

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0053215

Facility Name: Aperion Care Amboy

Address: 15 West Wasson Road Amboy 61310
Number City Zip Code

County: Lee

Telephone Number: (815) 857-2550 Fax # (815) 857-4016

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2014

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. 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 01/01/16 to 12/31/16 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) _____
* Subject to the attached Accountants Consulting Report
(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 Aperion Care Amboy

0053215 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,502</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,502</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,403</u>	<u>4,344</u>	<u>2,057</u>	<u>17,804</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,403</u>	<u>4,344</u>	<u>2,057</u>	<u>17,804</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.15%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 10/01/14

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/01/14 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 97 and days of care provided 1,629

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Aperion Care Amboy # 0053215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	128,573	10,248	11,334	150,155		150,155	(4,348)	145,807			1
2	Food Purchase		95,886		95,886		95,886	(1,567)	94,319			2
3	Housekeeping	73,933	16,123	225	90,281		90,281		90,281			3
4	Laundry	26,878	7,676		34,554		34,554		34,554			4
5	Heat and Other Utilities			86,055	86,055		86,055	(7,317)	78,738			5
6	Maintenance	41,563	21,958	56,648	120,169		120,169	1,724	121,893			6
7	Other (specify):*							1,205	1,205			7
8	TOTAL General Services	270,947	151,891	154,262	577,100		577,100	(10,303)	566,797			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,052,930	88,029	105,386	1,246,345		1,246,345	(53,599)	1,192,746			10
10a	Therapy	41,059	3,326	1,086	45,471		45,471		45,471			10a
11	Activities	71,507	2,273	955	74,735		74,735		74,735			11
12	Social Services	76,976		4,687	81,663		81,663		81,663			12
13	CNA Training											13
14	Program Transportation			626	626		626		626			14
15	Other (specify):*							2,254	2,254			15
16	TOTAL Health Care and Programs	1,242,472	93,628	119,940	1,456,040		1,456,040	(51,345)	1,404,695			16
	C. General Administration											
17	Administrative	77,134		150,281	227,415		227,415	(120,234)	107,181			17
18	Directors Fees											18
19	Professional Services			192,929	192,929		192,929	(104,191)	88,738			19
20	Dues, Fees, Subscriptions & Promotions			121,616	121,616		121,616	(64,457)	57,159			20
21	Clerical & General Office Expenses	35,059	2,954	128,710	166,723		166,723	(45,145)	121,578			21
22	Employee Benefits & Payroll Taxes			188,535	188,535		188,535		188,535			22
23	Inservice Training & Education			(185)	(185)		(185)		(185)			23
24	Travel and Seminar			6,430	6,430		6,430	1,363	7,793			24
25	Other Admin. Staff Transportation			8,793	8,793		8,793	5,729	14,522			25
26	Insurance-Prop.Liab.Malpractice			86,500	86,500		86,500	1,163	87,663			26
27	Other (specify):*							7,501	7,501			27
28	TOTAL General Administration	112,193	2,954	883,609	998,756		998,756	(318,271)	680,485			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,625,612	248,473	1,157,811	3,031,896		3,031,896	(379,919)	2,651,977			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,878	8,878		8,878	8,763	17,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,140	24,140		24,140	3,495	27,635			32
33	Real Estate Taxes			36,478	36,478		36,478	1,382	37,860			33
34	Rent-Facility & Grounds			312,695	312,695		312,695	(29,847)	282,848			34
35	Rent-Equipment & Vehicles			8,418	8,418		8,418	852	9,270			35
36	Other (specify):*			6,734	6,734		6,734	(6,734)				36
37	TOTAL Ownership			397,343	397,343		397,343	(22,089)	375,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,833	257,692	322,525		322,525	(18,570)	303,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,766	151,766		151,766		151,766			42
43	Other (specify):*			16,568	16,568		16,568	(16,568)				43
44	TOTAL Special Cost Centers		64,833	426,026	490,859		490,859	(35,138)	455,721			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,625,612	313,306	1,981,180	3,920,098		3,920,098	(437,146)	3,482,952			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,710)	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	5,410	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(234)	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	(3,637)	21		18
19	Entertainment	(2,942)	21		19
20	Contributions	(65,047)	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	(87,117)	21		24
25	Fund Raising, Advertising and Promotional	(12,156)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(20,667)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (194,112)		\$	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)	(243,033)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (243,033)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (437,145)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 788	06	1
2	Promotional Products	(4,412)	43	2
3	Bank Charges	(6,674)	21	3
4	Amortization	(6,734)	36	4
5	PAC Dues	(2,992)	20	5
6	Non Allowable Legal	(98)	19	6
7	Credit Card Processing	(545)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(20,667)		49

Aperion Care Amboy

ID#	0053215
Report Period Beginning:	01/01/16
Ending:	12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Amboy # 0053215 Report Period Beginning: 01/01/16 Ending: 12/31/16

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				(4,348)								(4,348)	1
2	Food Purchase	(234)		117	(1,450)								(1,567)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,710)		21			129	244					(7,317)	5
6	Maintenance	788		474	(13)		231	244					1,724	6
7	Other (specify):*			21	1,081			103					1,205	7
8	TOTAL General Services	(7,156)		633	(4,730)		360	590					(10,303)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,132	(55,731)								(53,599)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			128	2,126								2,254	15
16	TOTAL Health Care and Programs			2,260	(53,605)								(51,345)	16
	C. General Administration													
17	Administrative			(121,214)		980							(120,234)	17
18	Directors Fees													18
19	Professional Services	(98)		(55,930)	465	(46,479)	439	30	(2,617)				(104,191)	19
20	Fees, Subscriptions & Promotions	(68,039)		2,616	752	160		54					(64,457)	20
21	Clerical & General Office Expenses	(100,915)		15,037	249	39,797	301	385					(45,145)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			814	526	23							1,363	24
25	Other Admin. Staff Transportation			2,939	2,180	610							5,729	25
26	Insurance-Prop.Liab.Malpractice			1,052				111					1,163	26
27	Other (specify):*			2,764		4,737							7,501	27
28	TOTAL General Administration	(169,052)		(151,922)	4,172	(172)	740	579	(2,617)				(318,271)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(176,208)		(149,029)	(54,163)	(172)	1,100	1,170	(2,617)				(379,919)	29

Summary B

Facility Name & ID Number	Aperion Care Amboy	#	0053215	Report Period Beginning:	01/01/16	Ending:	12/31/16
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	5,410		697	107	42	558	1,949					8,763
31	Amortization of Pre-Op. & Org.												31
32	Interest	(12)		2,469	9		421	608					3,495
33	Real Estate Taxes						651	732					1,382
34	Rent-Facility & Grounds			304			(7,150)	(23,000)					(29,847)
35	Rent-Equipment & Vehicles			47	206	185	197	217					852
36	Other (specify):*	(6,734)											(6,734)
37	TOTAL Ownership	(1,336)		3,517	322	227	(5,324)	(19,495)					(22,089)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers									(18,570)			(18,570)
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(16,568)											(16,568)
44	TOTAL Special Cost Centers	(16,568)								(18,570)			(35,138)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(194,112)		(145,512)	(53,840)	55	(4,224)	(18,325)	(2,617)	(18,570)			(437,146)

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	100.00%	\$ 117	\$ 117	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	21	21	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	474	474	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	21	21	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	2,132	2,132	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	128	128	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	29,067	29,067	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,168	1,168	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	2,616	2,616	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	15,037	15,037	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	814	814	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	2,939	2,939	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,052	1,052	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	2,764	2,764	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	697	697	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	2,469	2,469	30
31	V	34	RENT		APERION CARE, INC.	100.00%	304	304	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	47	47	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	150,281	APERION CARE, INC.	100.00%		(150,281)	35
36	V	19	HOME OFFICE	57,098	APERION CARE, INC.	100.00%		(57,098)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 207,379			\$ 61,867	\$ * (145,512)	39

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

Facility Name & ID Number	Aperion Care Amboy	#	0053215	Report Period Beginning:	01/01/16	Ending:	12/31/16
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VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 5,132	\$ 5,132	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	2,987	2,987	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,081	1,081	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	15,919	15,919	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,126	2,126	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	465	465	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	752	752	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	249	249	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	526	526	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	2,180	2,180	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	107	107	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	9	9	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	206	206	27
28	V				APERION CONSULTING, LLC	100.00%			28
29	V				APERION CONSULTING, LLC	100.00%			29
30	V				APERION CONSULTING, LLC	100.00%			30
31	V				APERION CONSULTING, LLC	100.00%			31
32	V				APERION CONSULTING, LLC	100.00%			32
33	V				APERION CONSULTING, LLC	100.00%			33
34	V	10	CONSULTING	71,650	APERION CONSULTING, LLC	100.00%		(71,650)	34
35	V	01	DIETICIAN	9,480	APERION CONSULTING, LLC	100.00%		(9,480)	35
36	V	02	FOOD SERVICE	1,450	APERION CONSULTING, LLC	100.00%		(1,450)	36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	3,000	APERION CONSULTING, LLC	100.00%		(3,000)	38
39	Total			\$ 85,580			\$ 31,740	\$ * (53,840)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	APERION FINANCIAL, LLC	100.00%	\$ 980	\$ 980	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	769	769	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	160	160	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	39,797	39,797	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	23	23	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	610	610	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	4,737	4,737	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	42	42	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	185	185	23
24	V				APERION FINANCIAL, LLC	100.00%			24
25	V				APERION FINANCIAL, LLC	100.00%			25
26	V				APERION FINANCIAL, LLC	100.00%			26
27	V				APERION FINANCIAL, LLC	100.00%			27
28	V				APERION FINANCIAL, LLC	100.00%			28
29	V				APERION FINANCIAL, LLC	100.00%			29
30	V				APERION FINANCIAL, LLC	100.00%			30
31	V				APERION FINANCIAL, LLC	100.00%			31
32	V				APERION FINANCIAL, LLC	100.00%			32
33	V				APERION FINANCIAL, LLC	100.00%			33
34	V	19	HOME OFFICE EXPENSE	47,248	APERION FINANCIAL, LLC	100.00%		(47,248)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 47,248			\$ 47,303	\$ * 55	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 129	\$ 129	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		231	231	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		439	439	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		301	301	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		558	558	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		421	421	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		154	154	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		197	197	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		651	651	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	304	8131 N. MONTICELLO, LLC			(304)	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			\$ 7,304			\$ 3,080	\$ * (4,224)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 244	\$ 244	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		244	244	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		103	103	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		30	30	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		54	54	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		385	385	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		111	111	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		1,949	1,949	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		608	608	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		732	732	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		217	217	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC			(23,000)	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			\$ 23,000			\$ 4,675	\$ * (18,325)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 10,906	ProPay HR LLC	24.00%	\$ 8,289	\$ (2,617)	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			\$ 10,906			\$ 8,289	\$ * (2,617)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 248,587	Renewal Rehab	100.00%	\$ 230,017	\$ (18,570)	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			\$ 248,587			\$ 230,017	\$ * (18,570)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YESNO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	MICHAEL ROSEN	49.00%	Aperion Care Bloomington	Bloomington	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	YOSEF MEYSEL TRUST	10.00%	Aperion Care Bridgeport	Bridgeport	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	DAVID BERKOWITZ DELTA TRUST	10.00%	Aperion Care Burbank	Burbank	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	DAVID BERKOWITZ TRUST	10.00%	Aperion Care Chicago Heights	Chicago Heights	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	YOSEF MEYSEL DELTA TRUST	10.00%	Aperion Care Colfax	Colfax	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	FREDERICK S. FRANKEL	2.00%	Aperion Care Demotte	Demotte,IN	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	STEVEN TUROFSKY	2.00%	Aperion Care Dolton	Dolton	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	JEREMY BOSHES	2.00%	Aperion Care Elgin	Elgin	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	MICHELLE KODER	2.00%	Aperion Care Evanston	Evanston	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	42170 LIMITED PARTNERSHIP	1.00%	Aperion Care Forest Park	Forest Park	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11	257 LIMITED PARTNERSHIP	1.00%	Aperion Care Galesburg	Galesburg	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12	1219 LIMITED PARTNERSHIP	1.00%	Aperion Care Hidden Lake	St. Louis, MO	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Highwood	Highwood	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care International	Chicago	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care Jacksonville	Jacksonville	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Kokomo	Kokomo, IN	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Oak Lawn	Oak Lawn	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Peru	Peru, IN	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Plum Grove	Palatine				22
23			Aperion Care Spring Valley	Spring Valley				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

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			Baypointe Rehab Center	Brockton, MA				1
2			Eastpointe Rehab Center	Chelsea, MA				2
3			Southpointe Rehab Center	Falls River, MA				3
4			The Arbors at Michigan City	Michigan City, IN				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Amboy # 0053215 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attached	0.7	1.75%	Alloc. Salary	\$ 3,380	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.3	0.75%	Alloc. Salary	522	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.3	1.50%	Alloc. Salary	1,247	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc. Salary	510	21-7	4
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.7	1.75%	Alloc. Salary	3,380	17-7	5
6	Fred Frankel	Owner	Administrative	2%	See Attached	0.7	1.75%	Alloc. Salary	3,118	17-7	6
7	Steve Turofsky	Owner	Administrative	2%	See Attached	0.7	1.75%	Alloc. Salary	3,241	17-7	7
8	Michael Rosen	Owner	Administrative	49.00%	See Attached	0.7	1.75%	Alloc. Salary	3,380	17-7	8
9	Nasson Factor	Relative	Clerical	0%	See Attached	0.6	1.82%	Alloc. Salary	1,434	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 20,212		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

<u>Facility Name & ID Number</u>	<u>Aperion Care Amboy</u>
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0053215

Report Period Beginning:

01/01/16

Ending: 12/31/16

Ending: 12/31/16

7

IL478-2471

Ending: 12/31/16

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IL478-2471

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

7

Facility Name & ID Number	Aperion Care Amboy
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0053215

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

ProPay HR LLC

Street Address

2201 W Main St

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847) 905-3268

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	19	Payroll Services			34	\$	\$		\$ 8,289	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					\$	\$		\$ 8,289	25

Facility Name & ID Number	Aperion Care Amboy
--------------------------------------	---------------------------

0053215

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Renewal Rehab

Street Address

4655 W Chase Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services		34	\$	\$		\$ 2,300,017	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				\$	\$		\$ 2,300,017	25

Facility Name & ID Number	Aperion Care Amboy
--------------------------------------	---------------------------

0053215

Report Period Beginning:

01/01/16

Ending: 12/31/16

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	Aperion Care Amboy
--------------------------------------	---------------------------

0053215

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				641,185				22,165	6
7	Inurance Policies		X									1,975	7
8	Note Payable		X	Auto Loan	-			56,445					8
9	TOTAL Facility Related						\$	697,630				\$ 24,140	9
	B. Non-Facility Related*												
10	Interest Income		X									(12)	10
11	Allocated from Aperion Care	X										2,469	11
12	Allocated from Aperion Consul	X										9	12
13	See Supplemental Schedule				-							1,029	13
14	TOTAL Non-Facility Related						\$					\$ 3,495	14
15	TOTALS (line 9+line14)						\$	697,630				\$ 27,635	15

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

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

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

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

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from 8131 N Montice	X		Interest Expense			\$					\$	421
16	Allocated from Chase Office, LI	X		Interest Expense									608
17													17
18													18
19													19
20	TOTAL Non-Facility Related												1,029

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	30,894	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.)			\$	35,068	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,174	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	33,686	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	37,860	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013	31,978	10	
		2014	36,315	11	
		2015	33,686	12	
2016 Accrual = 2015 Tax					
Beginning Accrual Adjusted					
Allocated from 8131 N Monticello= \$651					
Allocated from Chase Office = \$732					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	<u>Aperion Care Amboy</u>	COUNTY	<u>Lee</u>
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CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Aperion Care Amboy

COUNTY

Lee

FACILITY IDPH LICENSE NUMBER

0053215

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

20,000

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Allocated from Chase Office, LLC					\$1,049	1
2							2
3	TOTALS					\$1,049	3

Facility Name & ID Number Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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)		58,016	1,752		1,488	(264)	4,897	68
69	Financial Statement Depreciation			8,878			(8,878)		69
70	TOTAL (lines 4 thru 69)		\$ 58,016	\$ 10,630		\$ 1,488	\$ (9,142)	\$ 4,897	70

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

Facility Name & ID Number Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 58,016	\$ 10,630		\$ 1,488	\$ (9,142)	\$ 4,897	1
2 Thatcher Oaks Awnings	2014	6,200		20	310	310	620	2
3 Installation Of Cable For Voice & Data	2015	6,850		20	343	343	685	3
4 Life Safety & Critical Branch Circuits	2016	32,445		20	1,622	1,622	1,622	4
5 Water Heater	2016	5,200		20	260	260	260	5
6 Installed Mag Lights In Alzheimer Wing	2016	2,619		20	131	131	131	6
7 Repurposed Existing Keypad At South Door To Open Mag Locks	2016	2,619		20	131	131	131	7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	34

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

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		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	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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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)		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	34

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

Facility Name & ID Number Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	34

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

Facility Name & ID Number Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 113,949	\$ 10,630		\$ 4,285	\$ (6,345)	\$ 8,346	34

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

Facility Name & ID Number Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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									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 Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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
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 Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 8131 N Monticello	2010		201	39	175	(26)	1,810	3
4	Allocated from Chase Office, LLC	2016	9,444	101	39	101		101	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	503	81	10	25	(56)	176	9
10	Allocated from Aperion Care	2012	143	11	15	7	(4)	36	10
11	Allocated from Aperion Care	2013	61	7	10	3	(4)	12	11
12									12
13	Allocated from 8131 N Monticello	2010		354	10	153	(201)	1,602	13
14	Allocated from 8131 N Monticello	2013				27	27	163	14
15									15
16									16
17	Allocated Chase Office, LLC	2016	47,865	997	10	997		997	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)		\$ 58,016	\$ 1,752		\$ 1,488	\$ (264)	\$ 4,897	34

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

XI. OWNERSHIP COSTS (continued)

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

1 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		\$ 58,016	\$ 1,752		\$ 1,488	\$ (264)	\$ 4,897	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 58,016	\$ 1,752		\$ 1,488	\$ (264)	\$ 4,897	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 10,195	\$ 345	\$ 1,054	\$ 709	10	\$ 2,210	71
72	Current Year Purchases	21,517	1,065	956	(109)	10	956	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 31,712	\$ 1,410	\$ 2,010	\$ 600		\$ 3,166	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		2016 GMC Savanna Passenger V	2016	\$ 55,778	\$	\$ 11,156	\$ 11,156	5	\$ 11,156
77		Allocated from Aperion Care	2016	565	115	113	(2)	5	254
78		Allocated from Aperion Consulti	2016	392	76	78	2	5	157
79									
80	TOTALS			\$ 56,735	\$ 191	\$ 11,347	\$ 11,156		\$ 11,567

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	203,445
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	12,231
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	17,641
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	5,410
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	23,079

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		\$	\$	
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Green Acres Property
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		97		\$282,400			3
4	Additions							4
5	Storage Unit				295			5
6	Allocated From 8131 N Monticello				154			6
7	TOTAL		97		\$282,849			7

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$9,064Description:See Attached Schedule
- ☐ YES☐ NO
- (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	Allocated from Aperion Consulting		\$	\$206	17
18					18
19					19
20					20
21	TOTAL		\$-	\$206	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2017\$
13. /2018\$
14. /2019\$

* 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.

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

☒ 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)	\$			

- (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.
- 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	
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$		\$ 103,247	\$		\$ 103,247	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,614			14,614	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			130,393			130,393	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				54,863		54,863	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					9,438	9,970		19,408	13
14	TOTAL			\$		\$ 257,692	\$ 64,833		\$ 322,525	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,092,545		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,279		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	34,699		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,162,523	\$	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	50,695		15
16	Equipment, at Historical Cost	71,589		16
17	Accumulated Depreciation (book methods)	(12,653)		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): <u>See Attached Schedule</u>	175,932		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 285,563	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,448,086	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 215,785	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	697,630		29
30	Accrued Salaries Payable	108,357		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,709		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,686		32
33	Accrued Interest Payable	2,216		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,175,258		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,238,641	\$	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	<u>See Attached Schedule</u>	269,852		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 269,852	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,508,493	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,060,407)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,448,086	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (618,817)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (618,818)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(441,589)	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)	\$ (441,589)	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)	\$ (1,060,407)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Amboy**# **0053215**Report Period Beginning: **01/01/16**Ending: **12/31/16****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense****1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,268,859	1
2	Discounts and Allowances for all Levels	116,515	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,385,374	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	73,910	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 73,910	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	7,625	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,376	19
20	Radiology and X-Ray	1,251	20
21	Other Medical Services	7,961	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,213	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,478,509	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	577,100	31
32	Health Care	1,456,040	32
33	General Administration	998,756	33
	B. Capital Expense		
34	Ownership	397,343	34
	C. Ancillary Expense		
35	Special Cost Centers	339,093	35
36	Provider Participation Fee	151,766	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,920,098	40
41	Income before Income Taxes (line 30 minus line 40)**	(441,589)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (441,589)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,760,473	44
45	Private Pay - Net Inpatient Revenue	729,418	45
46	Medicare - Net Inpatient Revenue	797,246	46
47	Other-(specify) <u>Insurance</u>	98,237	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,385,374	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,712	2,051	\$ 66,138	\$ 32.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,444	7,956	263,470	33.12	3
4	Licensed Practical Nurses	9,848	10,883	289,074	26.56	4
5	CNAs & Orderlies	30,724	33,092	434,248	13.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,791	1,926	41,059	21.32	8
9	Activity Director	1,881	2,136	30,301	14.19	9
10	Activity Assistants	1,842	1,902	18,427	9.69	10
11	Social Service Workers	3,644	3,958	76,976	19.45	11
12	Dietician					12
13	Food Service Supervisor	1,608	2,077	25,172	12.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,573	10,372	103,401	9.97	15
16	Dishwashers					16
17	Maintenance Workers	2,179	2,536	41,563	16.39	17
18	Housekeepers	7,743	8,205	73,933	9.01	18
19	Laundry	2,860	2,983	26,878	9.01	19
20	Administrator	1,908	2,034	77,134	37.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,683	1,749	26,172	14.96	23
24	Clerical	640	692	8,887	12.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,835	1,971	22,779	11.56	33
34	TOTAL (lines 1 - 33)	88,915	96,523	\$ 1,625,612 *	\$ 16.84	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,334	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	960	71,650	10-03	38
39	Pharmacist Consultant	Monthly	5,145	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	1,086	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	955	11-03	44
45	Social Service Consultant	Monthly	1,692	12-03	45
46	Other(specify) <u>Psychiatric Consult</u>	Monthly	2,995	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	960	\$ 102,057		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	572	\$ 28,591	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	572	\$ 28,591		53

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

** See instructions.

STATE OF ILLINOIS

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Facility Name & ID Number

Aperion Care Amboy

0053215

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount			
Florencia Rocha 01/01-02/12	Administrator	0	\$ 7,096	Workers' Compensation Insurance		\$ 631		IDPH License Fee		\$ 3,980			
Lynn Klein 02/29-12/18	Administrator	0	67,184	Unemployment Compensation Insurance		38,935		Advertising: Employee Recruitment		30,548			
Bernadean McCoy 12/19-12/31	Administrator	0	2,854	FICA Taxes		122,666		Health Care Worker Background Check					
				Employee Health Insurance		22,897		(Indicate # of checks performed 68)		675			
				Employee Meals				Patient Background Checks	150	1,505			
				Illinois Municipal Retirement Fund (IMRF)*				Dues & Subscriptions		10,742			
				Employee Physicals		530		Licenses and Permits		6,127			
				Employee Meals		548		Allocated from Aperion Care		2,616			
				Employee Benefits - Other		2,328		Allocated from Aperion Consulting		752			
								See Supplemental Schedule		214			
								Less: Public Relations Expense	(		)		
								Non-allowable advertising	(		)		
								Yellow page advertising	(		)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								TOTAL (agree to Sch. V, line 20, col. 8)					
						\$ 188,535						\$ 57,159	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Description			Amount	Description			Line #	Amount	Description			Amount	
Aperion Care -Management Fees			\$ 150,281						Out-of-State Travel			\$	
									In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,281										
C. Professional Services													
Vendor/Payee	Type		Amount										
Creative Technology	Data Processing		\$ 8,256										
National Datacare Corportation	Data Processing		1,768										
Galaxy Hosted Software	Data Processing		3,750										
Wescom Solutions	Data Processing		17,266										
Aperion Care	Data Processing		7,494										
E-Health Data Solutions	Data Processing		1,800										
Ability Network	Data Processing		3,211										
Point Click Care	Data Processing		3,671										
Dmitry Kantarovich	Data Processing		835										
Propay HR	Payroll Processing		10,906										
Aperion Care	Home Office		57,098										
See Supplemental Schedule			76,877										
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								\$	Seminar Expense				6,430
									Allocated from Aperion Care				814
									Allocated from Aperion Consulting				526
									See Supplemental Schedule				23
									Entertainment Expense				(
									(agree to Sch. V, line 24, col. 8)				
									TOTAL				\$ 7,793

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number <u>Aperion Care Amboy</u>	STATE OF ILLINOIS # <u>0053215</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. ICLTC \$9068

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,460 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 151,766
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees