

		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: 0052324 Facility Name: Aperion Care East Moline Address: 430 South 30th Ave East Moline 61244 County: Rock Island Telephone Number: (309) 755-3466 Fax #: (309) 755-6670 HFS ID Number: Date of Initial License for Current Owners: 5/1/2013 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steven N. Lavenda Telephone Number: (847) 282-6300 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) * Subject to the attached Accountants Consulting Report (Print Name and Title) (Firm Name & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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#	0052324	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 05/01/13

YES ☒ Date 05/01/13 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 72 and days of care provided 2,807

IV. ACCOUNTING BASIS

ACCRUAL	X
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CASH*	
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CASH* ☐

YES ☒ NO ☐

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	120		7,644	7,764	8
9	SNF/PED					9
10	ICF	18,864	3,070	3,583	25,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,984	3,070	11,227	33,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.78%

Facility Name & ID Number Aperion Care East Moline # 0052324 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	161,571	18,279	8,511	188,361		188,361	9,593	197,954			1
2	Food Purchase		200,158		200,158		200,158	34	200,192			2
3	Housekeeping	122,426	27,131		149,557		149,557		149,557			3
4	Laundry	35,075	19,046		54,121		54,121		54,121			4
5	Heat and Other Utilities			118,725	118,725		118,725	(5,836)	112,889			5
6	Maintenance	72,834	13,716	62,059	148,609		148,609	4,747	153,356			6
7	Other (specify):*							2,253	2,253			7
8	TOTAL General Services	391,906	278,330	189,295	859,531		859,531	10,792	870,323			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,501,347	126,273	94,289	1,721,909		1,721,909	(38,357)	1,683,552			10
10a	Therapy	43,831	4,695		48,526		48,526		48,526			10a
11	Activities	65,247	1,271		66,518		66,518		66,518			11
12	Social Services	153,129		2,503	155,632		155,632		155,632			12
13	CNA Training											13
14	Program Transportation			427	427		427		427			14
15	Other (specify):*							4,212	4,212			15
16	TOTAL Health Care and Programs	1,763,554	132,239	115,219	2,011,012		2,011,012	(34,144)	1,976,868			16
	C. General Administration											
17	Administrative	84,445		268,955	353,400		353,400	(212,789)	140,611			17
18	Directors Fees											18
19	Professional Services			308,121	308,121	(7,320)	300,801	(186,441)	114,360			19
20	Dues, Fees, Subscriptions & Promotions			107,696	107,696		107,696	(70,576)	37,120			20
21	Clerical & General Office Expenses	94,754		386,937	481,691		481,691	(227,236)	254,455			21
22	Employee Benefits & Payroll Taxes			397,209	397,209		397,209		397,209			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,147	6,147		6,147	2,310	8,457			24
25	Other Admin. Staff Transportation			15,514	15,514		15,514	10,710	26,224			25
26	Insurance-Prop.Liab.Malpractice			119,967	119,967		119,967	2,173	122,140			26
27	Other (specify):*							14,021	14,021			27
28	TOTAL General Administration	179,199		1,610,546	1,789,745	(7,320)	1,782,425	(667,829)	1,114,596			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,334,659	410,569	1,915,060	4,660,288	(7,320)	4,652,968	(691,182)	3,961,786			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			114,315	114,315		114,315	65,077	179,392			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,825	40,825		40,825	167,581	208,406			32
33	Real Estate Taxes			38,608	38,608	7,320	45,928	2,584	48,512			33
34	Rent-Facility & Grounds			344,635	344,635		344,635	(344,347)	288			34
35	Rent-Equipment & Vehicles			16,847	16,847		16,847	1,593	18,440			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)	0			36
37	TOTAL Ownership			561,708	561,708	7,320	569,028	(113,990)	455,038			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,776	448,570	555,346		555,346	(33,538)	521,808			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,788	253,788		253,788		253,788			42
43	Other (specify):*			23,470	23,470		23,470	(23,470)				43
44	TOTAL Special Cost Centers		106,776	725,828	832,604		832,604	(57,008)	775,596			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,334,659	517,345	3,202,596	6,054,600		6,054,600	(862,180)	5,192,420			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	(6,572)	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	(54,913)	30		9
10	Interest and Other Investment Income	(536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(185)	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	(828)	21		18
19	Entertainment	(2,911)	21		19
20	Contributions	(72,847)	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	(317,970)	21		24
25	Fund Raising, Advertising and Promotional	(23,470)	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	(107,025)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (587,257)		\$	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)	(274,923)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (274,923)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (862,180)		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	\$ (9,651)	21	1
2	Theft & Damage Loss	(126)	21	2
3	Amortization	(6,478)	36	3
4	Building Company - Accounting Fees	(9,575)	19	4
5	Building Company - Amortization	(65,017)	36	5
6	Building Company - Bank Charges	(6,424)	21	6
7	Building Company - Professional Fees	(2,650)	19	7
8	Building Company - State Replacement Tax	(801)	21	8
9	Additional R&M	6,794	06	9
10	PAC Dues	(4,426)	20	10
11	Non-allowable Seminar Expense	(239)	24	11
12	Non-allowable Legal Expense	(1,358)	19	12
13	Collections	(420)	19	13
14	Capitalized R&M	(6,654)	06	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	(107,025)		49

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 East Moline # 0052324 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				9,593								9,593	1
2	Food Purchase	(185)		219									34	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,572)		40			241	456					(5,836)	5
6	Maintenance	140		886	2,834		432	455					4,747	6
7	Other (specify):*			40	2,021			192					2,253	7
8	TOTAL General Services	(6,617)		1,185	14,448		673	1,103					10,792	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,985	(42,342)								(38,357)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			239	3,973								4,212	15
16	TOTAL Health Care and Programs			4,224	(38,368)								(34,144)	16
	C. General Administration													
17	Administrative			(214,620)		1,832							(212,789)	17
18	Directors Fees													18
19	Professional Services	(14,003)	12,225	(99,734)	870	(82,209)	820	55		(4,466)			(186,441)	19
20	Fees, Subscriptions & Promotions	(77,273)		4,890	1,406	300		101					(70,576)	20
21	Clerical & General Office Expenses	(338,711)	7,225	28,109	465	74,392	563	720					(227,236)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(239)		1,522	984	43							2,310	24
25	Other Admin. Staff Transportation			5,493	4,076	1,141							10,710	25
26	Insurance-Prop.Liab.Malpractice			1,966				207					2,173	26
27	Other (specify):*			5,166		8,855							14,021	27
28	TOTAL General Administration	(430,226)	19,450	(267,208)	7,801	4,354	1,383	1,083		(4,466)			(667,829)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(436,843)	19,450	(261,799)	(16,120)	4,354	2,056	2,186		(4,466)			(691,182)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care East Moline # 0052324 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(54,913)	113,723	1,303	200	78	1,043	3,643					65,077	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(536)	161,563	4,615	16		787	1,136					167,581	32
33	Real Estate Taxes						1,216	1,368					2,584	33
34	Rent-Facility & Grounds		(314,635)	567			(7,280)	(23,000)					(344,347)	34
35	Rent-Equipment & Vehicles			88	386	346	368	405					1,593	35
36	Other (specify):*	(71,495)	65,017										(6,478)	36
37	TOTAL Ownership	(126,944)	25,668	6,574	602	424	(3,866)	(16,448)					(113,990)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(33,538)				(33,538)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(23,470)											(23,470)	43
44	TOTAL Special Cost Centers	(23,470)							(33,538)				(57,008)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(587,257)	45,118	(255,225)	(15,518)	4,778	(1,810)	(14,262)	(33,538)	(4,466)			(862,180)	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

☐ 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	Rental Income	\$ 314,635	430 South 30th Avenue	100.00%	\$	\$ (314,635)	1
2	V	19	Accounting Fees		430 South 30th Avenue	100.00%	9,575	9,575	2
3	V	36	Amortization		430 South 30th Avenue	100.00%	65,017	65,017	3
4	V	21	Bank Charges		430 South 30th Avenue	100.00%	6,424	6,424	4
5	V	30	Depreciation Expense		430 South 30th Avenue	100.00%	113,723	113,723	5
6	V	32	Interest Expense	6	430 South 30th Avenue	100.00%	161,569	161,563	6
7	V	19	Professional Fees		430 South 30th Avenue	100.00%	2,650	2,650	7
8	V	21	State Replacement Tax		430 South 30th Avenue	100.00%	801	801	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 314,641			\$ 359,759	\$ * 45,118	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%	\$ 219	\$ 219	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	40	40	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	886	886	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	40	40	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	3,985	3,985	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	239	239	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	54,335	54,335	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,183	2,183	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,890	4,890	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	28,109	28,109	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,522	1,522	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,493	5,493	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,966	1,966	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	5,166	5,166	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,303	1,303	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,615	4,615	30
31	V	34	RENT		APERION CARE, INC.	100.00%	567	567	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	88	88	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	268,955	APERION CARE, INC.	100.00%		(268,955)	35
36	V	19	HOME OFFICE	101,917	APERION CARE, INC.	100.00%		(101,917)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 370,872			\$ 115,647	\$ * (255,225)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 9,593	\$ 9,593	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,584	5,584	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	2,021	2,021	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	29,758	29,758	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,973	3,973	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	870	870	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,406	1,406	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	465	465	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	984	984	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	4,076	4,076	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	200	200	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	16	16	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	386	386	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	72,100	APERION CONSULTING, LLC	100.00%		(72,100)	34
35	V	01	DIETICIAN		APERION CONSULTING, LLC	100.00%			35
36	V	02	FOOD SERVICE		APERION CONSULTING, LLC	100.00%			36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	2,750	APERION CONSULTING, LLC	100.00%		(2,750)	38
39	Total			\$ 74,850			\$ 59,332	\$ * (15,518)	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%	\$ 1,832	\$ 1,832	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,438	1,438	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	300	300	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	74,392	74,392	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	43	43	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,141	1,141	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,855	8,855	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	78	78	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	346	346	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	83,647	APERION FINANCIAL, LLC	100.00%		(83,647)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 83,647			\$ 88,425	\$ * 4,778	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%	\$ 241	\$ 241	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		432	432	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		820	820	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		563	563	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,043	1,043	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		787	787	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		287	287	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		368	368	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,216	1,216	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	567	8131 N. MONTICELLO, LLC			(567)	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			\$ 7,567			\$ 5,757	\$ * (1,810)	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%	\$ 456	\$ 456	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		455	455	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		192	192	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		55	55	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		101	101	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		720	720	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		207	207	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		3,643	3,643	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,136	1,136	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,368	1,368	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		405	405	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC			(23,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 23,000			\$ 8,738	\$ * (14,262)	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	\$ 448,967	Renewal Rehab	100.00%	\$ 415,429	\$ (33,538)	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			\$ 448,967			\$ 415,429	\$ * (33,538)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 18,600	ProPay HR	24.00%	\$ 14,134	\$ (4,466)	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			\$ 18,600			\$ 14,134	\$ * (4,466)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

Facility Name & ID Number

Aperion Care East Moline

0052324

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	DAVID A. BERKOWITZ REVOCABLE TRUST	33.33%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	DECLARATION OF TRUST OF YOSEF MEYSEL	33.34%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	MICHAEL ROSEN	33.33%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4			Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5			Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			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 Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care 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	430 SOUTH 30TH AVE	EAST MOLINE	BUILDING COMPANY	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 East Moline # 0052324 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attached	1.3	3.25%	Alloc. Salary	\$ 6,318	17-07	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.6	1.50%	Alloc. Salary	975	17-07	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.6	3.00%	Alloc. Salary	2,331	21-07	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc. Salary	953	21-07	4
5	Meir Meystel	Relative	Clerical	0%	See Attached	0.2	2.90%	Alloc. Salary	831	21-07	5
6	Nosson Factor	Relative	Clerical	0%	See Attached	1	3.04%	Alloc. Salary	2,681	21-07	6
7	David Berkowitz	Relative	Administrative	0%	See Attached	1.3	3.25%	Alloc. Salary	6,318	17-07	7
8	Michael Rosen	Shareholder	Administrative	33.33%	See Attached	1.3	3.25%	Alloc. Salary	6,318	17-07	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 anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13								TOTAL	\$ 26,725		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

Facility Name & ID Number	Aperion Care East Moline
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0052324

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	33,281	\$ 9,593	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	33,281	5,584	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		33,281	2,021	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	33,281	29,758	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		33,281	3,973	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		33,281	870	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		33,281	1,406	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		33,281	465	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		33,281	984	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		33,281	4,076	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		33,281	200	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		33,281	16	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		33,281	386	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		\$ 59,332	25

Ending: 12/31/16

7

IL478-2471

Ending: 12/31/16

Ending: 12/31/16

7

IL478-2471

Facility Name & ID Number	Aperion Care East Moline
--------------------------------------	---------------------------------

0052324

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) 262 - 3800

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	39	Therapy Services	Direct			\$	\$		\$ 415,429	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					\$	\$		\$ 415,429	25

Ending: 12/31/16

()

Ending: 12/31/16

Ending: 12/31/16

Fax Number

()

()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage			\$	7,058,804			\$	161,569	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				1,206,836				38,042	6
7	GMC		X	Note Payable - Auto				7,972					7
8					-								8
9	TOTAL Facility Related						\$	8,273,612			\$	199,611	9
	B. Non-Facility Related*												
10	Interest - Insurance Policies		X									2,783	10
11	Interest Income		X									(536)	11
12	Bldg. Co. - Interest Income		X									(6)	12
13	See Supplemental Schedule				-							6,554	13
14	TOTAL Non-Facility Related						\$				\$	8,795	14
15	TOTALS (line 9+line14)						\$	8,273,612			\$	208,406	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 - Aperion Care, Inc	X					\$					\$ 4,615	15
16	Allocated - Aperion Consulting	X										16	16
17	Allocated - 8131 N Monticello	X										787	17
18	Allocated - Chase Office, LLC	X										1,136	18
19													19
20	TOTAL Non-Facility Related											6,554	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

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 NAME

Aperion Care East Moline

COUNTY

Rock Island

FACILITY IDPH LICENSE NUMBER

0052324

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

27,040

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2015	\$ 373,200	1
2	Allocated - Chase Office, LLC			1,962	2
3	TOTALS			\$ 375,162	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2015	1971	\$ 3,358,800	\$ 86,123	35	\$ 95,966	\$ 9,843	\$ 232,014	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		108,450	3,276		2,781	(495)	9,156	68
69	Financial Statement Depreciation			114,315			(114,315)		69
70	TOTAL (lines 4 thru 69)		\$ 3,467,250	\$ 203,714		\$ 98,747	\$ (104,967)	\$ 241,170	70

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

Facility Name & ID Number Aperion Care East Moline

0052324

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		\$ 3,467,250	\$ 203,714		\$ 98,747	\$ (104,967)	\$ 241,170	1
2	<u>Roof</u>	2013	52,500		20	2,625	2,625	9,625	2
3	<u>Gutters</u>	2013	7,990		20	400	400	1,465	3
4	<u>Plumbing - New Roof Drains & Sheeting</u>	2013	3,051		20	204	204	712	4
5	<u>Water Heater</u>	2013	3,560		20	178	178	608	5
6	<u>Landscaping</u>	2013	10,980		20	732	732	2,623	6
7	<u>Sidewalk</u>	2013	8,900		20	593	593	1,928	7
8	<u>New Roof</u>	2013	7,942		20	397	397	1,291	8
9	<u>C-Wing Corridor Flooring & 2 New Closets</u>	2013	5,284		20	264	264	815	9
10	<u>Admissions Office Carpet, Admissions & Guest Bathrooms Toilets</u>	2013	284,923		20	14,246	14,246	43,926	10
11	<u>C-Wing Cooridor Remove Sprinklers; Lobby Circuits; Corridor C</u>	2014	21,541		20	1,077	1,077	3,231	11
12	<u>Lobby Drywall,Doors,Light Fixtures;Lounge Light Fixtures;Admi</u>	2014	103,270		20	5,164	5,164	15,491	12
13	<u>Storage Room Drywall</u>	2014	2,860		20	143	143	417	13
14	<u>Therapy Room Bathtub, Plumbing, Wallcovering, Flooring, Light</u>	2014	35,703		20	1,785	1,785	4,314	14
15	<u>Dining Rm Handrail & Bumper Guard, Paint Corridors B-E, Ad</u>	2014	13,278		20	664	664	1,604	15
16	<u>Cables & Wiring For Voice Data</u>	2014	6,625		20	331	331	718	16
17	<u>Awning & Sign</u>	2014	4,720		20	236	236	551	17
18	<u>Therapy Room / Corridor - Cove Base, Vct, Activity Sign</u>	2015	7,494		20	375	375	749	18
19	<u>Installed Full Privacy Fence With Walk Gate</u>	2016	6,654		20	6,654	6,654	333	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)		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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)		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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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19									19
20									20
21									21
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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)		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	34

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

Facility Name & ID Number Aperion Care East Moline

0052324

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
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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.

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 - 8131 N. Monticello	2010		376	39	327	(49)	3,384	3
4	Allocated - Chase Office, LLC	2016	17,654	189	39	189		189	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - Aperion Care, Inc	2010	941	151	20	47	(104)	329	9
10	Allocated - Aperion Care, Inc	2012	267	21	20	13	(8)	67	10
11	Allocated - Aperion Care, Inc	2013	114	13	20	6	(7)	23	11
12									12
13	Allocated - 8131 N. Monticello	2010		662	20	285	(377)	2,995	13
14	Allocated - 8131 N. Monticello	2013			20	50	50	305	14
15									15
16	Allocated - Chase Office, LLC	2016	89,474	1,864	20	1,864		1,864	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)		\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	34

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

Facility Name & ID Number Aperion Care East Moline

0052324

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		\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	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)		\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	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	\$ 286,003	\$ 28,244	\$ 35,736	\$ 7,492	10	\$ 89,679	71
72	Current Year Purchases	40,221	1,989	1,787	(202)	10	1,787	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 326,224	\$ 30,233	\$ 37,523	\$ 7,290		\$ 91,466	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		2013 GMC SAVANNA	2013	\$ 54,662	\$	\$ 6,696	\$ 6,696	5	\$ 31,228
77		Allocated - Aperion Care, Inc	2016	1,057	214	211	(3)	5	474
78		Allocated - Aperion Consulting, I	2016	732	142	146	4	5	293
79									
80	TOTALS			\$ 56,451	\$ 356	\$ 7,053	\$ 6,697		\$ 31,995

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)			\$	4,812,362
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	234,303
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	179,390
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(54,913)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	455,031

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

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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				287			5
6								6
7	TOTAL				\$ 287			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: \$ 8,594
- 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	Facility	BMW	\$ 830	\$ 9,460	17
18	Allocated - Aperion Consulting, LLC			386	18
19					19
20					20
21	TOTAL		\$ 830	\$ 9,846	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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	\$		\$ 159,805	\$		\$ 159,805	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,024			85,024	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			202,650			202,650	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				91,964		91,964	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					1,091	14,812		15,903	13
14	TOTAL			\$		\$ 448,570	\$ 106,776		\$ 555,346	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	\$ 124,753	\$ 390,253	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,218,108	2,218,108	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,242	79,242	6
7	Other Prepaid Expenses	935	935	7
8	Accounts Receivable (owners or related parties)	500,000	500,000	8
9	Other(specify):		147,115	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,923,038	\$ 3,335,653	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		373,200	13
14	Buildings, at Historical Cost		3,358,800	14
15	Leasehold Improvements, at Historical Cost	691,023	691,023	15
16	Equipment, at Historical Cost	114,463	252,463	16
17	Accumulated Depreciation (book methods)	(351,542)	(537,492)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,603,219	2,665,003	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,057,163	\$ 6,802,997	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,980,201	\$ 10,138,650	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 300,493	\$ 300,492	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,214,808	1,214,808	29
30	Accrued Salaries Payable	149,148	149,148	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,877	5,877	31
32	Accrued Real Estate Taxes(Sch.IX-B)		64,915	32
33	Accrued Interest Payable	4,247	18,842	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	49,652	49,652	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,724,225	\$ 1,803,734	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,058,804	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	4,378,979	1,454,174	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,378,979	\$ 8,512,978	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,103,204	\$ 10,316,712	46
47	TOTAL EQUITY(page 18, line 24)	\$ (123,003)	\$ (178,062)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,980,201	\$ 10,138,650	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 38,019	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)	\$ 38,018	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	137,312	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	(298,333)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (161,021)	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)	\$ (123,003)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care East Moline**# **0052324**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	\$ 5,516,458	1
2	Discounts and Allowances for all Levels	444,108	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,960,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,886	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 148,886	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	71,356	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,283	19
20	Radiology and X-Ray	1,878	20
21	Other Medical Services	3,407	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 81,924	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	536	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 536	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)	\$ 6,191,912	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	859,531	31
32	Health Care	2,011,012	32
33	General Administration	1,789,745	33
	B. Capital Expense		
34	Ownership	561,708	34
	C. Ancillary Expense		
35	Special Cost Centers	578,816	35
36	Provider Participation Fee	253,788	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,054,600	40
41	Income before Income Taxes (line 30 minus line 40)**	137,312	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 137,312	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,719,095	44
45	Private Pay - Net Inpatient Revenue	520,310	45
46	Medicare - Net Inpatient Revenue	1,455,609	46
47	Other-(specify) <u>Insurance</u>	1,265,552	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,960,566	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	1,744	2,091	\$ 67,939	\$ 32.49	1
2	Assistant Director of Nursing	1,977	2,324	65,220	28.06	2
3	Registered Nurses	7,611	7,978	229,177	28.73	3
4	Licensed Practical Nurses	18,384	19,392	448,260	23.12	4
5	CNAs & Orderlies	59,062	61,340	661,523	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,176	2,411	43,831	18.18	8
9	Activity Director	1,683	1,725	24,156	14.00	9
10	Activity Assistants	4,118	4,331	38,142	8.81	10
11	Social Service Workers	7,086	7,833	153,129	19.55	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,174	39,854	18.33	13
14	Head Cook	6,084	6,620	58,863	8.89	14
15	Cook Helpers/Assistants	6,909	7,280	62,854	8.63	15
16	Dishwashers					16
17	Maintenance Workers	4,645	5,004	72,834	14.56	17
18	Housekeepers	13,102	13,897	122,426	8.81	18
19	Laundry	3,400	3,796	35,075	9.24	19
20	Administrator	2,051	2,160	84,445	39.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,864	1,978	37,321	18.87	23
24	Clerical	5,502	5,939	57,433	9.67	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	2,076	2,136	29,228	13.68	31
32	Other Health Care(specify)					32
33	Other(specify)	257	265	2,949	11.13	33
34	TOTAL (lines 1 - 33)	151,715	160,674	\$ 2,334,659 *	\$ 14.53	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	155	\$ 8,511	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	72,200	10-03	38
39	Pharmacist Consultant	Monthly	10,089	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				44
45	Social Service Consultant	39	2,503	12-03	45
46	Other(specify) Psychiatric MD	Monthly	12,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	\$ 123,303		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 East Moline

0052324

Report Period Beginning:

01/01/16

Ending:

12/31/16

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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	
Tamara Stoneberger (1/1/16 - 3/31/16)		Administrator	0	\$ 22,800	Workers' Compensation Insurance		\$ 142,211	IDPH License Fee		\$ 1,990	
Laurie Paxton (Started 4/5/16)		Administrator	0	61,645	Unemployment Compensation Insurance		69,325	Advertising: Employee Recruitment		1,649	
					FICA Taxes		174,898	Health Care Worker Background Check		9,361	
					Employee Health Insurance		5,845	(Indicate # of checks performed 936)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions		16,754	
					Employee Physicals		1,520	Licenses and Permits		669	
					Employee Meals		327				
					Employee Benefits - Other		3,083	Allocated - Aperion Care, Inc		4,890	
TOTAL (agree to Schedule V, line 17, col. 1)									See Supplemental Schedule		1,807
(List each licensed administrator separately.)				\$ 84,445					Less: Public Relations Expense		()
B. Administrative - Other									Non-allowable advertising		()
Description				Amount					Yellow page advertising		()
Aperion Care Inc.				\$ 268,955					TOTAL (agree to Sch. V,		\$ 37,120
					TOTAL (agree to Schedule V,			\$ 397,209	line 20, col. 8)		
					line 22, col.8)						
					E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**			
					to Owners or Employees						
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 268,955	Description		Line #	Amount	Description		Amount
(Attach a copy of any management service agreement)								\$	Out-of-State Travel		\$
C. Professional Services											
Vendor/Payee		Type		Amount					In-State Travel		
Aperion Care		Home Office Expense		\$ 101,917							
Aperion Financial		Home Office Expense		83,647							
ProPay HR		Payroll Processing		18,600							
Galaxy Hosted Software		Clinical Solutions		3,750							
Creative Technology Solutions		Data Processing		14,549							
Wescom Solutions		E.H.R. Software		16,088							
National Datacare Corp		Financial Software		2,507							
Aperion Care		Data Processing		7,911					Seminar Expense		5,908
e-Health Data Solutions		MDS Software		4,111					Allocated - Aperion Care, Inc		1,522
Marcum		Accounting		20,992					Allocated - Aperion Consulting, LLC		984
Legal		See Attached		11,025					See Supplemental Schedule		43
See Supplemental Schedule				23,025					Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)				\$ 308,122					line 24, col. 8)		\$ 8,457

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Aperion Care East Moline	STATE OF ILLINOIS # 0052324	Report Period Beginning: 01/01/16	Ending: 12/31/16
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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? Yes
 If YES, give association name and amount. ICLTC \$13,413

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,197 Line 10-02

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 253,788
 This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 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