

		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: 0053983 Facility Name: Aperion Care Bloomington Address: 1509 N Calhoun St Bloomington 61701 County: Mclean Telephone Number: (309) 827-6046 Fax #: (309) 829-1992 HFS ID Number: Date of Initial License for Current Owners: 12/1/2015 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X 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) (Type or Print Name) (Title) Paid Preparer (Signed) * Subject to the attached Accountants Consulting Report (Print Name and Title) (Firm Name & Address) (Telephone) 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
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Facility Name & ID Number Aperion Care Bloomington

0053983 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 _____

	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>117</u>	Skilled (SNF)	<u>117</u>	<u>42,822</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>117</u>	TOTALS	<u>117</u>	<u>42,822</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>1,693</u>	<u>1,693</u>	8
9	SNF/PED					9
10	ICF	<u>21,795</u>	<u>1,772</u>	<u>6,033</u>	<u>29,600</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,795</u>	<u>1,772</u>	<u>7,726</u>	<u>31,293</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.08%

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 12/01/15

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/01/15 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 115 and days of care provided 1,693

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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 Bloomington # 0053983 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	230,141	21,385	32,080	283,606		283,606	(23,060)	260,546			1
2	Food Purchase		188,019		188,019		188,019	100	188,119			2
3	Housekeeping	75,565	25,512	67,959	169,036		169,036		169,036			3
4	Laundry	28,144	6,391	45,306	79,841		79,841		79,841			4
5	Heat and Other Utilities			123,558	123,558		123,558	(4,278)	119,280			5
6	Maintenance	38,714	25,170	110,606	174,490		174,490	(24,669)	149,821			6
7	Other (specify):*							2,118	2,118			7
8	TOTAL General Services	372,564	266,477	379,509	1,018,550		1,018,550	(49,789)	968,761			8
	B. Health Care and Programs											
9	Medical Director			17,900	17,900		17,900		17,900			9
10	Nursing and Medical Records	1,463,231	93,185	90,426	1,646,842		1,646,842	(49,572)	1,597,270			10
10a	Therapy	36,854			36,854		36,854		36,854			10a
11	Activities	94,410	6,094	585	101,089		101,089		101,089			11
12	Social Services	101,703		1,788	103,491		103,491		103,491			12
13	CNA Training											13
14	Program Transportation			723	723		723		723			14
15	Other (specify):*							3,961	3,961			15
16	TOTAL Health Care and Programs	1,696,198	99,279	111,422	1,906,899		1,906,899	(45,611)	1,861,288			16
	C. General Administration											
17	Administrative	90,617		229,434	320,051		320,051	(176,622)	143,429			17
18	Directors Fees											18
19	Professional Services			216,174	216,174		216,174	(115,227)	100,947			19
20	Dues, Fees, Subscriptions & Promotions			81,082	81,082		81,082	(35,325)	45,757			20
21	Clerical & General Office Expenses	57,135		153,886	211,021		211,021	(16,477)	194,544			21
22	Employee Benefits & Payroll Taxes			339,616	339,616		339,616		339,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,009	13,009		13,009	2,396	15,405			24
25	Other Admin. Staff Transportation			11,444	11,444		11,444	10,070	21,514			25
26	Insurance-Prop.Liab.Malpractice			96,554	96,554		96,554	2,043	98,597			26
27	Other (specify):*							13,184	13,184			27
28	TOTAL General Administration	147,752		1,141,199	1,288,951		1,288,951	(315,958)	972,993			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,216,514	365,756	1,632,130	4,214,400		4,214,400	(411,358)	3,803,042			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			10,209	10,209		10,209	(1,181)	9,028			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,357	33,357		33,357	5,254	38,611			32
33	Real Estate Taxes			20,656	20,656		20,656	2,430	23,086			33
34	Rent-Facility & Grounds			633,716	633,716		633,716	(29,730)	603,986			34
35	Rent-Equipment & Vehicles			24,718	24,718		24,718	1,498	26,216			35
36	Other (specify):*			(208)	(208)		(208)	208				36
37	TOTAL Ownership			722,448	722,448		722,448	(21,521)	700,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,731	269,701	378,432		378,432	(19,989)	358,443			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,363	245,363		245,363		245,363			42
43	Other (specify):*			27,007	27,007		27,007	(27,007)				43
44	TOTAL Special Cost Centers		108,731	542,071	650,802		650,802	(46,996)	603,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,216,514	474,487	2,896,649	5,587,650		5,587,650	(479,875)	5,107,775			45

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

	1	2	3	
	Amount	Refer- ence	BHF USE ONLY	
NON-ALLOWABLE EXPENSES				
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	(4,971)	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	(7,073)	30		9
10 Interest and Other Investment Income	(909)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(106)	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	(857)	21		18
19 Entertainment	(3,129)	21		19
20 Contributions	(40,797)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(105,153)	21		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(38,696)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,691)		\$	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	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			
33 Adjustments for Related Organization			33
34 Costs (Schedule VII)	(278,184)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (278,184)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (479,875)		37

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

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

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

Aperion Care Bloomington

	ID#	0053983
Report Period Beginning:		01/01/16
Ending:		12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Advertising/Marketing	\$ (27,007)	43	1
2	Bank Charges	(5,361)	21	2
3	Cable TV Repairs	(640)	06	3
4	Additional R&M	13,708	06	4
5	Non Allowable legal fees	(98)	19	5
6	PAC Dues	(825)	20	6
7	Non Allowable Professional Fees	(4,576)	19	7
8	Amortization Exp	208	36	8
9	Capitalized R&M	(14,105)	06	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	(38,696)		49

ID#

0053983

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 Bloomington # 0053983 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				(23,060)								(23,060)	1
2	Food Purchase	(106)		206									100	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,971)		38			226	429					(4,278)	5
6	Maintenance	(1,037)		833	(25,299)		406	428					(24,669)	6
7	Other (specify):*			38	1,900			180					2,118	7
8	TOTAL General Services	(6,114)		1,115	(46,459)		632	1,037					(49,789)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,747	(53,319)								(49,572)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			225	3,736								3,961	15
16	TOTAL Health Care and Programs			3,972	(49,583)								(45,611)	16
	C. General Administration													
17	Administrative			(178,344)		1,722							(176,622)	17
18	Directors Fees													18
19	Professional Services	(4,674)		(59,580)	818	(49,074)	771	52		(3,540)			(115,227)	19
20	Fees, Subscriptions & Promotions	(41,622)		4,598	1,322	282		95					(35,325)	20
21	Clerical & General Office Expenses	(114,500)		26,430	437	69,949	530	677					(16,477)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,431	925	40							2,396	24
25	Other Admin. Staff Transportation			5,165	3,832	1,073							10,070	25
26	Insurance-Prop.Liab.Malpractice			1,849				194					2,043	26
27	Other (specify):*			4,858		8,326							13,184	27
28	TOTAL General Administration	(160,796)		(193,593)	7,334	32,318	1,301	1,019		(3,540)			(315,958)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(166,910)		(188,506)	(88,708)	32,318	1,933	2,056		(3,540)			(411,358)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bloomington # 0053983 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

	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	(7,073)		1,225	188	73	981	3,425					(1,181)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(909)		4,340	15		740	1,069					5,254	32
33	Real Estate Taxes						1,144	1,286					2,430	33
34	Rent-Facility & Grounds			534			(7,264)	(23,000)					(29,730)	34
35	Rent-Equipment & Vehicles			83	363	325	346	381					1,498	35
36	Other (specify):*	208											208	36
37	TOTAL Ownership	(7,774)		6,182	566	398	(4,054)	(16,839)					(21,521)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(19,989)				(19,989)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(27,007)											(27,007)	43
44	TOTAL Special Cost Centers	(27,007)							(19,989)				(46,996)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(201,691)		(182,324)	(88,143)	32,716	(2,121)	(14,784)	(19,989)	(3,540)			(479,875)	45

VII. RELATED PARTIES

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

[illegible]

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

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

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V			Line	Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
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.

☒ 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	2	FOOD	\$	APERION CARE, INC.	100.00%	\$ 206	\$ 206	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	38	38	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	833	833	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	38	38	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	3,747	3,747	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	225	225	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	51,089	51,089	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,052	2,052	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,598	4,598	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	26,430	26,430	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,431	1,431	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,165	5,165	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,849	1,849	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,858	4,858	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,225	1,225	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,340	4,340	30
31	V	34	RENT		APERION CARE, INC.	100.00%	534	534	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	83	83	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	229,434	APERION CARE, INC.	100.00%		(229,434)	35
36	V	19	HOME OFFICE	61,632	APERION CARE, INC.	100.00%		(61,632)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 291,066			\$ 108,741	\$ * (182,324)	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	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 9,020	\$ 9,020	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,251	5,251	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,900	1,900	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	27,981	27,981	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,736	3,736	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	818	818	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,322	1,322	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	437	437	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	925	925	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,832	3,832	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	188	188	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	15	15	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	363	363	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	81,300	APERION CONSULTING, LLC	100.00%		(81,300)	34
35	V	01	DIETICIAN	28,080	APERION CONSULTING, LLC	100.00%		(28,080)	35
36	V	01	FOOD SERVICE	4,000	APERION CONSULTING, LLC	100.00%		(4,000)	36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	30,550	APERION CONSULTING, LLC	100.00%		(30,550)	38
39	Total			\$ 143,930			\$ 55,787	\$ * (88,143)	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	17	ADMINISTRATIVE	\$	APERION FINANCIAL, LLC	100.00%	\$ 1,722	\$ 1,722	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,352	1,352	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	282	282	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	69,949	69,949	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	40	40	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,073	1,073	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,326	8,326	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	73	73	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	325	325	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	50,426	APERION FINANCIAL, LLC	100.00%		(50,426)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 50,426			\$ 83,143	\$ * 32,716	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	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 226	\$ 226	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		406	406	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		771	771	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		530	530	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		981	981	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		740	740	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		270	270	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		346	346	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,144	1,144	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	534				(534)	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			\$ 7,534			\$ 5,413	\$ * (2,121)	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	\$	CHASE OFFICE,LLC	100.00%	\$ 429	\$ 429	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		428	428	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		180	180	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		52	52	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		95	95	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		677	677	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		194	194	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		3,425	3,425	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,069	1,069	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,286	1,286	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		381	381	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			\$ 8,216	\$ * (14,784)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 267,588	Renewal Rehab	100.00%	\$ 247,599	\$ (19,989)	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			\$ 267,588			\$ 247,599	\$ * (19,989)	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	19	Payroll Services	\$ 14,752	Propay HR LLC	24.00%	\$ 11,212	\$ (3,540)	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			\$ 14,752			\$ 11,212	\$ * (3,540)	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.

☐ 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

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			Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	Yosef Meystel Trust	21.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Delta Trust	21.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	David Berkowitz Trust	21.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Yosef Meystel Delta Trust	21.50%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Fred Frankel	3.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Steve Turofsky	3.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Jeremy Boshes	3.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Michelle Koder	3.00%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	Naftali Wilhelm	2.00%	Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				24
25			Aperion Care Springfield	Springfield				25
26			Aperion Care St. Elmo	St. Elmo				26
27			Aperion Care Tolleston Park	Gary, IN				27
28			Aperion Care Toluca	Toluca				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Wilmington	Wilmington				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			Burgin Manor	Olney				1
2			Baypointe Rehab Center	Brockton, MA				2
3			Eastpointe Rehab Center	Chelsea, MA				3
4			Southpointe Rehab Center	Falls River, MA				4
5			The Arbors at Michigan City	Michigan City, IN				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 Bloomington # 0053983 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		See Attached	1.2	3.00%	Allocated Salary	\$ 5,941	17-7	1
2	Jay Meystel	Relative	Administrative		See Attached	0.6	1.50%	Allocated Salary	917	17-7	2
3	Joel Meystel	Relative	Administrative		See Attached	0.6	3.00%	Allocated Salary	2,192	21-7	3
4	Cynthia Meystel	Relative	Clerical		See Attached	0.1	3.03%	Allocated Salary	896	21-7	4
5	Meir Meystel	Relative	Clerical		See Attached	0.2	2.90%	Allocated Salary	781	21-7	5
6	David Berkowitz	Relative	Administrative		See Attached	1.2	3.00%	Allocated Salary	5,941	17-7	6
7	Fred Frankel	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Allocated Salary	5,480	17-7	7
8	Steve Turofsky	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Allocated Salary	5,697	17-7	8
9	Nosson Factor	Relative	Clerical		See Attached	1	3.04%	Allocated Salary	2,521	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	\$ 30,366		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

Ending: 12/31/16

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

Ending: 12/31/16

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	2	FOOD	ACTUAL CENSUS	34	\$ 6,946	\$	31,293	\$ 206	1
2	5	UTILITIES	ACTUAL CENSUS	34	1,265		31,293	38	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	28,061	21,169	31,293	833	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	34	1,271		31,293	38	4
5	10	SALARY- NURSE	ACTUAL CENSUS	34	126,141	126,141	31,293	3,747	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	34	7,576		31,293	225	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	34	1,719,984	1,519,984	31,293	51,089	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	69,096		31,293	2,052	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	34	154,783		31,293	4,598	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	34	889,796	1,222,825	31,293	26,430	10
11	24	SEMINARS	ACTUAL CENSUS	34	48,189		31,293	1,431	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	34	173,887		31,293	5,165	12
13	26	INSURANCE	ACTUAL CENSUS	34	62,237		31,293	1,849	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	34	163,535		31,293	4,858	14
15	30	DEPRECIATION	ACTUAL CENSUS	34	41,232		31,293	1,225	15
16	32	INTEREST	ACTUAL CENSUS	34	146,102		31,293	4,340	16
17	34	RENT	ACTUAL CENSUS	34	17,963		31,293	534	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	2,801		31,293	83	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,660,864	\$ 2,890,119		\$ 108,741	25

Ending: 12/31/16

	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	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 303,659	31,293	\$ 9,020	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	31,293	5,251	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		31,293	1,900	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	31,293	27,981	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		31,293	3,736	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		31,293	818	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		31,293	1,322	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		31,293	437	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		31,293	925	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		31,293	3,832	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		31,293	188	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		31,293	15	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		31,293	363	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,878,156	\$ 1,421,169		\$ 55,787	25

Ending: 12/31/16

7

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE	ACTUAL CENSUS	34	\$ 57,979	\$ 57,979	31,293	\$ 1,722	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	45,525		31,293	1,352	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	34	9,485		31,293	282	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	34	2,354,900	2,320,500	31,293	69,949	4
5	24	SEMINARS	ACTUAL CENSUS	34	1,360		31,293	40	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	34	36,125		31,293	1,073	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	34	280,317		31,293	8,326	7
8	30	DEPRECIATION	ACTUAL CENSUS	34	2,458		31,293	73	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	10,954		31,293	325	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				\$ 2,799,102	\$ 2,378,479		\$ 83,143	25

Ending: 12/31/16

7

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	ACTUAL CENSUS	34	\$ 7,614	\$	31,293	\$ 226	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	13,676		31,293	406	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	25,960		31,293	771	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	34	17,828		31,293	530	4
5	30	DEPRECIATION	ACTUAL CENSUS	34	33,024		31,293	981	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	34	24,903		31,293	740	6
7	34	RENT	ACTUAL CENSUS	34	9,100		31,293	270	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	11,640		31,293	346	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	34	38,500		31,293	1,144	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				\$ 182,245	\$		\$ 5,413	25

Ending: 12/31/16

	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	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$	31,293	\$ 429	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		31,293	428	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		31,293	180	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		31,293	52	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		31,293	95	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		31,293	677	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		31,293	194	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		31,293	3,425	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		31,293	1,069	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		31,293	1,286	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		31,293	381	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					\$ 276,616	\$		\$ 8,216	25

Ending: 12/31/16

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct Allocation			\$	\$		\$ 247,599	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					\$	\$		\$ 247,599	25

Ending: 12/31/16

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll services	Direct Allocation		\$	\$		\$ 11,212	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				\$	\$		\$ 11,212	25

Ending: 12/31/16

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

Ending: 12/31/16

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

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	Retirement Home TV Corp		X	Capitalized lease				11,995					6
7	The Private Bank		X	Line of Credit				957,908				31,330	7
8					-								8
9	TOTAL Facility Related						\$	\$ 969,903				\$ 31,330	9
	B. Non-Facility Related*												
10	Interest Income		X									(909)	10
11	Interest Ins. Policies		X									2,027	11
12													12
13	See Supplemental Schedule				-							6,164	13
14	TOTAL Non-Facility Related						\$	\$				\$ 7,282	14
15	TOTALS (line 9+line14)						\$	\$ 969,903				\$ 38,612	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # 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	Aperion Care	X					\$				\$ 4,340	15	
16	Aperion Consulting	X									15	16	
17	8131 Monticello	X									740	17	
18	Chase Office	X									1,069	18	
19												19	
20	TOTAL Non-Facility Related										6,164	20	

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	28,468	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.)			\$	26,992	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,476)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	24,562	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.			\$	23,086	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015	24,562	12	
2016 accrual =2015 tax \$24,562					
Allocated from 8131 Monticello:1144					
Allocated from Chase Office:1286					
		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 Bloomington</u>	COUNTY	<u>Mclean</u>
FACILITY IDPH LICENSE NUMBER	<u>0053983</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-6300	FAX #:	(847) 236-6301

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.

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: 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.

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.

FACILITY NAME Aperion Care Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0053983

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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.

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?

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.)

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:

B. General Construction Type:

Exterior

Frame

Number of Stories

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).

N/A

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from Chase Office, LLC			\$1,844	1
2					2
3	TOTALS			\$1,844	3

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		101,971	3,079		2,614	(465)	8,609	68
69	Financial Statement Depreciation			10,209			(10,209)		69
70	TOTAL (lines 4 thru 69)		\$ 101,971	\$ 13,288		\$ 2,614	\$ (10,674)	\$ 8,609	70

**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 12B, Carried Forward		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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)		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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 12C, Carried Forward		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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 12D, Carried Forward		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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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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)		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	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.

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
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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.

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 Chase Office, LLC	2016	16,599	177	20	177		177	3
4	Allocated from 8131 N. Monticello	2010		353	20	307	(46)	3,182	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	885	142	20	44	(98)	310	9
10	Allocated from Aperion Care	2012	251	19	20	13	(6)	63	10
11	Allocated from Aperion Care	2013	107	12	20	5	(7)	21	11
12									12
13	Allocated from Chase Office, LLC	2016	84,129	1,753	20	1,753		1,753	13
14									14
15	Allocated from 8131 N Monticello	2010		623	20	268	(355)	2,816	15
16	Allocated from 8131 N Monticello	2013			20	47	47	287	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)		\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	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 12H, Carried Forward		\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	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	\$ 3,320	\$ 606	\$ 392	\$ (214)	10	\$ 965	71
72	Current Year Purchases	47,912	1,871	2,363	492	10	2,363	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 51,232	\$ 2,477	\$ 2,755	\$ 278		\$ 3,328	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Allocated from Aperion Care	2016	\$ 993	\$ 202	\$ 199	\$ (3)	5	\$ 446
77		Allocated from Aperion consultin	2016	689	134	138	4	5	275
78									
79									
80	TOTALS			\$ 1,682	\$ 336	\$ 337	\$ 1		\$ 721

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)			\$	259,489
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	16,101
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	9,028
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(7,073)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	15,952

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	Architects project 15074	\$ 197,919
93	Project 155 roof replacement	260,950
94		
95		\$ 458,869

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

☒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:		117		603,716			3
4	Additions							4
5								5
6	Allocated from Aperion				270			6
7	TOTAL		117		\$603,986			7

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

9. Option to Buy:

☒YES

☐NO

Terms:

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

15. Is Movable equipment rental included in building rental?

☐YES

☐NO
16. Rental Amount for movable equipment:\$13,383Description: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	GM	\$1,039	\$12,470	17
18	Allocated from Aperion Consulting			363	18
19					19
20					20
21	TOTAL		\$1,039	\$12,833	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

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

		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	\$		\$ 128,728	\$		\$ 128,728	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,739			9,739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			129,124			129,124	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				91,093		91,093	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					2,110	17,638		19,748	13
14	TOTAL			\$		\$ 269,701	\$ 108,731		\$ 378,432	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)	1,790,537		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,464		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	189,620		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,090,621	\$	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	100,855		15
16	Equipment, at Historical Cost	23,115		16
17	Accumulated Depreciation (book methods)	(10,492)		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>	463,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 576,783	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,667,404	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 777,019	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	969,903		29
30	Accrued Salaries Payable	115,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,890		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,562		32
33	Accrued Interest Payable	3,349		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	37,402		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,932,993	\$	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>	1,150,046		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,150,046	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,083,039	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (415,635)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,667,404	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (42,266)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (42,266)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,369)	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)	\$ (373,369)	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)	\$ (415,635)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,259,765	1
2	Discounts and Allowances for all Levels	(1,193,684)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,066,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,973	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,973	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	73,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,918	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,765	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 87,318	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	909	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 909	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)	\$ 5,214,281	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,018,550	31
32	Health Care	1,906,899	32
33	General Administration	1,288,951	33
	B. Capital Expense		
34	Ownership	722,448	34
	C. Ancillary Expense		
35	Special Cost Centers	405,439	35
36	Provider Participation Fee	245,363	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,587,650	40
41	Income before Income Taxes (line 30 minus line 40)**	(373,369)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (373,369)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,096,060	44
45	Private Pay - Net Inpatient Revenue	353,050	45
46	Medicare - Net Inpatient Revenue	752,205	46
47	Other-(specify) Insurance, MC, Contract. Adj.	864,766	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,066,081	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash basis 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	1,821	\$ 74,149	\$ 40.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,244	8,777	252,469	28.76	3
4	Licensed Practical Nurses	15,901	16,699	421,178	25.22	4
5	CNAs & Orderlies	54,608	58,145	683,776	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,208	2,389	36,854	15.43	8
9	Activity Director	1,956	2,036	26,536	13.03	9
10	Activity Assistants	4,975	5,520	50,882	9.22	10
11	Social Service Workers	4,988	5,340	101,703	19.05	11
12	Dietician					12
13	Food Service Supervisor	2,060	2,107	42,692	20.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,981	16,284	187,449	11.51	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,363	38,714	16.38	17
18	Housekeepers	7,657	8,170	75,565	9.25	18
19	Laundry	2,907	3,255	28,144	8.65	19
20	Administrator	2,011	2,040	90,617	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,294	4,433	57,135	12.89	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	1,986	2,115	31,659	14.97	31
32	Other Health Care(specify)					32
33	Other(specify)	1,248	1,392	16,992	12.21	33
34	TOTAL (lines 1 - 33)	133,738	142,886	\$ 2,216,514 *	\$ 15.51	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	548	\$ 32,080	01-03	35
36	Medical Director	Monthly	17,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	81,300	10-03	38
39	Pharmacist Consultant	Monthly	9,126	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	585	11-03	44
45	Social Service Consultant	33	1,788	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	593	\$ 142,779		49

C. CONTRACT NURSES

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

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

** See instructions.

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 2,500
- (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? _____
- (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. \$ 16,596 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. \$ 245,363
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ 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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees