

		FOR BHF USE					

LL1

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: 0052688 Facility Name: Aperion Care Bridgeport Address: 900 E Corporation St Bridgeport 62417 County: Lawrence Telephone Number: (618) 945-2091 Fax #: (618) 945-9017 HFS ID Number: Date of Initial License for Current Owners: 2/1/2014 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 (Date) (Date) (Date) Phone # (217) 782-1630
--	--

#	0052688	Report Period Beginning:	01/01/16	Ending:	12/31/16
---	---------	--------------------------	----------	---------	----------

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 2/1/2014

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

YES ☒ Date 2/1/2014 NO ☐

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

YES ☒ NO ☐ If YES, enter number
of beds certified 56 and days of care provided

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X
---------	---

CASH*	
-------	--

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2016 **Fiscal Year:** 12/31/2016

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,650	2,199	3,559	20,408	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,650	2,199	3,559	20,408	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.32%

Facility Name & ID Number Aperion Care Bridgeport # 0052688 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	147,534	12,999	9,855	170,388		170,388	5,882	176,270			1
2	Food Purchase		114,204		114,204		114,204	12	114,216			2
3	Housekeeping	96,234	12,735		108,969		108,969		108,969			3
4	Laundry	36,738	7,803		44,541		44,541		44,541			4
5	Heat and Other Utilities			79,224	79,224		79,224	(5,605)	73,619			5
6	Maintenance	29,295	14,844	52,824	96,963		96,963	11,163	108,126			6
7	Other (specify):*							1,382	1,382			7
8	TOTAL General Services	309,801	162,585	141,903	614,289		614,289	12,834	627,123			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	988,850	79,727	24,284	1,092,861		1,092,861	(308)	1,092,553			10
10a	Therapy	35,403	632		36,035		36,035		36,035			10a
11	Activities	67,721	3,924	4,439	76,084		76,084		76,084			11
12	Social Services	74,414			74,414		74,414		74,414			12
13	CNA Training											13
14	Program Transportation			5,266	5,266		5,266		5,266			14
15	Other (specify):*							2,584	2,584			15
16	TOTAL Health Care and Programs	1,166,388	84,283	42,989	1,293,660		1,293,660	2,275	1,295,935			16
	C. General Administration											
17	Administrative	76,074		178,242	254,316		254,316	(143,801)	110,515			17
18	Directors Fees											18
19	Professional Services			231,341	231,341		231,341	(129,910)	101,431			19
20	Dues, Fees, Subscriptions & Promotions			121,117	121,117		121,117	(81,695)	39,422			20
21	Clerical & General Office Expenses	91,037		149,008	240,045		240,045	(42,760)	197,285			21
22	Employee Benefits & Payroll Taxes			351,531	351,531		351,531		351,531			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,388	3,388		3,388	1,562	4,950			24
25	Other Admin. Staff Transportation			16,461	16,461		16,461	6,567	23,028			25
26	Insurance-Prop.Liab.Malpractice			60,627	60,627		60,627	1,333	61,960			26
27	Other (specify):*							8,598	8,598			27
28	TOTAL General Administration	167,111		1,111,715	1,278,826		1,278,826	(380,106)	898,720			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,643,300	246,868	1,296,607	3,186,775		3,186,775	(364,997)	2,821,778			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			14,572	14,572		14,572	74,023	88,595			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,382	29,382		29,382	144,919	174,301			32
33	Real Estate Taxes			28,925	28,925		28,925	1,196	30,121			33
34	Rent-Facility & Grounds			323,180	323,180		323,180	(320,824)	2,356			34
35	Rent-Equipment & Vehicles			9,898	9,898		9,898	977	10,875			35
36	Other (specify):*			4,070	4,070		4,070	(4,070)				36
37	TOTAL Ownership			410,027	410,027		410,027	(103,780)	306,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		160,252	419,416	579,668		579,668	(30,460)	549,208			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,401	156,401		156,401		156,401			42
43	Other (specify):*			36,963	36,963		36,963	(36,963)				43
44	TOTAL Special Cost Centers		160,252	612,780	773,032		773,032	(67,423)	705,609			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,643,300	407,120	2,319,414	4,369,834		4,369,834	(536,199)	3,833,635			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	(6,057)	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	(22,733)	30		9
10	Interest and Other Investment Income	(92)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(123)	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	(4,874)	21		18
19	Entertainment	(3,275)	21		19
20	Contributions	(81,097)	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	(83,608)	21		24
25	Fund Raising, Advertising and Promotional				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	(105,285)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (307,144)		\$	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)	(229,055)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (229,055)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (536,199)		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	Advertising/Marketing	\$ (21,402)	43	1
2	Marketing Fees	(7,591)	43	2
3	Marketing - Food	(365)	43	3
4	Promotional Products	(7,605)	43	4
5	Bank Charges	(14,308)	21	5
6	Theft & Damage Loss	(589)	21	6
7	Amortization	(4,070)	36	7
8	Bldg Co - Accounting Fees	(1,725)	19	8
9	Bldg Co - Amortization	(45,342)	36	9
10	Bldg Co - Bank Service Charges	(183)	21	10
11	Bldg Co - Professional Fees	(3,500)	19	11
12	Additional R&M	12,919	06	12
13	PAC Dues	(4,704)	20	13
14	Non Allowable Professional Fees	(750)	19	14
15	Non Allowable Legal	(169)	19	15
16	Credit Card Processing	(8)	21	16
17	Collections	(25)	21	17
18	Capitalized R&M	(5,868)	06	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	(105,285)		49

Aperion Care Bridgeport

ID# 0052688
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 Bridgeport # 0052688 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				5,882								5,882	1
2	Food Purchase	(123)		135									12	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,057)		25			147	279					(5,605)	5
6	Maintenance	7,051		544	3,024		265	279					11,163	6
7	Other (specify):*			25	1,239			118					1,382	7
8	TOTAL General Services	871		729	10,145		412	676					12,834	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,444	(2,752)								(308)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			147	2,437								2,584	15
16	TOTAL Health Care and Programs			2,591	(316)								2,275	16
	C. General Administration													
17	Administrative			(144,924)		1,123							(143,801)	17
18	Directors Fees													18
19	Professional Services	(6,144)	5,225	(68,989)	533	(57,737)	503	34		(3,335)			(129,910)	19
20	Fees, Subscriptions & Promotions	(85,801)		2,998	862	184		62					(81,695)	20
21	Clerical & General Office Expenses	(106,870)	183	17,237	285	45,618	345	442					(42,760)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			933	603	26							1,562	24
25	Other Admin. Staff Transportation			3,368	2,499	700							6,567	25
26	Insurance-Prop.Liab.Malpractice			1,206				127					1,333	26
27	Other (specify):*			3,168		5,430							8,598	27
28	TOTAL General Administration	(198,815)	5,408	(185,002)	4,782	(4,656)	848	664		(3,335)			(380,106)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(197,944)	5,408	(181,682)	14,611	(4,656)	1,261	1,341		(3,335)			(364,997)	29

Summary B

12/31/16

Capital Expense	PAGES	PAGE	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)		
Depreciation	(22,733)	92,913	799	122	48	640	2,234					74,023	30	
Amortization of Pre-Op. & Org.													31	
Interest	(92)	140,992	2,830	10		482	697					144,919	32	
Real Estate Taxes		(389)				746	839					1,196	33	
Rent-Facility & Grounds		(290,000)	348			(7,172)	(24,000)					(320,824)	34	
Rent-Equipment & Vehicles			54	236	212	225	248					977	35	
Other (specify):*	(49,412)	45,342										(4,070)	36	
TOTAL Ownership	(72,237)	(11,142)	4,031	368	260	(5,078)	(19,982)					(103,780)	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation													38	
Ancillary Service Centers								(30,460)				(30,460)	39	
Barber and Beauty Shops													40	
Coffee and Gift Shops													41	
Provider Participation Fee													42	
Other (specify):*	(36,963)											(36,963)	43	
TOTAL Special Cost Centers	(36,963)							(30,460)				(67,423)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(307,144)	(5,734)	(177,651)	14,980	(4,396)	(3,818)	(18,642)	(30,460)	(3,335)			(536,199)	45	

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 290,000	900 East Corporation	100.00%	\$	\$ (290,000)	1
2	V	33	Rent Income - RE Tax	28,925	900 East Corporation	100.00%		(28,925)	2
3	V	36	Amortization		900 East Corporation	100.00%	45,342	45,342	3
4	V	33	Real Estate Tax		900 East Corporation	100.00%	28,536	28,536	4
5	V	21	Bank Service Charges		900 East Corporation	100.00%	183	183	5
6	V	30	Depreciation		900 East Corporation	100.00%	92,913	92,913	6
7	V	32	Interest	4	900 East Corporation	100.00%	140,996	140,992	7
8	V	19	Professional Fees		900 East Corporation	100.00%	3,500	3,500	8
9	V	19	Accounting Fees		900 East Corporation	100.00%	1,725	1,725	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 318,929			\$ 313,195	\$ * (5,734)	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%	\$ 135	\$ 135	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	25	25	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	544	544	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	25	25	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	2,444	2,444	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	147	147	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	33,318	33,318	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,338	1,338	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	2,998	2,998	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	17,237	17,237	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	933	933	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	3,368	3,368	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,206	1,206	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,168	3,168	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	799	799	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	2,830	2,830	30
31	V	34	RENT		APERION CARE, INC.	100.00%	348	348	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	54	54	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	178,243	APERION CARE, INC.	100.00%		(178,243)	35
36	V	19	HOME OFFICE	70,327	APERION CARE, INC.	100.00%		(70,327)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 248,569			\$ 70,918	\$ * (177,651)	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	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 5,882	\$ 5,882	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	3,424	3,424	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,239	1,239	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	18,248	18,248	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,437	2,437	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	533	533	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	862	862	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	285	285	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	603	603	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	2,499	2,499	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	122	122	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	10	10	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	236	236	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	21,000	APERION CONSULTING, LLC	100.00%		(21,000)	34
35	V	01	DIETICIAN		APERION CONSULTING, LLC	100.00%			35
36	V	02	FOOD SERVICE		APERION CONSULTING, LLC	100.00%			36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	400	APERION CONSULTING, LLC	100.00%		(400)	38
39	Total			\$ 21,400			\$ 36,380	\$ * 14,980	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%	\$ 1,123	\$ 1,123	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	882	882	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	184	184	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	45,618	45,618	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	26	26	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	700	700	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	5,430	5,430	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	48	48	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	212	212	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	58,619	APERION FINANCIAL, LLC	100.00%		(58,619)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 58,619			\$ 54,223	\$ * (4,396)	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%	\$ 147	\$ 147	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		265	265	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		503	503	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		345	345	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		640	640	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		482	482	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		176	176	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		225	225	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		746	746	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	348	8132 N. MONTICELLO, LLC			(348)	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			\$ 7,348			\$ 3,530	\$ * (3,818)	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%	\$ 279	\$ 279	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		279	279	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		118	118	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		34	34	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		62	62	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		442	442	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		127	127	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,234	2,234	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		697	697	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		839	839	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		248	248	25
26	V	34	RENT	24,000	CHASE OFFICE,LLC			(24,000)	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			\$ 24,000			\$ 5,358	\$ * (18,642)	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	\$ 407,765	Renewal Rehab	100.00%	\$ 377,305	\$ (30,460)	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			\$ 407,765			\$ 377,305	\$ * (30,460)	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	\$ 13,889	ProPay HR LLC	24.00%	\$ 10,554	\$ (3,335)	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			\$ 13,889			\$ 10,554	\$ * (3,335)	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	04		\$			\$	\$	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.

Facility Name & ID Number

Aperion Care Bridgeport

0052688

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	FREDRICK S. FRANKEL	1.50%	Aperion Care Amboy	Amboy	900 EAST CORPORATION	CHICAGO	BLDG CO	1
2	STEVEN TUROFSKY	1.50%	Aperion Care Bloomington	Bloomington	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	2
3	DAVID BERKOWITZ TRUST	48.50%	Aperion Care Burbank	Burbank	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	YOSEF MEYSEL TRUST	48.50%	Aperion Care Chicago Heights	Chicago Heights	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	4
5			Aperion Care Colfax	Colfax	PROPAY	EVANSTON	PAYROLL SERVICES	5
6			Aperion Care Demotte	Demotte,IN	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7			Aperion Care Dolton	Dolton	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	7
8			Aperion Care Elgin	Elgin	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	8
9			Aperion Care Evanston	Evanston	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	9
10			Aperion Care Forest Park	Forest Park	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Galesburg	Galesburg	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Hidden Lake	St. Louis, MO	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	12
13			Aperion Care Highwood	Highwood	ECO-BRITE	SKOKIE	LAUNDRY	13
14			Aperion Care International	Chicago	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	14
15			Aperion Care Jacksonville	Jacksonville	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	15
16			Aperion Care Kokomo	Kokomo, IN	APERION ESTATES PERU	PERU, IN	ALF	16
17			Aperion Care Litchfield	Litchfield	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	17
18			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	19
20			Aperion Care Oak Lawn	Oak Lawn	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	20
21			Aperion Care Peru	Peru, IN	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	21
22			Aperion Care Plum Grove	Palatine	PHARMORE	SKOKIE	PHARMACY	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 Bridgeport # 0052688 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	0.00%	See Attached	0.8	2.00%	Alloc. Salary	\$ 3,874	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.4	1.00%	Alloc. Salary	598	17-7	2
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.4	2.00%	Alloc. Salary	1,429	21-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	584	21-7	4
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	3,874	17-7	5
6	Fred Frankel	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	3,574	17-7	6
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	3,715	17-7	7
8	Nosson Factor	Relative	Clerical	0.00%	See Attached	0.6	1.82%	Alloc. Salary	1,644	21-7	8
9	Meir Meystel	Relative	Clerical	0.00%	See Attached	0.1	1.45%	Alloc. Salary	510	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 anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13								TOTAL	\$ 19,802		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

7

IL478-2471

Ending: 12/31/16

Ending: 12/31/16

5

IL478-2471

Ending: 12/31/16

7

IL478-2471

Ending: 12/31/16

Ending: 12/31/16

(847) 673-6768

Ending: 12/31/16

()

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

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	First Midwest Bank		X	Mortgage			\$	2,775,000			\$	140,996	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Bank Leumi		X	Line of Credit				978,800				29,287	6
7	Insurance Policies		X									95	7
8					-								8
9	TOTAL Facility Related						\$	3,753,800			\$	170,378	9
	B. Non-Facility Related*												
10	Interest Income		X									(92)	10
11	Bldg Co - Interest Income		X									(4)	11
12	Allocated from Aperion Care		X									2,830	12
13	See Supplemental Schedule				-							1,189	13
14	TOTAL Non-Facility Related						\$				\$	3,923	14
15	TOTALS (line 9+line14)						\$	3,753,800			\$	174,301	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 Aperion Consult	X					\$					\$	10
16	Allocated from 8131 N. Montice	X											482
17	Allocated from Chase Office	X											697
18													18
19													19
20	TOTAL Non-Facility Related												1,189

* 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.				\$	27,716 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.)				\$	28,912 2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	1,196 3																				
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	28,925 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.				\$	30,121 7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2011	27,107	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2015</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td colspan="2">AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr></table>		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
	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																						
		2012		9																					
		2013	26,032	10																					
		2014	27,716	11																					
		2015	27,327	12																					
2016 Accrual = \$27,327 x 1.058 = \$28,925																									
Allocated from 8131 N. Monticello - \$746																									
Allocated from Chase Office LLC - \$839																									

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 Bridgeport</u>	COUNTY	<u>Lawrence</u>
---------------	--------------------------------	--------	-----------------

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

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 Bridgeport COUNTY Lawrence
 FACILITY IDPH LICENSE NUMBER 0052688
 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 Applicable to Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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.

A. Square Feet:23,766

B. General Construction Type:ExteriorBrickFrameBrickNumber of Stories1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$180,000	1
2	Allocated from Chase Home Office			1,203	2
3	TOTALS			\$181,203	3

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		2014	1976	\$ 2,438,000	\$ 92,913	39	\$ 62,513	\$ (30,400)	\$ 187,539	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 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)		66,522	2,009		1,704	(305)	5,615	68
69	Financial Statement Depreciation			14,572			(14,572)		69
70	TOTAL (lines 4 thru 69)		\$ 2,504,522	\$ 109,494		\$ 64,217	\$ (45,277)	\$ 193,154	70

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

Facility Name & ID Number Aperion Care Bridgeport

0052688

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 12A, Carried Forward		\$ 2,504,522	\$ 109,494		\$ 64,217	\$ (45,277)	\$ 193,154	1
2	Data & Voip Line Installation	2014	6,000		20	600	600	1,400	2
3	Computer Installation And Back-Up	2014	4,910		20	982	982	2,291	3
4	New Phone System	2014	2,598		20	260	260	584	4
5	Remodel Design Work	2014	3,150		20	158	158	328	5
6	Installed 2 New Mixing Valves	2014	4,950		20	248	248	536	6
7	Electrical Rewiring To Room 47 & 49	2015	2,500		20	125	125	167	7
8	New Cooling System With Refrigeration Lines & Pads	2015	15,000		20	3,000	3,000	4,250	8
9	Mobilization & Drilling Of Test Borings	2016	2,980		20	75	75	75	9
10	New Light System	2016	4,618		20	58	58	58	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)		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	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		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	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)		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	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		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	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)		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	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)		\$ 2,551,227	\$ 109,494		\$ 69,721	\$ (39,773)	\$ 202,843	34

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

Facility Name & ID Number Aperion Care Bridgeport

0052688

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.

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 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 Bridgeport

0052688

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		230	35	200	(30)	2,075	3
4	Allocated from Chase Office, LLC	2016	10,825	116	35	116		116	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	577	93	20	29	(64)	202	9
10	Allocated from Aperion Care	2012	164	13	20	8	(5)	41	10
11	Allocated from Aperion Care	2013	70	8	20	3	(5)	14	11
12									12
13	Allocated from 8131 N. Monticello	2010		406	20	175	(231)	1,837	13
14	Allocated from 8131 N. Monticello	2013			20	30	30	187	14
15									15
16	Allocated from Chase Office, LLC	2016	54,886	1,143	20	1,143		1,143	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)		\$ 66,522	\$ 2,009		\$ 1,704	\$ (305)	\$ 5,615	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		\$ 66,522	\$ 2,009		\$ 1,704	\$ (305)	\$ 5,615	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)		\$ 66,522	\$ 2,009		\$ 1,704	\$ (305)	\$ 5,615	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	\$ 161,746	\$ 395	\$ 16,971	\$ 16,576	10	\$ 48,578	71
72	Current Year Purchases	30,532	1,220	1,682	462	10	1,682	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 192,278	\$ 1,615	\$ 18,653	\$ 17,038		\$ 50,260	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	\$ 648	\$ 131	\$ 130	\$ (1)	5	\$ 291
77		Allocated from Aperion Consulti	2016	449	87	90	3	5	180
78									
79									
80	TOTALS			\$ 1,097	\$ 218	\$ 220	\$ 2		\$ 471

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)			\$	2,925,805
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	111,327
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	88,594
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(22,733)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	253,574

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	SAS Architects Construction	\$ 339,763
93		
94		
95		\$ 339,763

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YESNO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				2,180			5
6	Allocated from 8131 N. Monticello				176			6
7	TOTAL				\$2,356			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:

YESNO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$10,638Description: 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	Allocated from Aperion Consulting		\$	\$236	17
18					18
19					19
20					20
21	TOTAL		\$-	\$236	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.
- HFS 3745 (N-4-99)
- IL478-2471

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	\$		\$	141,919	\$		\$	141,919	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				119,518				119,518	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				146,742				146,742	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					129,554			129,554	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						11,237	30,698			41,935	13
14	TOTAL			\$		\$	419,416	\$	160,252	\$	579,668	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	158,805	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,355,962	1,355,962	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,580	77,580	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	700,000	700,000	8
9	Other(specify): <u>See Attached Schedule</u>	4,012	54,563	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,137,554	\$ 2,346,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,438,000	14
15	Leasehold Improvements, at Historical Cost	29,941	29,941	15
16	Equipment, at Historical Cost	63,636	215,636	16
17	Accumulated Depreciation (book methods)	(26,777)	(295,168)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,303,724	2,081,176	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,370,524	\$ 4,649,585	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,508,078	\$ 6,996,495	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 474,901	\$ 474,901	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	978,800	978,800	29
30	Accrued Salaries Payable	122,786	122,786	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	5,017	5,017	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,925	32
33	Accrued Interest Payable	3,339	15,474	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	28,221	28,221	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,613,064	\$ 1,654,124	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,775,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	2,154,089	2,746,226	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,154,089	\$ 5,521,226	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,767,153	\$ 7,175,350	46
47	TOTAL EQUITY(page 18, line 24)	\$ (259,075)	\$ (178,855)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,508,078	\$ 6,996,495	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (195,972)	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (195,966)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(66,776)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	45,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(41,333)	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)	\$ (63,109)	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)	\$ (259,075)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Bridgeport**

0052688

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	\$ 3,275,745	1
2	Discounts and Allowances for all Levels	877,209	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,152,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,934	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 122,934	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	17,873	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,229	19
20	Radiology and X-Ray	1,359	20
21	Other Medical Services	5,617	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	92	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 92	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)	\$ 4,303,058	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	614,289	31
32	Health Care	1,293,660	32
33	General Administration	1,278,826	33
	B. Capital Expense		
34	Ownership	410,027	34
	C. Ancillary Expense		
35	Special Cost Centers	616,631	35
36	Provider Participation Fee	156,401	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,369,834	40
41	Income before Income Taxes (line 30 minus line 40)**	(66,776)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (66,776)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,162,627	44
45	Private Pay - Net Inpatient Revenue	378,618	45
46	Medicare - Net Inpatient Revenue	1,572,003	46
47	Other-(specify) <u>Insurance</u>	39,706	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,152,954	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	1,936	1,992	\$ 63,120	\$ 31.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,178	9,426	203,386	21.58	3
4	Licensed Practical Nurses	12,908	13,723	269,854	19.66	4
5	CNAs & Orderlies	39,250	42,239	452,490	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,675	1,875	35,403	18.88	8
9	Activity Director	1,832	2,080	24,757	11.90	9
10	Activity Assistants	4,459	4,739	42,964	9.07	10
11	Social Service Workers	2,840	3,188	53,048	16.64	11
12	Dietician					12
13	Food Service Supervisor	1,824	2,080	33,543	16.13	13
14	Head Cook	5,091	5,859	55,710	9.51	14
15	Cook Helpers/Assistants	6,140	6,552	58,281	8.90	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,221	29,295	13.19	17
18	Housekeepers	8,935	10,046	96,234	9.58	18
19	Laundry	3,794	4,041	36,738	9.09	19
20	Administrator	1,880	2,080	76,074	36.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,800	4,192	91,037	21.72	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)	1,721	1,991	21,366	10.73	33
34	TOTAL (lines 1 - 33)	108,273	118,324	\$ 1,643,300 *	\$ 13.89	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	183	\$ 9,855	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,000	10-03	38
39	Pharmacist Consultant	Monthly	3,284	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	43	4,439	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 47,578		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?
If YES, give association name and amount. ICLTC - \$14,255
- (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?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,453 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. \$ 156,401
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. \$ 429 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