

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051151

Facility Name: Aperion Care Dolton

Address: 14325 S Blackstone Dolton 60419
Number City Zip Code

County: Cook

Telephone Number: (708)849-5000 Fax # (708)849-3190

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2010

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

#	0051151	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 10/1/2010

YES ☒ Date 10/1/2010 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 39 and days of care provided

IV. ACCOUNTING BASIS

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

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.51%

91.51%

Facility Name & ID Number Aperion Care Dolton # 0051151 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	183,667	14,277	25,326	223,270		223,270	(14,667)	208,603			1
2	Food Purchase		150,596		150,596		150,596	(2,787)	147,809			2
3	Housekeeping	119,101	17,593		136,694		136,694		136,694			3
4	Laundry	793	5,819	94,541	101,153		101,153		101,153			4
5	Heat and Other Utilities			78,281	78,281		78,281	(3,694)	74,587			5
6	Maintenance	47,193	21,635	43,948	112,776		112,776	10,951	123,727			6
7	Other (specify):*							1,814	1,814			7
8	TOTAL General Services	350,754	209,920	242,096	802,770		802,770	(8,384)	794,386			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,350,549	84,146	53,620	1,488,315		1,488,315	(20,735)	1,467,580			10
10a	Therapy	84,212	1,304		85,516		85,516		85,516			10a
11	Activities	107,683	13,152	4,023	124,858		124,858		124,858			11
12	Social Services	76,878		720	77,598		77,598		77,598			12
13	CNA Training											13
14	Program Transportation			2,002	2,002		2,002		2,002			14
15	Other (specify):*							3,392	3,392			15
16	TOTAL Health Care and Programs	1,619,322	98,602	75,365	1,793,289		1,793,289	(17,343)	1,775,946			16
	C. General Administration											
17	Administrative	121,137		294,127	415,264		415,264	(248,910)	166,354			17
18	Directors Fees											18
19	Professional Services			343,901	343,901	(20,120)	323,781	(203,507)	120,274			19
20	Dues, Fees, Subscriptions & Promotions			122,688	122,688		122,688	(74,478)	48,210			20
21	Clerical & General Office Expenses	103,774		253,984	357,758		357,758	(127,396)	230,362			21
22	Employee Benefits & Payroll Taxes			579,056	579,056		579,056		579,056			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,432	5,432		5,432	2,053	7,485			24
25	Other Admin. Staff Transportation			2,378	2,378		2,378	8,622	11,000			25
26	Insurance-Prop.Liab.Malpractice			122,585	122,585		122,585	1,749	124,334			26
27	Other (specify):*							11,288	11,288			27
28	TOTAL General Administration	224,911		1,724,151	1,949,062	(20,120)	1,928,942	(630,578)	1,298,364			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,194,987	308,522	2,041,612	4,545,121	(20,120)	4,525,001	(656,305)	3,868,696			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			57,987	57,987		57,987	(18,218)	39,769			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,718	34,718		34,718	3,533	38,251			32
33	Real Estate Taxes			327,528	327,528	20,120	347,648	2,080	349,728			33
34	Rent-Facility & Grounds			538,306	538,306		538,306	(30,769)	507,537			34
35	Rent-Equipment & Vehicles			10,589	10,589		10,589	1,282	11,871			35
36	Other (specify):*			16,417	16,417		16,417	(16,417)				36
37	TOTAL Ownership			985,545	985,545	20,120	1,005,665	(58,508)	947,157			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,992	494,956	640,948		640,948	(35,535)	605,413			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,119	179,119		179,119		179,119			42
43	Other (specify):*			7,743	7,743		7,743	(7,743)	(0)			43
44	TOTAL Special Cost Centers		145,992	681,818	827,810		827,810	(43,278)	784,532			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,194,987	454,514	3,708,975	6,358,476		6,358,476	(758,091)	5,600,385			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	(4,287)	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	(23,264)	30		9
10	Interest and Other Investment Income	(1,744)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(28)	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	(5,074)	21		18
19	Entertainment	(13,234)	21		19
20	Contributions	(75,750)	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	(171,782)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,130)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,802)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (341,095)		\$	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)	(416,996)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (416,996)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (758,091)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (6,300)	43	1
2	Marketing Fees - YAM	(1,250)	43	2
3	Promotional Products	(193)	43	3
4	Bank Charges	(9,470)	21	4
5	Theft & Damage Loss	(1,803)	21	5
6	Amortization	(16,417)	36	6
7	Additional R&M	6,577	06	7
8	PAC Dues	(4,118)	20	8
9	Non Allowable Legal Fees	(2,999)	19	9
10	Credit Card Processing	(829)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,802)		49

Aperion Care Dolton

ID#	0051151
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 Dolton # 0051151 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				(14,667)								(14,667)	1
2	Food Purchase	(28)		177	(2,936)								(2,787)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,287)		32			194	367					(3,694)	5
6	Maintenance	6,577		714	2,946		348	367					10,951	6
7	Other (specify):*			32	1,627			155					1,814	7
8	TOTAL General Services	2,262		955	(13,030)		541	888					(8,384)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,208	(23,943)								(20,735)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			193	3,199								3,392	15
16	TOTAL Health Care and Programs			3,401	(20,744)								(17,343)	16
	C. General Administration													
17	Administrative			(250,384)		1,475							(248,910)	17
18	Directors Fees													18
19	Professional Services	(2,999)		(108,889)	700	(89,242)	660	44		(3,782)			(203,507)	19
20	Fees, Subscriptions & Promotions	(79,868)		3,936	1,132	241		81					(74,478)	20
21	Clerical & General Office Expenses	(211,323)		22,629	374	59,890	453	580					(127,396)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,226	792	35							2,053	24
25	Other Admin. Staff Transportation			4,422	3,281	919							8,622	25
26	Insurance-Prop.Liab.Malpractice			1,583				166					1,749	26
27	Other (specify):*			4,159		7,129							11,288	27
28	TOTAL General Administration	(294,189)		(321,318)	6,279	(19,554)	1,114	872		(3,782)			(630,578)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(291,927)		(316,962)	(27,495)	(19,554)	1,655	1,760		(3,782)			(656,305)	29

Summary B

12/31/16

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(23,264)		1,049	161	63	840	2,933					(18,218)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,744)		3,716	13		633	915					3,533	32
33	Real Estate Taxes						979	1,101					2,080	33
34	Rent-Facility & Grounds			457			(7,226)	(24,000)					(30,769)	34
35	Rent-Equipment & Vehicles			71	310	279	296	326					1,282	35
36	Other (specify):*	(16,417)											(16,417)	36
37	TOTAL Ownership	(41,425)		5,293	484	342	(4,477)	(18,725)					(58,508)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(35,535)				(35,535)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,743)											(7,743)	43
44	TOTAL Special Cost Centers	(7,743)							(35,535)				(43,278)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(341,095)		(311,669)	(27,011)	(19,213)	(2,822)	(16,965)	(35,535)	(3,782)			(758,091)	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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

YES

X NO

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

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

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	100.00%	\$ 177	\$ 177	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	32	32	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	714	714	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	32	32	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	3,208	3,208	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	193	193	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	43,743	43,743	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,757	1,757	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,936	3,936	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	22,629	22,629	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,226	1,226	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	4,422	4,422	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,583	1,583	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,159	4,159	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,049	1,049	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	3,716	3,716	30
31	V	34	RENT		APERION CARE, INC.	100.00%	457	457	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	71	71	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	294,127	APERION CARE, INC.	100.00%		(294,127)	35
36	V	19	HOME OFFICE	110,646	APERION CARE, INC.	100.00%		(110,646)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 404,773			\$ 93,104	\$ * (311,669)	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%	\$ 7,723	\$ 7,723	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	4,496	4,496	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,627	1,627	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	23,957	23,957	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,199	3,199	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	700	700	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,132	1,132	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	374	374	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	792	792	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,281	3,281	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	161	161	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	13	13	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	310	310	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	47,900	APERION CONSULTING, LLC	100.00%		(47,900)	34
35	V	01	DIETICIAN	22,390	APERION CONSULTING, LLC	100.00%		(22,390)	35
36	V	02	FOOD SERVICE	2,936	APERION CONSULTING, LLC	100.00%		(2,936)	36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	1,550	APERION CONSULTING, LLC	100.00%		(1,550)	38
39	Total			\$ 74,776			\$ 47,765	\$ * (27,011)	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%	\$ 1,475	\$ 1,475	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,158	1,158	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	241	241	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	59,890	59,890	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	35	35	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	919	919	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	7,129	7,129	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	63	63	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	279	279	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	90,400	APERION FINANCIAL, LLC	100.00%		(90,400)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 90,400			\$ 71,188	\$ * (19,213)	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%	\$ 194	\$	194
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		348		348
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		660		660
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		453		453
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		840		840
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		633		633
21	V	34	RENT		8131 N. MONTICELLO, LLC		231		231
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		296		296
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		979		979
24	V								
25	V								
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)
27	V	34	RENT	457	8132 N. MONTICELLO, LLC				(457)
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 7,457			\$ 4,635	\$ *	(2,822)

* 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%	\$ 367	\$ 367	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		367	367	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		155	155	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		44	44	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		81	81	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		580	580	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		166	166	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,933	2,933	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		915	915	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,101	1,101	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		326	326	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			\$ 7,035	\$ * (16,965)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 475,696	Renewal Rehab	100.00%	\$ 440,161	\$ (35,535)	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			\$ 475,696			\$ 440,161	\$ * (35,535)	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	\$ 15,751	ProPay HR LLC	24.00%	\$ 11,969	\$ (3,782)	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			\$ 15,751			\$ 11,969	\$ * (3,782)	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	04	Laundry Services	\$ 94,541	EcoBrite Linen	100.00%	\$ 94,541	\$	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			\$ 94,541			\$ 94,541	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES☐ NO

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

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

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

Facility Name & ID Number

Aperion Care Dolton

0051151

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	39.00%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	Jay Meystel Trust	4.00%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Steven Turofsky	1.00%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Frederick S. Frankel	1.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	David A. Berkowitz Trust	47.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Joel Meystel	8.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Demotte	Demotte,IN	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				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 Dolton # 0051151 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1	2.50%	Alloc. Salary	\$ 5,086	17-07	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc. Salary	785	17-07	2
3	Joel Meystel	Shareholder	Clerical	8.00%	See Attached	0.5	2.50%	Mgmt/Al Sal	1,876	21-07	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	767	21-07	4
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1	2.50%	Alloc. Salary	5,086	17-07	5
6	Fred Frankel	Shareholder	Administrative	1.00%	See Attached	1	2.50%	Alloc. Salary	4,692	17-07	6
7	Steve Turofsky	Shareholder	Administrative	1.00%	See Attached	1	2.50%	Alloc. Salary	4,878	17-07	7
8	Nosson Factor	Relative	Clerical	0.00%	See Attached	0.8	2.43%	Alloc. Salary	2,158	21-07	8
9	Meir Meystel	Relative	Clerical	0.00%	See Attached	0.2	2.90%	Alloc. Salary	669	21-07	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	\$ 25,997		13

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

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

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

7

Ending: 12/31/16

7

IL478-2471

Ending: 12/31/16

Ending: 12/31/16

((847) 673-6768

IL478-2471

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

0051151

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

ProPay HR LLC

Street Address

2201 W. MAIN ST

City / State / Zip Code

EVANSTON , ILLINOIS 60202

Phone Number

(847) 905-3268

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			\$	\$		\$ 11,969	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 11,969	25

Ending: 12/31/16

()

Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				1,013,250				31,800	6
7	Insurance Policies		X									2,918	7
8					-								8
9	TOTAL Facility Related						\$	1,013,250			\$	34,718	9
	B. Non-Facility Related*												
10	Interest Income		X									(1,744)	10
11	Allocated from Aperion Care	X										3,716	11
12	Allocated from Aperion Consult	X										13	12
13	See Supplemental Schedule				-							1,548	13
14	TOTAL Non-Facility Related						\$				\$	3,533	14
15	TOTALS (line 9+line14)						\$	1,013,250			\$	38,251	15

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

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from 8131 N. Montice	X					\$		\$			\$	633
16	Allocated from Chase Office LI	X											915
17													17
18													18
19													19
20	TOTAL Non-Facility Related												1,548

* 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.			\$ 319,423	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.)			\$ 325,555	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 6,132	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 323,475	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.)			\$ 20,120	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 \$ 59,380 For 2012, 2013 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.			\$ 349,727	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	280,833	8	
	2012	304,881	9	
	2013	317,324	10	
	2014	319,423	11	
	2015	323,475	12	
2016 Accrual = 2015 Tax Bills				
Allocated from 8131 N. Monticello - \$979				
Allocated from Chase Office LLC - \$1,101				

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

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.

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 DoltonCOUNTYCook

FACILITY IDPH LICENSE NUMBER0051151

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:

17,952

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

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	Allocated from Chase Office, LLC			\$1,579	1
2					2
3	TOTALS			\$1,579	3

Facility Name & ID Number Aperion Care Dolton

0051151

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)		87,307	2,637		2,240	(397)	7,371	68
69	Financial Statement Depreciation			57,987			(57,987)		69
70	TOTAL (lines 4 thru 69)		\$ 380,511	\$ 60,624		\$ 24,418	\$ (36,206)	\$ 128,647	70

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

Facility Name & ID Number Aperion Care Dolton

0051151

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 380,511	\$ 60,624		\$ 24,418	\$ (36,206)	\$ 128,647	1
2	Aluminum Face Panels Installation	2014	5,867		20	391	391	945	2
3	Water And Fuel Pumps	2015	6,387		20	319	319	612	3
4	Door Wander	2015	6,340		20	317	317	423	4
5	Upgrade Walk-In Cooler: Support Rails For Condenser Unit, Pipi	2015	8,557		20	428	428	535	5
6	Installation Of 2 Magnetic Locks	2016	3,724		20	186	186	186	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	34

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

Facility Name & ID Number Aperion Care Dolton

0051151

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		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	34

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

Facility Name & ID Number Aperion Care Dolton

0051151

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		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	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)		\$ 411,386	\$ 60,624		\$ 26,060	\$ (34,564)	\$ 131,348	34

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

Facility Name & ID Number Aperion Care Dolton

0051151

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

0051151

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010		302	35	263	(39)	2,724	3
4	Allocated from Chase Office, LLC	2016	14,212	152	35	152		152	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	758	122	20	38	(84)	265	9
10	Allocated from Aperion Care	2012	215	17	20	11	(6)	54	10
11	Allocated from Aperion Care	2013	91	10	20	5	(5)	18	11
12									12
13	Allocated from 8131 N. Monticello	2010		533	20	230	(303)	2,411	13
14	Allocated from 8131 N. Monticello	2013			20	40	40	246	14
15									15
16	Allocated from Chase Office, LLC	2016	72,031	1,501	20	1,501		1,501	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)		\$ 87,307	\$ 2,637		\$ 2,240	\$ (397)	\$ 7,371	34

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

Facility Name & ID Number Aperion Care Dolton

0051151

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		\$ 87,307	\$ 2,637		\$ 2,240	\$ (397)	\$ 7,371	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 87,307	\$ 2,637		\$ 2,240	\$ (397)	\$ 7,371	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	\$ 86,335	\$ 519	\$ 11,229	\$ 10,710	10	\$ 46,527	71
72	Current Year Purchases	44,242	1,600	2,190	590	10	2,190	72
73	Fully Depreciated Assets	25,876				10	25,876	73
74								74
75	TOTALS	\$ 156,452	\$ 2,119	\$ 13,419	\$ 11,300		\$ 74,594	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	\$ 851	\$ 173	\$ 170	\$ (3)	5	\$ 382
77		Allocated from Aperion Consulti	2016	590	115	118	3	5	236
78									
79									
80	TOTALS			\$ 1,441	\$ 288	\$ 288	\$		\$ 618

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)				\$ 570,858
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$ 63,031
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$ 39,767
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$ (23,264)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$ 206,560

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	SAS Architects Construction	\$ 268,800
93		
94		
95		\$ 268,800

* 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:Unrelated Lease
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:		80		\$507,306			3
4	Additions							4
5	Allocated from 8131 N. Monticello				231			5
6								6
7	TOTAL		80		\$507,537			7

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

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$11,561
- 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		\$	\$310	17
18					18
19					19
20					20
21	TOTAL		\$-	\$310	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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 185,369	\$		\$ 185,369	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			80,318			80,318	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			209,751			209,751	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				138,476		138,476	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					19,518	7,516		27,034	13
14	TOTAL			\$		\$ 494,956	\$ 145,992		\$ 640,948	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,729	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	694,740		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	178,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	753,996		8
9	Other(specify): <u>See Attached Schedule</u>	571,919		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,206,375	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	219,934		15
16	Equipment, at Historical Cost	286,392		16
17	Accumulated Depreciation (book methods)	(327,653)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,522,470		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,701,143	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,907,518	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 401,205	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,013,250		29
30	Accrued Salaries Payable	98,026		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,338		31
32	Accrued Real Estate Taxes(Sch.IX-B)	323,475		32
33	Accrued Interest Payable	3,436		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	23,643		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,865,373	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	886,243		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 886,243	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,751,616	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,155,902	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,907,518	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,193,354	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,193,355	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	407,547	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	(445,000)	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)	\$ (37,453)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,155,902	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Dolton**# **0051151**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	\$ 6,634,657	1
2	Discounts and Allowances for all Levels	(18,379)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,616,278	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,959	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 74,959	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	8,828	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,236	19
20	Radiology and X-Ray	546	20
21	Other Medical Services	3,051	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,744	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	59,381	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 59,381	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,766,023	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	802,770	31
32	Health Care	1,793,289	32
33	General Administration	1,949,062	33
	B. Capital Expense		
34	Ownership	985,545	34
	C. Ancillary Expense		
35	Special Cost Centers	648,691	35
36	Provider Participation Fee	179,119	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,358,476	40
41	Income before Income Taxes (line 30 minus line 40)**	407,547	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 407,547	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,636,703	44
45	Private Pay - Net Inpatient Revenue	135,922	45
46	Medicare - Net Inpatient Revenue	2,043,813	46
47	Other-(specify) Insurance	1,799,840	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,616,278	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,104	1,263	\$ 43,606	\$ 34.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,761	5,107	172,918	33.86	3
4	Licensed Practical Nurses	21,490	23,042	618,166	26.83	4
5	CNAs & Orderlies	44,021	47,371	515,859	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,764	4,336	84,212	19.42	8
9	Activity Director	1,768	1,951	28,291	14.50	9
10	Activity Assistants	7,211	7,784	79,392	10.20	10
11	Social Service Workers	3,912	4,433	76,878	17.34	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	42,716	20.54	13
14	Head Cook	2,519	3,023	34,111	11.28	14
15	Cook Helpers/Assistants	9,078	9,891	106,840	10.80	15
16	Dishwashers					16
17	Maintenance Workers	1,856	2,080	47,193	22.69	17
18	Housekeepers	9,331	10,819	119,101	11.01	18
19	Laundry	83	83	793	9.55	19
20	Administrator	1,952	2,116	121,137	57.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,442	7,882	103,774	13.17	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)	122,268	133,261	\$ 2,194,987 *	\$ 16.47	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	\$ 25,326	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	47,900	10-03	38
39	Pharmacist Consultant	Monthly	5,720	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	74	4,023	11-03	44
45	Social Service Consultant	12	720	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	86	\$ 98,689		49

C. CONTRACT NURSES

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

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

** See instructions.

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0051151

Report Period Beginning:

01/01/16

Ending:

Page 22

12/31/16

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. ICLTC - \$12,478
- (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. \$ 17,010 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. \$ 179,119
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? 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 1
- 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