxes			951,731	951,731	52,283	1,004,014	(87,355)	916,659			33
34	Rent-Facility & Grounds			1,284,100	1,284,100		1,284,100	(1,281,872)	2,228			34
35	Rent-Equipment & Vehicles			58,478	58,478		58,478	9,675	68,153			35
36	Other (specify):*			228	228		228	(228)				36
37	TOTAL Ownership			2,622,838	2,622,838	52,283	2,675,121	(181,894)	2,493,227			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		769,287	2,179,031	2,948,318		2,948,318	(7,535)	2,940,783			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			476,039	476,039		476,039		476,039			42
43	Other (specify):*	56,441		46,889	103,330		103,330	(103,330)	0			43
44	TOTAL Special Cost Centers	56,441	769,287	2,701,959	3,527,687		3,527,687	(110,865)	3,416,822			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,498,294	1,536,951	9,454,142	16,489,387		16,489,387	(541,862)	15,947,525			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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	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	(8,064)	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	468,834	30		9
10	Interest and Other Investment Income	(3,832)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	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	(3,974)	21		18
19	Entertainment				19
20	Contributions	(18,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(261,809)	21		24
25	Fund Raising, Advertising and Promotional	(3,042)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,213,402)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,043,886)		$	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)	502,023		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 502,023		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (541,862)		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# 0053710

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (115,681)	21	1
2	Discounts Earned	(6,492)	21	2
3	Marketing Salaries	(4,574)	43	3
4	Guest Relations Salaries	(51,867)	43	4
5	Bank Charges	(16,946)	21	5
6	Marketing Services	(46,889)	43	6
7	Amortization - Goodwill	(22,593)	31	7
8	Building Company - License and Inspection	(250)	20	8
9	Building Company - Legal Fees	(2,200)	19	9
10	Building Company - Accounting Fees	(1,115)	19	10
11	Building Company - Office Expense	(440)	21	11
12	Building Company - Bank Charges	(45)	21	12
13	Building Company - Closing Costs	(303,914)	36	13
14	Capitalized R&M	(7,420)	06	14
15	Additional R&M	2,697	06	15
16	Non-Allowable Legal Fees	(7,834)	19	16
17	Non-Allowable Expense	(228)	36	17
18	Day Care Allocation - Real Estate	(90,933)	33	18
19	Day Care Allocation - Mortgage Interest	(66,022)	32	19
20	Day Care Allocation - Depreciation	(49,921)	30	20
21	Day Care Allocation - Insurance	(48,804)	26	21
22	Collections	(2,825)	21	22
23	PAC Dues	(8,905)	20	23
24	Rent for Sale / Leaseback Arrangement	(360,100)	34	24
25	Traffic Ticket	(100)	06	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**	(1,213,402)		49

Aria Post Acute Care

ID# 0053710

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aria Post Acute Care # 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(97)											(97)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,064)		3,405	135								(4,525)	5
6	Maintenance	(4,823)		23,380	3,048	(12)							21,593	6
7	Other (specify):*			2,941	503								3,444	7
8	**TOTAL General Services**	(12,984)		29,726	3,686	(12)							20,416	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			205,414	23,412	(101)							228,725	10
10a	Therapy						(4,695)						(4,695)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							(1,543)					(1,543)	14
15	Other (specify):*			40,078	5,356								45,434	15
16	**TOTAL Health Care and Programs**			245,493	28,767	(101)	(4,695)	(1,543)					267,921	16
	C. General Administration													
17	Administrative			(652,172)	(218,190)								(870,362)	17
18	Directors Fees													18
19	Professional Services	(11,149)	3,315	76,077	4,925								73,168	19
20	Fees, Subscriptions & Promotions	(30,697)	250	7,811	2,636								(20,000)	20
21	Clerical & General Office Expenses	(408,212)	485	204,812	55,186								(147,730)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,098	1,486								2,584	24
25	Other Admin. Staff Transportation			10,959	558								11,516	25
26	Insurance-Prop.Liab.Malpractice	(48,804)	406,699	14									357,909	26
27	Other (specify):*			43,511	11,963								55,474	27
28	**TOTAL General Administration**	(498,863)	410,749	(307,891)	(141,436)								(537,440)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(511,847)	410,749	(32,672)	(108,983)	(113)	(4,695)	(1,543)					(249,103)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Aria Post Acute Care** **#** **0053710** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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

	Capital Expense 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	418,913		8,217	1,035								428,165	30
31	Amortization of Pre-Op. & Org.	(22,593)											(22,593)	31
32	Interest	(69,854)	839,057	2,974	136								772,313	32
33	Real Estate Taxes	(90,933)		2,979	599								(87,355)	33
34	Rent-Facility & Grounds	(360,100)	(924,000)	2,228									(1,281,872)	34
35	Rent-Equipment & Vehicles			7,757	1,918								9,675	35
36	Other (specify):*	(304,142)	303,914										(228)	36
37	**TOTAL Ownership**	(428,709)	218,971	24,156	3,689								(181,894)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(7,535)							(7,535)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(103,330)											(103,330)	43
44	**TOTAL Special Cost Centers**	(103,330)				(7,535)							(110,865)	44
45	**GRAND TOTAL COST** **(sum of lines 29, 37 & 44)**	(1,043,886)	629,720	(8,516)	(105,294)	(7,648)	(4,695)	(1,543)					(541,862)	45

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Rental Income	$ 924,000	Encore Realty Partners LLC	100.00%	$	$ (924,000)	1
2	V	21	Bank Charges		Encore Realty Partners LLC	100.00%	45	45	2
3	V	20	Licenses & Inspections		Encore Realty Partners LLC	100.00%	250	250	3
4	V	26	Insurance		Encore Realty Partners LLC	100.00%	406,699	406,699	4
5	V	19	Legal Fees		Encore Realty Partners LLC	100.00%	2,200	2,200	5
6	V	19	Accounting		Encore Realty Partners LLC	100.00%	1,115	1,115	6
7	V	21	Office Expense		Encore Realty Partners LLC	100.00%	440	440	7
8	V	32	Interest Expense		Encore Realty Partners LLC	100.00%	839,057	839,057	8
9	V	36	Closing Costs		Encore Realty Partners LLC	100.00%	303,914	303,914	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 924,000			$ 1,553,720	$ * 629,720	14

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$ 3,405	$ 3,405	15
16	V	6	MAINTENANCE SALARIES		NUCARE SERVICES CORP.	100.00%	15,074	15,074	16
17	V	6	MAINTENANCE EXPENSES		NUCARE SERVICES CORP.	100.00%	8,306	8,306	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		NUCARE SERVICES CORP.	100.00%	2,941	2,941	18
19	V	10	CLINICAL SALARIES		NUCARE SERVICES CORP.	100.00%	205,414	205,414	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		NUCARE SERVICES CORP.	100.00%	40,078	40,078	20
21	V	17	ADMINISTRATIVE SALARIES - NON-OWNER		NUCARE SERVICES CORP.	100.00%	46,409	46,409	21
22	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	76,077	76,077	22
23	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		NUCARE SERVICES CORP.	100.00%	7,811	7,811	23
24	V	21	CLERICAL & GENERAL SALARIES		NUCARE SERVICES CORP.	100.00%	176,598	176,598	24
25	V	21	CLERICAL & GENERAL EXPENSES		NUCARE SERVICES CORP.	100.00%	28,215	28,215	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,098	1,098	26
27	V	25	TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	10,959	10,959	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	14	14	28
29	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		NUCARE SERVICES CORP.	100.00%	43,511	43,511	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,217	8,217	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,974	2,974	31
32	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	2,979	2,979	32
33	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	2,228	2,228	33
34	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,222	2,222	34
35	V	35	AUTO LEASE		NUCARE SERVICES CORP.	100.00%	5,535	5,535	35
36	V								36
37	V	17	BOOKKEEPING FEE	698,581	NUCARE SERVICES CORP.	100.00%		(698,581)	37
38	V								38
39	Total			$ 698,581			$ 690,065	$ * (8,516)	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$	MAESTRO CONSULTING SERVICES LLC	100.00%	$ 135	$ 135	15
16	V	6	MAINTENANCE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,197	2,197	16
17	V	6	MAINTENANCE EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	851	851	17
18	V	7	EMPLOYEE BENEFITS - MAINTENANCE		MAESTRO CONSULTING SERVICES LLC	100.00%	503	503	18
19	V	10	CLINICAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	23,412	23,412	19
20	V	15	EMPLOYEE BENEFITS - CLINICAL		MAESTRO CONSULTING SERVICES LLC	100.00%	5,356	5,356	20
21	V	17	ADMINISTRATIVE SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	3,457	3,457	21
22	V	19	PROFESSIONAL FEES		MAESTRO CONSULTING SERVICES LLC	100.00%	4,925	4,925	22
23	V	20	DUES, FEES, SUBSCRIPTIONS, ETC.		MAESTRO CONSULTING SERVICES LLC	100.00%	2,636	2,636	23
24	V	21	CLERICAL & GENERAL SALARIES		MAESTRO CONSULTING SERVICES LLC	100.00%	52,208	52,208	24
25	V	21	CLERICAL & GENERAL EXPENSES		MAESTRO CONSULTING SERVICES LLC	100.00%	2,978	2,978	25
26	V	24	SEMINARS AND EDUCATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,486	1,486	26
27	V	25	TRANSPORTATION		MAESTRO CONSULTING SERVICES LLC	100.00%	558	558	27
28	V	27	EMPLOYEE BENEFITS - ADMINISTRATIVE		MAESTRO CONSULTING SERVICES LLC	100.00%	11,963	11,963	28
29	V	30	DEPRECIATION		MAESTRO CONSULTING SERVICES LLC	100.00%	1,035	1,035	29
30	V	32	INTEREST EXPENSE		MAESTRO CONSULTING SERVICES LLC	100.00%	136	136	30
31	V	33	REAL ESTATE TAX		MAESTRO CONSULTING SERVICES LLC	100.00%	599	599	31
32	V	35	EQUIPMENT RENTAL		MAESTRO CONSULTING SERVICES LLC	100.00%	1,372	1,372	32
33	V	35	AUTO LEASE		MAESTRO CONSULTING SERVICES LLC	100.00%	546	546	33
34	V								34
35	V	17	BOOKKEEPING FEE	221,647	MAESTRO CONSULTING SERVICES LLC	100.00%		(221,647)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 221,647			$ 116,353	$ * (105,294)	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	6	Repairs & Maintenance	$ 118	Integra Healthcare Equipment LLC		$ 106	$ (12)	15
16	V	10	Nursing Supplies & Equipment	994	Integra Healthcare Equipment LLC		893	(101)	16
17	V	39	DME & Medical Supplies	74,387	Integra Healthcare Equipment LLC		66,852	(7,535)	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			$ 75,499			$ 67,851	$ * (7,648)	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	10A	Respiratory Services	$ 38,869	Integra Respiratory Service LLC		$ 34,174	$ (4,695)	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			$ 38,869			$ 34,174	$ * (4,695)	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	14	Transportation	$ 20,180	Lifeline Ambulance LLC		$ 18,637	$ (1,543)	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			$ 20,180			$ 18,637	$ * (1,543)	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 23,962	MAPLE LEAF INSURANCE		$ 23,962	$	15
16	V	26	LIABILITY INSURANCE	78,264	MAPLE LEAF INSURANCE		78,264		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			$ 102,226			$ 102,226	$ *	39

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Michael Munter	19.00%	SYMPHONY OF DECATUR	DECATUR	ENCORE REALTY PARTNERS		BUILDING COMPANY	1
2	Mark Hartman	19.00%	SYMPHONY OF DEERBROOK	JOLIET	MAPLE LEAF INSURANCE	GRAND CAYMAN	LIABILITY INSURANCE	2
3	David Hartman	60.00%	SYMPHONY OF COUNTRYSIDE	AURORA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	Other	2.00%	SYMPHONY OF CRESTWOOD	CRESTWOOD	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	4
5			SYMPHONY OF MAPLE CREST	BELVIDERE	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING	5
6			SYMPHONY OF LINCOLN	LINCOLN	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	6
7			SYMPHONY OF MCKINLEY	DECATUR	DRAKE LOUIS ENTERPRISE, LL	LINCOLNWOOD	MANAGEMENT CO.	7
8			SYMPHONY OF NORTHWOODS	BELVIDERE	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME & MEDICAL SUPPLIES	8
9			SYMPHONY OF SYCAMORE	SWANSEA	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	9
10			SYMPHONY AT THE TILLERS	OSWEGO	INTEGRA RESPIRATORY SERV	ELMHURST	RESPIRATORY SERV.	10
11			SYMPHONY OF EVANSTON	EVANSTON	MAESTRO CONSULTING	LINCOLNWOOD,IL	BOOKEEPING	11
12			SEVEN OAKS	GLENDALE, WISCONSIN				12
13			SYMPHONY OF DYER	DYER, INDIANA				13
14			SYMPHONY OF CHESTERTON	CHESTERTON, INDIANA				14
15			SYMPHONY OF CROWN POINT	CROWN POINT, INDIANA				15
16			SYMPHONY SOUTH SHORE	CHICAGO				16
17			SYMPHONY BEVERLY	CHICAGO				17
18			SYMPHONY BRONZEVILLE	CHICAGO				18
19			SYMPHONY BUFFALO GROVE	BUFFALO GROVE				19
20			SYMPHONY IVY	CHICAGO				20
21			SYMPHONY JACKSON SQUARE	CHICAGO				21
22			SYMPHONY LINCOLN PARK	CHICAGO				22
23			SYMPHONY MIDWAY	CHICAGO				23
24			SYMPHONY PARK SOUTH	CHICAGO				24
25			CLAREMONT HANOVER PARK	HANOVER PARK				25
26			CALIFORNIA GARDENS	CHICAGO				26
27			MONROE CORP	CHICAGO				27
28								28
29								29
30								30

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	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	Michael Munter	Owner	Administrative	19.00%	See Attached	1.97	3.93%	Alloc. Salary	$ 3,457	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,457		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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,031,168	17	$ 58,329	$	60,192	$ 3,405	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	258,238	258,238	60,192	15,074	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	1,031,168	17	142,295		60,192	8,306	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	1,031,168	17	50,385		60,192	2,941	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,031,168	17	3,519,020	3,519,020	60,192	205,414	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	1,031,168	17	686,596		60,192	40,078	6
7	17	ADMINISTRATIVE SALARIES -	AVAIL. CENSUS DAYS	1,031,168	17	795,048	795,048	60,192	46,409	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,031,168	17	1,303,295		60,192	76,077	8
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	1,031,168	17	133,814		60,192	7,811	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	1,031,168	17	3,025,348	3,025,348	60,192	176,598	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	1,031,168	17	483,355		60,192	28,215	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,031,168	17	18,809		60,192	1,098	12
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	1,031,168	17	187,735		60,192	10,959	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	1,031,168	17	238		60,192	14	14
15	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	1,031,168	17	745,397		60,192	43,511	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,031,168	17	140,764		60,192	8,217	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,031,168	17	50,953		60,192	2,974	17
18	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,031,168	17	51,037		60,192	2,979	18
19	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,031,168	17	38,171		60,192	2,228	19
20	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,031,168	17	38,069		60,192	2,222	20
21	35	AUTO LEASE	AVAIL. CENSUS DAYS	1,031,168	17	94,822		60,192	5,535	21
22										22
23										23
24										24
25	TOTALS					$ 11,821,715	$ 7,597,654		$ 690,065	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MAESTRO CONSULTING SERVICES LLC
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	307,257	28	$ 3,424	$	12,078	$ 135	1
2	6	MAINTENANCE SALARIES	AVAIL. CENSUS DAYS	307,257	28	55,893	55,893	12,078	2,197	2
3	6	MAINTENANCE EXPENSES	AVAIL. CENSUS DAYS	307,257	28	21,648		12,078	851	3
4	7	EMPLOYEE BENEFITS - MAIN	AVAIL. CENSUS DAYS	307,257	28	12,799		12,078	503	4
5	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	307,257	28	595,582	595,582	12,078	23,412	5
6	15	EMPLOYEE BENEFITS - CLINI	AVAIL. CENSUS DAYS	307,257	28	136,244		12,078	5,356	6
7	17	ADMINISTRATIVE SALARIES	AVAIL. CENSUS DAYS	307,257	28	87,954	2,420	12,078	3,457	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	307,257	28	125,288		12,078	4,925	8
9	20	DUES, FEES, SUBSCRIPTIONS,	AVAIL. CENSUS DAYS	307,257	28	67,058		12,078	2,636	9
10	21	CLERICAL & GENERAL SALA	AVAIL. CENSUS DAYS	307,257	28	1,328,131	1,328,131	12,078	52,208	10
11	21	CLERICAL & GENERAL EXPE	AVAIL. CENSUS DAYS	307,257	28	75,756		12,078	2,978	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	307,257	28	37,815		12,078	1,486	12
13	25	TRANSPORTATION	AVAIL. CENSUS DAYS	307,257	28	14,185		12,078	558	13
14	27	EMPLOYEE BENEFITS - ADMI	AVAIL. CENSUS DAYS	307,257	28	304,341		12,078	11,963	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS	307,257	28	26,334		12,078	1,035	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	307,257	28	3,464		12,078	136	16
17	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	307,257	28	15,239		12,078	599	17
18	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	307,257	28	34,911		12,078	1,372	18
19	35	AUTO LEASE	AVAIL. CENSUS DAYS	307,257	28	13,885		12,078	546	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,959,951	$ 1,982,025		$ 116,353	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	6	Repairs & Maintenance	Direct Allocation			$	$		$ 106	1
2	10	Nursing Supplies & Equipment	Direct Allocation						893	2
3	39	DME & Medical Supplies	Direct Allocation						66,852	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					$	$		$ 67,851	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Integra Respiratory Service 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	10A	Respiratory Services	Direct Allocation			$	$		$ 34,174	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					$	$		$ 34,174	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	14	Transportation	Direct Allocation			$	$		$ 18,637	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					$	$		$ 18,637	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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			$	$		$ 23,962	1
2	26	LIABILITY INSURANCE	DIRECT ALLOCATION						78,264	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					$	$		$ 102,226	25

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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	The Private Bank		X	Loan Payable			$	$			$ 484,160	1
2	Hillside BF Holdings		X	Loan Payable							247,250	2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit							149,024	6
7	CapEx		X								41,625	7
8	See Supplemental Schedule										3,110	8
9	TOTAL Facility Related						$	$			$ 925,169	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,832)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,832)	14
15	TOTALS (line 9+line14)						$	$			$ 921,337	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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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				$	$			$ 2,974	8
9	Allocated from Maestro		X								136	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,110	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 # 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 469,006	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.)		$ 670,419	2
3. Under or (over) accrual (line 2 minus line 1).		$ 201,413	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 132,450	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.**		$ 52,283	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.		$ 386,146	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	537,756	8
	2011	584,963	9
	2012	611,161	10
	2013	561,720	11
	2014	666,841	12

The amount on line 7 does not agree to page 4, line 33. This is the result of the accrual on line 4 above being for only 2 months.

Allocated from NuCare: $2,979

Allocated from NuCare: $599

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aria Post Acute Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053710

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) 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	$ 757,774.24	$ 666,841.24
2.	10-27-319-028-0000	NuCare - Home Office Allocation	$ 91,415.94	$ 2,979.19
3.	10-27-319-028-0000	Maestro - Home Office Allocation	$ 91,415.94	$ 1,513.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 940,606.12	$ 671,333.63

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

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 0053710

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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 [ ] (b) Rent from a Related Organization. [X] (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.		2004	7,306	2
3	TOTALS			$ 1,207,306	3

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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	$	35	$ 259,323	$ 259,323	$ 799,856	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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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)		145,488	4,243		3,673	(570)	55,818	68
69	Financial Statement Depreciation			104,806			(104,806)		69
70	TOTAL (lines 4 thru 69)		$ 9,221,777	$ 109,049		$ 262,996	$ 153,947	$ 855,674	70

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 9,221,777	$ 109,049		$ 262,996	$ 153,947	$ 855,674	1
2	Awning	2012	15,960		20	665	665	2,527	2
3	Ceiling Under Awning	2012	3,796		20	158	158	585	3
4	Wi-Fi Wiring	2012	5,500		20	229	229	848	4
5	Fixtures For Awning	2012	6,185		20	258	258	928	5
6	Lightbox	2012	4,639		20	193	193	696	6
7	4 Cctv Cameras	2013	3,400		20	567	567	1,757	7
8	Outlets For Tvs, Installed Wall Mounts, Overhead Lights	2013	4,000		20	667	667	2,067	8
9	15 Cctvs	2013	7,490		20	1,248	1,248	3,495	9
10	Fire Alarm Work. Upgrade Motherboard, Intellignet Loop Interfa	2013	17,895		20	746	746	1,864	10
11	Chiller Unit Repairs	2013	4,310		20	180	180	485	11
12	Resident Rms,Bathrms,Hallways-Roofing,Painting,Wiring,Floorin	2013	698,212		20	29,092	29,092	98,913	12
13	Asphalt Curbs, Landscaping	2013	92,444		20	3,852	3,852	13,096	13
14	Coffee Station & Dining Room Bistro	2014	9,300		20	388	388	853	14
15	2 Boiler Pump Replacements	2014	4,084		20	170	170	374	15
16	Stained Concrete Sidewalk Installation	2014	4,760		20	264	264	450	16
17	Trane Chiller	2014	12,249		20	510	510	766	17
18	Card Reader Replacement Panel	2014	3,325		20	139	139	236	18
19	Electrical Work - Fire Alarm System	2014	5,250		20	219	219	284	19
20	Doors, Frames And Sideliters	2015	2,622		20	11	11	11	20
21	Install 2 Fans On Boiler	2015	3,485		20	581	581	581	21
22	Chiler - Leak Repair	2015	7,420		20	371	371	371	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)		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	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)		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	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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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)		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	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
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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)		$ 10,138,104	$ 109,049		$ 303,502	$ 194,453	$ 986,859	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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
14									14
15									15
16									16
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19									19
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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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 7257 N. Lincoln Ave. - NuCare	2004	56,318	1,203	35	1,341	138	19,510	3
4	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	9,436	242	35	270	28	3,269	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Nucare	2003	684	40	20	24	(16)	409	9
10	Allocated from Nucare	2004	13,881	807	20	462	(345)	8,144	10
11	Allocated from Nucare	2005	823	48	20	29	(19)	440	11
12	Allocated from Nucare	2006	1,116	65	20	39	(26)	513	12
13	Allocated from Nucare	2008	1,176	68	20	41	(27)	417	13
14	Allocated from Nucare	2009	18,938	1,101	20	658	(443)	6,101	14
15	Allocated from Nucare	2010	2,910	169	20	121	(48)	656	15
16	Allocated from Nucare	2011	157	9	20	5	(4)	37	16
17	Allocated from Nucare	2012	175	10	20	6	(4)	31	17
18	Allocated from Nucare	2014	2,189	127	20	76	(51)	158	18
19	Allocated from Nucare	2015	616		20	4	4	5	19
20									20
21	Allocated from 7257 N. Lincoln Ave. - Nucare	2015	888	37	20	16	(21)	20	21
22	Allocated from 7257 N. Lincoln Ave. - Nucare	2005	5,134	30	20	271	241	3,397	22
23	Allocated from 7257 N. Lincoln Ave. - Nucare	2004	1,119		20	47	47	644	23
24									24
25	Allocated from Maestro Consulting Services	2003	460	4	20	3	(1)	275	25
26	Allocated from Maestro Consulting Services	2004	9,348	91	20	62	(29)	5,484	26
27	Allocated from Maestro Consulting Services	2005	554	5	20	4	(1)	296	27
28	Allocated from Maestro Consulting Services	2006	751	7	20	5	(2)	346	28
29	Allocated from Maestro Consulting Services	2008	792	8	20	5	(3)	281	29
30	Allocated from Maestro Consulting Services	2009	12,753	124	20	89	(35)	4,108	30
31	Allocated from Maestro Consulting Services	2010	1,960	19	20	16	(3)	442	31
32	Allocated from Maestro Consulting Services	2011	106	1	20	1		25	32
33	Allocated from Maestro Consulting Services	2012	118	1	20	1		21	33
34	TOTAL (lines 1 thru 33)		$ 142,402	$ 4,216		$ 3,596	$ (620)	$ 55,029	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 142,402	$ 4,216		$ 3,596	$ (620)	$ 55,029	1
2	Allocated from Maestro Consulting Services	2014	1,474	14	20	10	(4)	106	2
3	Allocated from Maestro Consulting Services	2015	415		20	1	1	3	3
4									4
5	Allocated from 7257 N. Lincoln Ave. - Maestro	2015	149	7	20	3	(4)	3	5
6	Allocated from 7257 N. Lincoln Ave. - Maestro	2005	860	6	20	54	48	569	6
7	Allocated from 7257 N. Lincoln Ave. - Maestro	2004	188		20	9	9	108	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 145,488	$ 4,243		$ 3,673	$ (570)	$ 55,818	34

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,557,544	$ 4,370	$ 274,253	$ 269,883	10	$ 920,711	71
72	Current Year Purchases	35,032	605	5,001	4,396	10	5,568	72
73	Fully Depreciated Assets	39,953		78	78	10	39,953	73
74								74
75	TOTALS	$ 1,632,528	$ 4,975	$ 279,332	$ 274,357		$ 966,233	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	Facility	Ford E350	2015	$ 9,783	$ 1,957	$ 1,957	$ (0)	5	$ 1,957	76
77		Alloc. From Nucare	2014	517	30	50	20	5	517	77
78		Alloc. From Nucare	2015	348	3	7	4	5	348	78
79										79
80	TOTALS			$ 10,648	$ 1,990	$ 2,014	$ 24		$ 2,822	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)	$ 12,988,586	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,014	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 584,848	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 468,834	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,955,914	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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Main Street (sale/leaseback arrangement)
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. [X] 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:		198		$ 360,100			3
4	Additions							4
5					(360,100)			5
6	Parking Lot - Allocated From NuCare				2,228			6
7	TOTAL		198		$ 2,228 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 44,474 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	$	$ 13,189	17
18	Van Rental			4,410	18
19	Allocated from Nucare Services			5,535	19
20	Allocated from Maestro Consulting			546	20
21	TOTAL		$	$ 23,680	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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 755,920	$		$ 755,920	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			312,325			312,325	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			885,686			885,686	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				616,919		616,919	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					225,100	152,368		377,468	13
14	TOTAL			$		$ 2,179,031	$ 769,287		$ 2,948,318	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 **#** 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 36,311	$ 3,118,564	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,764,893	2,884,059	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,241	1,241	6
7	Other Prepaid Expenses	17,923	17,923	7
8	Accounts Receivable (owners or related parties)		928,539	8
9	Other(specify):	45,818	2,223,818	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,866,186	$ 9,174,144	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	9,784	9,784	16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	13,472	13,472	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 23,256	$ 23,256	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,889,442	$ 9,197,400	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,678,986	$ 1,679,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,619	195,619	30
31	Accrued Taxes Payable (excluding real estate taxes)	105,521	105,521	31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,450	132,450	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	654,464	654,464	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,767,040	$ 2,767,731	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,767,040	$ 2,767,731	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 122,402	$ 6,429,669	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,889,442	$ 9,197,400	48

***(See instructions.)**

Facility Name & ID Number Aria Post Acute Care **#** 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**Adjustment for ownership change**	(469,793)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (469,793)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	592,195	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)**	$ 592,195	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)**	$ 122,402	24 *

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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,379,401	1
2	Discounts and Allowances for all Levels	(275,885)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,103,516	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	962,640	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 962,640	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	1,096	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,546	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,460	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,102	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,832	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,832	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,492	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,492	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,081,582	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,691,541	31
32	Health Care	4,914,682	32
33	General Administration	3,732,639	33
	B. Capital Expense		
34	Ownership	2,622,838	34
	C. Ancillary Expense		
35	Special Cost Centers	3,051,648	35
36	Provider Participation Fee	476,039	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,489,387	40
41	**Income before Income Taxes (line 30 minus line 40)****	592,195	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 592,195	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,267,406	44
45	Private Pay - Net Inpatient Revenue	346,646	45
46	Medicare - Net Inpatient Revenue	5,895,808	46
47	Other-(specify) Managed Care	2,167,263	47
48	Other-(specify) Hospice	426,393	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,103,516	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 # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,979	2,138	$ 113,861	$ 53.26	1
2	Assistant Director of Nursing	1,832	1,925	89,298	46.40	2
3	Registered Nurses	48,631	52,884	1,554,788	29.40	3
4	Licensed Practical Nurses	33,461	37,216	973,939	26.17	4
5	CNAs & Orderlies	93,166	101,351	1,154,384	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,567	6,115	68,130	11.14	8
9	Activity Director	1,783	1,962	47,512	24.21	9
10	Activity Assistants	7,385	8,179	80,404	9.83	10
11	Social Service Workers	5,958	6,574	173,490	26.39	11
12	Dietician					12
13	Food Service Supervisor	1,615	2,114	55,498	26.25	13
14	Head Cook	5,396	5,805	68,504	11.80	14
15	Cook Helpers/Assistants	19,300	21,241	210,075	9.89	15
16	Dishwashers					16
17	Maintenance Workers	1,867	2,127	42,445	19.96	17
18	Housekeepers	24,523	27,337	313,004	11.45	18
19	Laundry	1,344	1,512	18,119	11.98	19
20	Administrator	1,938	2,151	103,382	48.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,379	2,545	75,309	29.59	23
24	Clerical	6,821	7,604	154,899	20.37	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	2,293	2,610	53,578	20.53	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,163	5,681	147,675	25.99	33
34	TOTAL (lines 1 - 33)	272,400	299,071	$ 5,498,294 *	$ 18.38	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	$ 34,079	01-03	35
36	Medical Director	Monthly	58,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	11,280	10-03	38
39	Pharmacist Consultant	Monthly	34,791	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	80	10a-03	41
42	Respiratory Therapy Consultant	Monthly	39,502	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,980	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatiric Consultant	Monthly	2,300	10-03	47
48					48
49	TOTAL (lines 35 - 48)	36	$ 182,412		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

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eitan Y. Zeffren	Administrator	0	$ 103,382
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,382

B. Administrative - Other

Description	Amount
Nucare - Bookkeeping Fees	$ 698,581
Maestro - Bookkeeping Fees	221,647
TOTAL (agree to Schedule V, line 17, col. 3)	$ 920,228
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 82,190
FR&R/Marcum LLP	Accounting	17,781
Joint Commision	Acreditation/Certification	3,200
Achieve Accreditation	Accreditation Assistance	10,755
Personnel Planners	Unepmloyment Consultant	2,650
RFMS	Cost Management	4,370
Kipp Computer	Computer Services	100
Creative Technology Solutions	Computer Services	12,601
Matrixcare	Computer Services	6,787
Wescom Solutions	Computer Services	23,333
Healthcare Services	Computer Services	908
See Supplemental Schedule		14,352
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 179,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 206,072
Unemployment Compensation Insurance	50,106
FICA Taxes	418,208
Employee Health Insurance	377,826
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	45,752
Employees' Physical Exams	825
Other Employee Benefits	13,198
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,111,986

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	290
Health Care Worker Background Check	
(Indicate # of checks performed 212)	2,114
Patient Background Checks 60	600
Dues and Subscriptions	47,719
License and Permits	2,885
Allocated from NuCare	7,811
Allocated from Maestro	2,636
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,055

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	899
Allocated from NuCare	1,098
Allocated from Maestro	1,486
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,483

**See instructions.

Facility Name & ID Number Aria Post Acute Care # 0053710 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Aria Post Acute Care **#** 0053710 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $26,985**

(3) Did the nursing home make political contributions or payments to a political action organization? _____ If YES, have these costs been properly adjusted out of the cost report? _____

(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. $ **None** Line **N/A**

(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? **Yes**
If YES, give effective date of lease. **11/1/2015**

(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 **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Aria Post Acute Care #52019

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **476,039**
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.