

		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: <u>0048496</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Burbank</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>5701 W 79th Street</u> <u>Burbank</u> <u>60459</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(708) 499-5400</u> Fax # <u>(708) 499-5571</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>10/1/2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

#	0048496	Report Period Beginning:	01/01/16	Ending:	12/31/16
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 10/01/2006

YES ☒ Date 10/01/2006 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 56 and days of care provided 5,922

IV. ACCOUNTING BASIS

ACCRUAL	X
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CASH*	
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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	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	7,341	1,613	10,586	19,540	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,341	1,613	10,586	19,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.34%

Facility Name & ID Number Aperion Care Burbank # 0048496 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	161,664	16,475	18,500	196,639		196,639	(12,868)	183,771			1
2	Food Purchase		117,100		117,100		117,100	32	117,132			2
3	Housekeeping	69,225	19,736		88,961		88,961		88,961			3
4	Laundry	33,590	2,238	54,748	90,576		90,576		90,576			4
5	Heat and Other Utilities			83,280	83,280		83,280	(6,354)	76,926			5
6	Maintenance	69,055	28,274	59,429	156,758		156,758	8,074	164,832			6
7	Other (specify):*							1,324	1,324			7
8	TOTAL General Services	333,534	183,823	215,957	733,314		733,314	(9,793)	723,521			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,126,793	51,490	17,355	1,195,638		1,195,638	6,512	1,202,150			10
10a	Therapy	66,449			66,449		66,449		66,449			10a
11	Activities	68,343	7,592	1,632	77,567		77,567		77,567			11
12	Social Services	92,203		1,280	93,483		93,483		93,483			12
13	CNA Training											13
14	Program Transportation			121	121		121		121			14
15	Other (specify):*							2,474	2,474			15
16	TOTAL Health Care and Programs	1,353,788	59,082	44,388	1,457,258		1,457,258	8,986	1,466,244			16
	C. General Administration											
17	Administrative	125,492		254,445	379,937		379,937	(221,468)	158,469			17
18	Directors Fees											18
19	Professional Services			295,523	295,523		295,523	(207,502)	88,021			19
20	Dues, Fees, Subscriptions & Promotions			100,073	100,073		100,073	(75,789)	24,284			20
21	Clerical & General Office Expenses	47,001		258,183	305,184		305,184	(156,833)	148,351			21
22	Employee Benefits & Payroll Taxes			260,006	260,006		260,006		260,006			22
23	Inservice Training & Education							385	385			23
24	Travel and Seminar			2,950	2,950		2,950	1,497	4,447			24
25	Other Admin. Staff Transportation			920	920		920	6,288	7,208			25
26	Insurance-Prop.Liab.Malpractice			144,613	144,613		144,613	1,275	145,888			26
27	Other (specify):*							8,232	8,232			27
28	TOTAL General Administration	172,493		1,316,713	1,489,206		1,489,206	(643,914)	845,292			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,859,815	242,905	1,577,058	3,679,778		3,679,778	(644,721)	3,035,057			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			92,856	92,856		92,856	43,527	136,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,485	39,485		39,485	264,343	303,828			32
33	Real Estate Taxes			190,349	190,349		190,349	5,914	196,263			33
34	Rent-Facility & Grounds			457,384	457,384		457,384	(457,215)	169			34
35	Rent-Equipment & Vehicles			5,068	5,068		5,068	935	6,003			35
36	Other (specify):*			6,239	6,239		6,239	(6,239)				36
37	TOTAL Ownership			791,381	791,381		791,381	(148,734)	642,647			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,842	627,999	778,841		778,841	(46,015)	732,826			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,686	114,686		114,686		114,686			42
43	Other (specify):*			10,514	10,514		10,514	(10,514)				43
44	TOTAL Special Cost Centers		150,842	753,199	904,041		904,041	(56,529)	847,512			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,859,815	393,747	3,121,638	5,375,200		5,375,200	(849,984)	4,525,216			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	(6,786)	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	(37,557)	30		9
10	Interest and Other Investment Income	(642)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(97)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,547)	21		18
19	Entertainment	(6,843)	21		19
20	Contributions	(76,775)	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	(201,342)	21		24
25	Fund Raising, Advertising and Promotional	(10,514)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(100,173)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (443,276)		\$	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)	(406,708)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (406,708)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (849,984)		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	Bank Charges	\$ (7,073)	21	1
2	Amortization	(6,239)	36	2
3	Building Co - Amortization	(55,263)	36	3
4	Building Co - State Replacement Tax	(275)	21	4
5	Building Co - Bank Service Charge	(160)	21	5
6	Building Co - Professional Fees	(7,040)	19	6
7	Additional R&M	7,254	06	7
8	Non-Allowable Legal	(28,582)	19	8
9	PAC Dues	(2,946)	20	9
10	Associated Behavioral Consultants PY Adj (Seminar&E:	385	23	10
11	Credit Card Processing	(64)	21	11
12	Website Expense	(170)	21	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	(100,173)		49

Aperion Care Burbank

ID#	0048496
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 Burbank # 0048496 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				(12,868)								(12,868)	1
2	Food Purchase	(97)		129									32	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,786)		23			141	268					(6,354)	5
6	Maintenance	7,254		520	(221)		254	267					8,074	6
7	Other (specify):*			24	1,187			113					1,324	7
8	TOTAL General Services	371		696	(11,902)		395	648					(9,793)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,340	4,172								6,512	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			141	2,333								2,474	15
16	TOTAL Health Care and Programs			2,481	6,505								8,986	16
	C. General Administration													
17	Administrative			(222,544)		1,075							(221,468)	17
18	Directors Fees													18
19	Professional Services	(35,622)	7,040	(97,118)	511	(80,102)	481	32		(2,726)			(207,502)	19
20	Fees, Subscriptions & Promotions	(79,721)		2,871	826	176		59					(75,789)	20
21	Clerical & General Office Expenses	(218,474)	435	16,503	273	43,677	331	423					(156,833)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education	385											385	23
24	Travel and Seminar			894	578	25							1,497	24
25	Other Admin. Staff Transportation			3,225	2,393	670							6,288	25
26	Insurance-Prop.Liab.Malpractice			1,154				121					1,275	26
27	Other (specify):*			3,033		5,199							8,232	27
28	TOTAL General Administration	(333,432)	7,475	(291,981)	4,581	(29,279)	812	636		(2,726)			(643,914)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(333,061)	7,475	(288,804)	(817)	(29,279)	1,207	1,284		(2,726)			(644,721)	29

Summary B

12/31/16

	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)	
	Depreciation	(37,557)	77,405	765	117	46	613	2,139					43,527	30
	Amortization of Pre-Op. & Org.													31
	Interest	(642)	261,137	2,710	9		462	667					264,343	32
	Real Estate Taxes		4,397				714	803					5,914	33
	Rent-Facility & Grounds		(426,384)	333			(7,164)	(24,000)					(457,215)	34
	Rent-Equipment & Vehicles			52	226	203	216	238					935	35
	Other (specify):*	(61,502)	55,263										(6,239)	36
	TOTAL Ownership	(99,701)	(28,182)	3,860	352	249	(5,160)	(20,153)					(148,734)	37
	Ancillary Expense													
	E. Special Cost Centers													
	Medically Necessary Transportation													38
	Ancillary Service Centers								(46,015)				(46,015)	39
	Barber and Beauty Shops													40
	Coffee and Gift Shops													41
	Provider Participation Fee													42
	Other (specify):*	(10,514)											(10,514)	43
	TOTAL Special Cost Centers	(10,514)							(46,015)				(56,529)	44
	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(443,276)	(20,707)	(284,944)	(464)	(29,030)	(3,953)	(18,869)	(46,015)	(2,726)			(849,984)	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	\$ 426,384	Exceptional NRC Realty	100.00%	\$	(426,384)	1
2	V	36	Amortization		Exceptional NRC Realty	100.00%	55,263	55,263	2
3	V	33	Rent Income -RE Taxes	190,349	Exceptional NRC Realty	100.00%	194,746	4,397	3
4	V	21	State Replacement Tax		Exceptional NRC Realty	100.00%	275	275	4
5	V	19	Home Office Expense		Exceptional NRC Realty	100.00%			5
6	V	21	Bank Service Charges		Exceptional NRC Realty	100.00%	160	160	6
7	V	30	Depreciation		Exceptional NRC Realty	100.00%	77,405	77,405	7
8	V	32	Interest		Exceptional NRC Realty	100.00%	261,137	261,137	8
9	V	19	Professional Fees		Exceptional NRC Realty	100.00%	1,200	1,200	9
10	V	19	Accounting Fees		Exceptional NRC Realty	100.00%	1,575	1,575	10
11	V	19	Legal Fees		Exceptional NRC Realty	100.00%	4,265	4,265	11
12	V								12
13	V								13
14	Total			\$ 616,733			\$ 596,026	\$ * (20,707)	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%	\$ 129	\$ 129	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	23	23	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	520	520	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	24	24	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	2,340	2,340	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	141	141	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	31,901	31,901	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,282	1,282	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	2,871	2,871	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	16,503	16,503	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	894	894	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	3,225	3,225	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,154	1,154	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,033	3,033	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	765	765	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	2,710	2,710	30
31	V	34	RENT		APERION CARE, INC.	100.00%	333	333	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	52	52	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	254,445	APERION CARE, INC.	100.00%		(254,445)	35
36	V	19	HOME OFFICE	98,400	APERION CARE, INC.	100.00%		(98,400)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 352,845			\$ 67,901	\$ * (284,944)	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%	\$ 5,632	\$ 5,632	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	3,279	3,279	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,187	1,187	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	17,472	17,472	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,333	2,333	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	511	511	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	826	826	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	273	273	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	578	578	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	2,393	2,393	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	117	117	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	9	9	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	226	226	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	13,300	APERION CONSULTING, LLC	100.00%		(13,300)	34
35	V	01	DIETICIAN	12,900	APERION CONSULTING, LLC	100.00%		(12,900)	35
36	V	01	FOOD SERVICE	5,600	APERION CONSULTING, LLC	100.00%		(5,600)	36
37	V	06	PAINTER	2,000	APERION CONSULTING, LLC	100.00%		(2,000)	37
38	V	06	PROJECT MANAGER	1,500	APERION CONSULTING, LLC	100.00%		(1,500)	38
39	Total			\$ 35,300			\$ 34,836	\$ * (464)	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%	\$ 1,075	\$ 1,075	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	844	844	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	176	176	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	43,677	43,677	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	25	25	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	670	670	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	5,199	5,199	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	46	46	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	203	203	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	80,946	APERION FINANCIAL, LLC	100.00%		(80,946)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 80,946			\$ 51,916	\$ * (29,030)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 141	\$ 141	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		254	254	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		481	481	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		331	331	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		613	613	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		462	462	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		169	169	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		216	216	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		714	714	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	333	8131 N. MONTICELLO, LLC			(333)	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			\$ 7,333			\$ 3,380	\$ * (3,953)	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%	\$ 268	\$ 268	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		267	267	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		113	113	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		32	32	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		59	59	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		423	423	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		121	121	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,139	2,139	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		667	667	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		803	803	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		238	238	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			\$ 5,131	\$ * (18,869)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 615,999	Renewal Rehab	100.00%	\$ 569,984	\$ (46,015)	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			\$ 615,999			\$ 569,984	\$ * (46,015)	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	\$ 11,360	ProPay HR LLC	24.00%	\$ 8,634	\$ (2,726)	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			\$ 11,360			\$ 8,634	\$ * (2,726)	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	4	Laundry Services	\$ 54,748	EcoBrite Linen	100.00%	\$ 54,748	\$	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			\$ 54,748			\$ 54,748	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

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

Facility Name & ID Number

Aperion Care Burbank

0048496

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	Yosef Meystel Trust	60.00%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	42170 LP	10.00%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	1219 LP	10.00%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	257 LP	19.00%	Aperion Care Chicago Heights	Chicago Heights	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	350 LP	1.00%	Aperion Care Colfax	Colfax	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			Aperion Care Demotte	Demotte,IN	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Dolton	Dolton	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Elgin	Elgin	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Evanston	Evanston	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Forest Park	Forest Park	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Galesburg	Galesburg	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Hidden Lake	St. Louis, MO	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Highwood	Highwood	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care International	Chicago	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care Jacksonville	Jacksonville	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Kokomo	Kokomo, IN	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Oak Lawn	Oak Lawn	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Peru	Peru, IN	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Plum Grove	Palatine	EXCEPTIONAL NRC REALTY	BURBANK	BUILDING CO	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 Burbank # 0048496 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attachment	0.7	1.75%	Alloc Salary	\$ 3,709	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attachment	0.4	1.00%	Alloc Salary	573	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attachment	0.4	2.00%	Alloc Salary	1,369	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attachment	0.1	3.03%	Alloc Salary	559	21-7	4
5	Meir Meystel	Relative	Clerical	0%	See Attachment	0.1	1.45%	Alloc Salary	488	21-7	5
6	Nosson Factor	Relative	Clerical	0%	See Attachment	0.6	1.82%	Alloc Salary	1,574	21-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 8,272		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number	Aperion Care Burbank
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0048496

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

Ending: 12/31/16

Facility Name & ID Number	Aperion Care Burbank
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0048496

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

APERION CONSULTING, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

7

	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	19,540	\$ 5,632	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	19,540	3,279	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		19,540	1,187	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	19,540	17,472	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		19,540	2,333	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		19,540	511	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		19,540	826	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		19,540	273	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		19,540	578	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		19,540	2,393	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		19,540	117	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		19,540	9	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		19,540	226	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		\$ 34,836	25

Ending: 12/31/16

7

Ending: 12/31/16

7

IL478-2471

Facility Name & ID Number	Aperion Care Burbank
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0048496

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 262-3800

Fax Number

7

	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	\$	19,540	\$ 268	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		19,540	267	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		19,540	113	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		19,540	32	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		19,540	59	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		19,540	423	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		19,540	121	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		19,540	2,139	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		19,540	667	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		19,540	803	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		19,540	238	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	\$		\$ 5,131	25

Facility Name & ID Number	Aperion Care Burbank
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0048496

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Renewal Rehab

Street Address

4655 W Chase Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 673-6767

Fax Number

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services		56	\$	\$		\$ 569,984	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				\$	\$		\$ 569,984	25

Ending: 12/31/16

()

Fax NumberIL478-2471

Ending: 12/31/16

()

IL478-2471

Facility Name & ID Number	Aperion Care Burbank
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0048496

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	First Midwest Bank		X	Mortgage Payable			\$		\$	7,350,000			\$	261,137	1				
2															2				
3															3				
4															4				
5					-										5				
	Working Capital																		
6	First Midwest Bank		X	Line of Credit						984,115				36,122	6				
7	Omnicare		X	Insurance										3,363	7				
8					-										8				
9	TOTAL Facility Related						\$		\$	8,334,115				\$	300,622	9			
	B. Non-Facility Related*																		
10	Interest Income		X											(642)	10				
11	Allocated from Aperion Care	X												2,710	11				
12	Allocated from Aperion Consult	X												9	12				
13	See Supplemental Schedule				-									1,129	13				
14	TOTAL Non-Facility Related						\$		\$					\$	3,206	14			
15	TOTALS (line 9+line14)						\$		\$	8,334,115				\$	303,828	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # NA

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

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

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

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from 8131 N Montice	X		Interest Expense			\$					\$	462
16	Allocated from Chase Office, LI	X		Interest Expense									667
17													17
18													18
19													19
20	TOTAL Non-Facility Related												1,129

* 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.			\$	<u>173,230</u>	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.)			\$	<u>184,647</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>11,417</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>184,846</u>	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.			\$	<u>196,263</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	<u>113,809</u>	8	
		2012	<u>120,835</u>	9	
		2013	<u>125,783</u>	10	
		2014	<u>177,627</u>	11	
		2015	<u>183,130</u>	12	
2016 Accrual = 2015 Real Estate Tax (Rounded)					
\$4397 Adjust to Beginning Accrual					
Allocated from 8131 N Monticello = \$714					
Allocated from Chase Office, LLC = \$803					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Aperion Care Burbank</u>	COUNTY	<u>Cook</u>
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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 NAMEAperion Care BurbankCOUNTYCook

FACILITY IDPH LICENSE NUMBER0048496

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847) 236-6300FAX #:(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.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	13,728	B. General Construction Type:	Exterior	Brick	Frame	Steel	Number of Stories	1
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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		2013	\$ 124,143	1
2	Allocated from 8131 N Monticello, LLC			1,152	2
3	TOTALS			\$ 125,295	3

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

0048496

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		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	56		2013	1972	\$ 1,902,416	\$ 77,405	39	\$ 48,780	\$ (28,625)	\$ 195,120	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			2007	4,773		20	318	318	3,023	9	
10	Various			2008	51,421		20	3,622	3,622	45,067	10	
11	Various			2009	34,839		20	1,370	1,370	29,485	11	
12	Various			2010	124,447		20	8,193	8,193	53,224	12	
13	Various			2011	25,485		20	1,349	1,349	7,671	13	
14	Various			2012	222,218		20	14,128	14,128	62,853	14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Burbank# 0048496

Report Period Beginning:

01/01/16

Ending:

12/31/16**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		63,674	1,923		1,633	(290)	5,375	68
69	Financial Statement Depreciation			92,856			(92,856)		69
70	TOTAL (lines 4 thru 69)		\$ 2,429,273	\$ 172,184		\$ 79,393	\$ (92,791)	\$ 401,818	70

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

Facility Name & ID Number Aperion Care Burbank

0048496

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,429,273	\$ 172,184		\$ 79,393	\$ (92,791)	\$ 401,818	1
2	Installation Of Ap Tac Units, Sleeves & Outlets	2013	23,140		20	1,157	1,157	3,953	2
3	Elevator Work - 2 New Car Gates, 1 New Complete Cab	2013	8,460		20	423	423	1,445	3
4	Sprinkler System	2013	7,315		20	366	366	1,463	4
5	International Paving 11287 - Alternate Patch For Overlay Patch "	2014	7,426		20	495	495	1,238	5
6	Protective Fire And Safety 404 - Fire Alarm System	2014	4,800		20	240	240	720	6
7	Illuminated Post And Panel Installation	2014	6,624		20	442	442	994	7
8	Labor & Materials To Install Tv Signal	2014	3,984		20	797	797	1,793	8
9	Installation Of Cables & Wall Mount Rack For Voice System	2015	3,422		20	171	171	242	9
10	Concrete Work For Sidwalk Patio And Ramp	2015	22,494		20	1,125	1,125	1,500	10
11	New Door	2015	3,850		20	192	192	241	11
12	New Chair Rail	2015	6,262		20	313	313	444	12
13	Curtains	2015	9,045		20	452	452	603	13
14	5 Air Conditioners	2015	4,134		20	207	207	396	14
15	New Spanish Quarry Floor In Dishwashing Room	2015	14,950		20	748	748	997	15
16	Resident Room/Bathroom - Vinyl Floor / Cove Base / Lights	2015	69,045		20	3,452	3,452	6,329	16
17	Installed New 240 Volt Amp Outlets-Dining & Excercise Rooms	2015	3,752		20	188	188	375	17
18	Window Treatments, Carpet, Lighting Offices	2016	5,120		20	256	256	256	18
19	Don & Mds Office Carpet, Lighting	2016	2,758		20	138	138	138	19
20	Therapy Rm - Wallcovering, Window Treatments, Millwork, Base	2016	19,866		20	993	993	993	20
21	Hallway Corridor - Vestibule Lighting, Wallcovering, Millwork	2016	27,206		20	1,360	1,360	1,360	21
22	Admin, Admiss, Mds, Don Offices - Installed Wallcovering	2016			20				22
23	Painted Doors, Reninstalled Hardware	2016	37,935		20	1,897	1,897	1,897	23
24	Admissions And Admin Offices -Prepared Flooring, Installed Dro	2016	17,360		20	868	868	868	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)		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

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 12B, Carried Forward		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	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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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)		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	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)		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	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)		\$ 2,738,220	\$ 172,184		\$ 95,673	\$ (76,511)	\$ 430,062	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

Facility Name & ID Number Aperion Care Burbank

0048496

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

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 LLC	2010		221	39	192	(29)	1,987	3
4	Allocated form Chase Office, LLC	2016	10,365	111	39	111		111	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello LLC	2010		389	20	168	(221)	1,759	9
10	Allocated from 8131 N. Monticello LLC	2013			20	29	29	179	10
11									11
12	Allocated from Aperion Care	2010	553	89	10	28	(61)	193	12
13	Allocated from Aperion Care	2012	157	12	15	8	(4)	39	13
14	Allocated from Aperion Care	2013	67	7	10	3	(4)	13	14
15									15
16	Allocated from Chase Office, LLC	2016	52,532	1,094	20	1,094		1,094	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)		\$ 63,674	\$ 1,923		\$ 1,633	\$ (290)	\$ 5,375	34

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

Facility Name & ID Number Aperion Care Burbank

0048496

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 12H, Carried Forward		\$ 63,674	\$ 1,923		\$ 1,633	\$ (290)	\$ 5,375	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 63,674	\$ 1,923		\$ 1,633	\$ (290)	\$ 5,375	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	\$ 310,390	\$ 379	\$ 37,268	\$ 36,889	10	\$ 166,229	71
72	Current Year Purchases	59,574	1,169	3,235	2,066	10	3,235	72
73	Fully Depreciated Assets	90,411				10	90,411	73
74								74
75	TOTALS	\$ 460,376	\$ 1,548	\$ 40,503	\$ 38,955		\$ 259,875	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	\$ 620	\$ 126	\$ 124	\$ (2)	5	\$ 124
77		Allocated from Aperion Consulti	2016	430	84	86	2	5	86
78									
79									
80	TOTALS			\$ 1,050	\$ 210	\$ 210	\$		\$ 210

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)			\$ 3,324,941	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 173,942	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 136,385	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (37,557)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 690,147	

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	Resident Rooms/bathrooms	\$ 18,894
93	and awnings	
94		
95		\$ 18,894

* 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?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from 8131 N Monticello				169			5
6								6
7	TOTAL				\$169			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: \$5,777
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Consulting		\$	\$226	17
18					18
19					19
20					20
21	TOTAL		\$-	\$226	21

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.)

12345678										
	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	\$		\$ 276,341	\$		\$ 276,341	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,118			36,118	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			303,541			303,541	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				147,546		147,546	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					11,999	3,296		15,295	13
14	TOTAL			\$		\$ 627,999	\$ 150,842		\$ 778,841	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	\$ 18,161	\$ 271,227	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,587,125	1,587,125	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	199,059	199,059	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		387,387	8
9	Other(specify): <u>See Attached Schedule</u>	4,447	102,884	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,808,792	\$ 2,547,682	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		239,130	13
14	Buildings, at Historical Cost		817,826	14
15	Leasehold Improvements, at Historical Cost	788,103	788,103	15
16	Equipment, at Historical Cost	315,306	597,480	16
17	Accumulated Depreciation (book methods)	(496,028)	(772,522)	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>	5,010,039	10,843,443	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,617,420	\$ 12,513,460	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,426,212	\$ 15,061,142	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 421,756	\$ 421,756	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	984,115	984,115	29
30	Accrued Salaries Payable	135,521	135,521	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,271	4,271	31
32	Accrued Real Estate Taxes(Sch.IX-B)		184,846	32
33	Accrued Interest Payable	3,394	35,535	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	5,011	5,011	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,554,068	\$ 1,771,055	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,350,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	6,283,813	6,283,813	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,283,813	\$ 13,633,813	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,837,881	\$ 15,404,868	46
47	TOTAL EQUITY(page 18, line 24)	\$ (411,669)	\$ (343,726)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,426,212	\$ 15,061,142	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (390,358)	1
2	Restatements (describe):		2
3	Depreciation Expense	29,803	3
4	Bad Debt	(75,000)	4
5	Misc Expense	7,081	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (428,474)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	606,680	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	(589,875)	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)	\$ 16,805	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)	\$ (411,669)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Burbank**# **0048496**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	\$ 4,220,774	1
2	Discounts and Allowances for all Levels	1,692,423	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,913,197	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,004	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 60,004	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,281	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	564	19
20	Radiology and X-Ray	16	20
21	Other Medical Services	176	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,037	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	642	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 642	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)	\$ 5,981,880	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	733,314	31
32	Health Care	1,457,258	32
33	General Administration	1,489,206	33
	B. Capital Expense		
34	Ownership	791,381	34
	C. Ancillary Expense		
35	Special Cost Centers	789,355	35
36	Provider Participation Fee	114,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,375,200	40
41	Income before Income Taxes (line 30 minus line 40)**	606,680	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 606,680	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,570,713	44
45	Private Pay - Net Inpatient Revenue	330,899	45
46	Medicare - Net Inpatient Revenue	3,101,212	46
47	Other-(specify) <u>Insurance/Managed Care</u>	910,373	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,913,197	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	2,010	3,142	\$ 124,059	\$ 39.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,145	11,981	400,327	33.41	3
4	Licensed Practical Nurses	7,810	8,615	229,585	26.65	4
5	CNAs & Orderlies	31,316	33,694	372,822	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,378	3,733	66,449	17.80	8
9	Activity Director	1,904	2,080	31,325	15.06	9
10	Activity Assistants	3,757	3,869	37,018	9.57	10
11	Social Service Workers	3,800	4,077	92,203	22.62	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	30,662	14.74	13
14	Head Cook	5,305	5,837	73,878	12.66	14
15	Cook Helpers/Assistants	5,410	5,882	57,124	9.71	15
16	Dishwashers					16
17	Maintenance Workers	3,987	4,385	69,055	15.75	17
18	Housekeepers	5,832	6,544	69,225	10.58	18
19	Laundry	3,041	3,509	33,590	9.57	19
20	Administrator	2,032	2,240	119,152	53.19	20
21	Assistant Administrator	384	400	6,340	15.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,525	3,906	47,001	12.03	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)					33
34	TOTAL (lines 1 - 33)	95,612	105,974	\$ 1,859,815 *	\$ 17.55	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 18,500	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	13,300	10-03	38
39	Pharmacist Consultant	Monthly	4,055	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	28	1,632	11-03	44
45	Social Service Consultant	21	1,280	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 62,767		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.

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Burbank

0048496

Report Period Beginning: 01/01/16

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Akeem Abiola</u>	<u>Administrator</u>	<u>0</u>	\$ <u>119,152</u>	<u>Workers' Compensation Insurance</u>	\$ <u>12,524</u>	<u>IDPH License Fee</u>	\$	
<u>Aryeh Russell</u>	<u>Asst Admin</u>	<u>0</u>	<u>6,340</u>	<u>Unemployment Compensation Insurance</u>	<u>16,623</u>	<u>Advertising: Employee Recruitment</u>	<u>235</u>	
				<u>FICA Taxes</u>	<u>140,068</u>	<u>Health Care Worker Background Check</u>	<u>410</u>	
				<u>Employee Health Insurance</u>	<u>72,874</u>	<u>(Indicate # of checks performed <u>41</u>)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>68</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>12,515</u>	
				<u>Union Pension Fund</u>	<u>13,528</u>	<u>License and Permits</u>	<u>6,512</u>	
				<u>401K Expense</u>		<u>Allocated from Aperion Care</u>	<u>2,871</u>	
				<u>Employee Physicals</u>	<u>720</u>	<u>Allocated from Aperion Consulting</u>	<u>826</u>	
				<u>Employee Meals</u>	<u>381</u>	<u>See Supplemental Schedule</u>	<u>235</u>	
				<u>Other Employee Benefits</u>	<u>3,288</u>	<u>Less: Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>125,492</u>	TOTAL (agree to Schedule V, line 22, col.8)		\$ <u>260,006</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Aperion Care, Inc.</u>			\$ <u>254,445</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ <u>254,445</u>					
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>See Attached</u>	<u>Legal</u>		\$ <u>29,178</u>					
<u>Creative Technology Solutions</u>	<u>Data Processing</u>		<u>8,612</u>					
<u>National Datacare Corporation</u>	<u>Data Processing</u>		<u>3,576</u>					
<u>Wescom Solution</u>	<u>Data Processing</u>		<u>13,495</u>					
<u>Galaxy Hosted Software</u>	<u>Data Processing</u>		<u>3,000</u>					
<u>Aperion Care, Inc</u>	<u>Data Processing</u>		<u>7,944</u>					
<u>E-Health Data Solutions</u>	<u>Data Processing</u>		<u>900</u>					
<u>Ability Network</u>	<u>Data Processing</u>		<u>3,913</u>				<u>Seminar Expense</u>	<u>2,950</u>
<u>Dmitry Kantarovich</u>	<u>Data Processing</u>		<u>1,040</u>				<u>Allocated from Aperion Care</u>	<u>894</u>
<u>Point Click Care</u>	<u>Data Processing</u>		<u>1,265</u>				<u>Allocated from Aperion Consulting</u>	<u>578</u>
<u>Aperion Care, Inc</u>	<u>Home Office</u>		<u>98,400</u>				<u>See Supplemental Schedule</u>	<u>25</u>
<u>See Supplemental Schedule</u>			<u>124,198</u>				<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ <u>295,522</u>	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ <u>4,447</u>

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. Il Council on LTC \$8926
- (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. \$ 10,328 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. \$ 114,686
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? _____ For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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