

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0054031</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																	
Facility Name: <u>Aperion Care Elgin</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																																	
Address: <u>134 N Mclean Blvd</u> <u>Elgin</u> <u>60123</u>																																																																																			
Number City Zip Code																																																																																			
County: <u>Kane</u>																																																																																			
Telephone Number: <u>(847) 742-8822</u> Fax # <u>(847) 742-6629</u>																																																																																			
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>12/1/2015</u></td><td colspan="2" rowspan="5"> 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 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____		Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>			(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Date of Initial License for Current Owners: <u>12/1/2015</u>		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		Type of Ownership:		<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____							In the event there are further questions about this report, please contact:		Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>		Email Address: _____	
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#	0054031	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 12/01/2015

YES ☒ Date 12/01/2015 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified	52	and days of care provided	2,694
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CGS

MODIFIEDCASH* ☐

YES ☒ NO ☐

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

B. Census-For the entire report period.						
	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			2,694	2,694	8
9	SNF/PED					9
10	ICF	9,639	609	18,021	28,269	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,639	609	20,715	30,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.94%

Facility Name & ID Number Aperion Care Elgin # 0054031 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	301,330	18,386	21,300	341,016		341,016	(12,375)	328,641			1
2	Food Purchase		209,402		209,402	(2,449)	206,953	166	207,119			2
3	Housekeeping	168,371	29,714	330	198,415		198,415		198,415			3
4	Laundry	22,501	5,091	56,445	84,037		84,037		84,037			4
5	Heat and Other Utilities			88,742	88,742		88,742	(3,657)	85,085			5
6	Maintenance	103,393	38,884	89,011	231,288		231,288	(33,880)	197,408			6
7	Other (specify):*							2,096	2,096			7
8	TOTAL General Services	595,595	301,477	255,828	1,152,900	(2,449)	1,150,451	(47,650)	1,102,801			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,523,018	121,138	60,456	1,704,612		1,704,612	(21,133)	1,683,479			10
10a	Therapy	126,676			126,676		126,676		126,676			10a
11	Activities	101,877	10,745	2,860	115,482		115,482		115,482			11
12	Social Services	107,009		1,284	108,293		108,293		108,293			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,920	3,920			15
16	TOTAL Health Care and Programs	1,858,580	131,883	76,600	2,067,063		2,067,063	(17,213)	2,049,850			16
	C. General Administration											
17	Administrative	127,857		269,893	397,750		397,750	(217,638)	180,112			17
18	Directors Fees											18
19	Professional Services			221,020	221,020		221,020	(130,349)	90,671			19
20	Dues, Fees, Subscriptions & Promotions			67,678	67,678		67,678	(38,520)	29,158			20
21	Clerical & General Office Expenses	130,874		136,049	266,923		266,923	9,331	276,254			21
22	Employee Benefits & Payroll Taxes			435,574	435,574	2,449	438,023		438,023			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,003	9,003		9,003	2,372	11,375			24
25	Other Admin. Staff Transportation			7,064	7,064		7,064	9,964	17,028			25
26	Insurance-Prop.Liab.Malpractice			154,291	154,291		154,291	2,021	156,312			26
27	Other (specify):*							13,045	13,045			27
28	TOTAL General Administration	258,731		1,300,572	1,559,303	2,449	1,561,752	(349,774)	1,211,978			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,712,906	433,360	1,633,000	4,779,266		4,779,266	(414,637)	4,364,629			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			11,008	11,008		11,008	(256)	10,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,126	33,126		33,126	3,785	36,911			32
33	Real Estate Taxes			90,585	90,585		90,585	2,404	92,989			33
34	Rent-Facility & Grounds			584,154	584,154		584,154	(29,733)	554,421			34
35	Rent-Equipment & Vehicles			9,222	9,222		9,222	1,482	10,704			35
36	Other (specify):*											36
37	TOTAL Ownership			728,095	728,095		728,095	(22,318)	705,777			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,444	463,211	583,655		583,655	(28,794)	554,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,993	221,993		221,993		221,993			42
43	Other (specify):*			13,916	13,916		13,916	(13,916)				43
44	TOTAL Special Cost Centers		120,444	699,120	819,564		819,564	(42,710)	776,854			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,712,906	553,804	3,060,215	6,326,925		6,326,925	(479,664)	5,847,261			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	(4,342)	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	(6,086)	30		9
10	Interest and Other Investment Income	(2,313)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(38)	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	(6,778)	21		18
19	Entertainment	(5,466)	21		19
20	Contributions	(43,100)	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	(65,699)	21		24
25	Fund Raising, Advertising and Promotional	(13,916)	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	(19,262)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,000)		\$	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)	(312,664)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (312,664)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (479,664)		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			Sch. V Line
	Amount	Reference	
1	Bank Fees	\$ (6,153)	211
2	Theft & Damages	(14)	212
3	Jury Duty Income	(25)	103
4	Capitalized R&M	(19,102)	064
5	Website Expense	(21)	215
6	Credit Card Processing Fees	(3,526)	216
7	Additional R&M	11,327	067
8	Non-Allowable Legal	(98)	198
9	PAC Dues	(1,650)	209
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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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	(19,262)	49

Aperion Care Elgin

ID# 0054031

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	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
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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 Elgin # 0054031 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(12,375)								(12,375)	1
2	Food Purchase	(38)		204									166	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,342)		37			224	424					(3,657)	5
6	Maintenance	(7,775)		825	(27,755)		402	424					(33,880)	6
7	Other (specify):*			37	1,880			179					2,096	7
8	TOTAL General Services	(12,155)		1,103	(38,250)		626	1,026					(47,650)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25)		3,707	(24,815)								(21,133)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			223	3,697								3,920	15
16	TOTAL Health Care and Programs	(25)		3,930	(21,118)								(17,213)	16
	C. General Administration													
17	Administrative			(219,342)		1,704							(217,638)	17
18	Directors Fees													18
19	Professional Services	(98)		(70,562)	809	(58,056)	763	51		(3,256)			(130,349)	19
20	Fees, Subscriptions & Promotions	(44,750)		4,549	1,308	279		94					(38,520)	20
21	Clerical & General Office Expenses	(87,657)		26,151	432	69,211	524	670					9,331	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,416	916	40							2,372	24
25	Other Admin. Staff Transportation			5,111	3,792	1,062							9,964	25
26	Insurance-Prop.Liab.Malpractice			1,829				192					2,021	26
27	Other (specify):*			4,806		8,239							13,045	27
28	TOTAL General Administration	(132,505)		(246,042)	7,257	22,479	1,287	1,008		(3,256)			(349,774)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(144,685)		(241,009)	(52,111)	22,479	1,913	2,034		(3,256)			(414,637)	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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(6,086)		1,212	186	72	971	3,389					(256)
31	Amortization of Pre-Op. & Org.												31
32	Interest	(2,313)		4,294	15		732	1,057					3,785
33	Real Estate Taxes						1,132	1,273					2,404
34	Rent-Facility & Grounds			528			(7,261)	(23,000)					(29,733)
35	Rent-Equipment & Vehicles			82	359	322	342	377					1,482
36	Other (specify):*												36
37	TOTAL Ownership	(8,399)		6,116	560	394	(4,084)	(16,904)					(22,318)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers							(28,794)					(28,794)
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(13,916)											(13,916)
44	TOTAL Special Cost Centers	(13,916)						(28,794)					(42,710)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(167,000)		(234,893)	(51,551)	22,873	(2,172)	(14,870)	(28,794)	(3,256)			(479,664)

VII. RELATED PARTIES

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

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

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

☐ YES

☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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%	\$ 204	\$ 204	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	37	37	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	825	825	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	37	37	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	3,707	3,707	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	223	223	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	50,551	50,551	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,031	2,031	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,549	4,549	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	26,151	26,151	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,416	1,416	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,111	5,111	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,829	1,829	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,806	4,806	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,212	1,212	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,294	4,294	30
31	V	34	RENT		APERION CARE, INC.	100.00%	528	528	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	82	82	32
33	V								33
34	V								34
35	V	17	MANAGEMENT FEE	269,893	APERION CARE, INC.	100.00%		(269,893)	35
36	V	19	HOME OFFICE	72,593	APERION CARE, INC.	100.00%		(72,593)	36
37	V								37
38	V								38
39	Total			\$ 342,486			\$ 107,593	\$ * (234,893)	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%	\$ 8,925	\$ 8,925	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,195	5,195	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,880	1,880	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	27,685	27,685	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,697	3,697	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	809	809	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,308	1,308	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	432	432	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	916	916	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,792	3,792	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	186	186	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	15	15	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	359	359	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	10	CONSULTING	52,500	APERION CONSULTING, LLC	100.00%		(52,500)	34
35	V	01	DIETICIAN	15,300	APERION CONSULTING, LLC	100.00%		(15,300)	35
36	V	01	FOOD SERVICE	6,000	APERION CONSULTING, LLC	100.00%		(6,000)	36
37	V	06	PAINTER	17,600	APERION CONSULTING, LLC	100.00%		(17,600)	37
38	V	06	PROJECT MANAGER	15,350	APERION CONSULTING, LLC	100.00%		(15,350)	38
39	Total			\$ 106,750			\$ 55,199	\$ * (51,551)	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%	\$ 1,704	\$ 1,704	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,338	1,338	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	279	279	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	69,211	69,211	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	40	40	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,062	1,062	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,239	8,239	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	72	72	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	322	322	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	19	HOME OFFICE EXPENSE	59,394	APERION FINANCIAL, LLC	100.00%		(59,394)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 59,394			\$ 82,267	\$ * 22,873	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%	\$ 224	\$ 224	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		402	402	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		763	763	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		524	524	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		971	971	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		732	732	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		267	267	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		342	342	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,132	1,132	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	528	8131 N. MONTICELLO, LLC			(528)	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			\$ 7,528			\$ 5,356	\$ * (2,172)	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 424	\$ 424	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		424	424	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		179	179	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		51	51	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		94	94	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		670	670	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		192	192	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		3,389	3,389	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,057	1,057	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,273	1,273	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		377	377	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			\$ 8,130	\$ * (14,870)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 385,456	Renewal Rehab	100.00%	\$ 356,662	\$ (28,794)	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			\$ 385,456			\$ 356,662	\$ * (28,794)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 13,562	ProPay HR LLC	24.00%	\$ 10,306	\$ (3,256)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,562			\$ 10,306	\$ * (3,256)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 56,445	Ecobrite Linen	100.00%	\$ 56,445	\$	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			\$ 56,445			\$ 56,445	\$ *	39

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

VII. RELATED PARTIES (continued)

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

YESNO

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

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

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

Facility Name & ID Number

Aperion Care Elgin

0054031

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	21.50%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz Delta Trust	21.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Trust	21.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Yosef Meystel Delta trust	21.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Fred Frankel	3.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Steve Turofsky	3.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Jeremy Boshes	3.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Michelle Koder	3.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Naftali Wilhelm	2.00%	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 Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				24
25			Aperion Care Springfield	Springfield				25
26			Aperion Care St. Elmo	St. Elmo				26
27			Aperion Care Tolleston Park	Gary, IN				27
28			Aperion Care Toluca	Toluca				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Wilmington	Wilmington				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Burgin Manor	Olney				1
2			Baypointe Rehab Center	Brockton, MA				2
3			Eastpointe Rehab Center	Chelsea, MA				3
4			Southpointe Rehab Center	Falls River, MA				4
5			The Arbors at Michigan City	Michigan City, IN				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Elgin # 0054031 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	1.2	0.03%	Alloc Salary	\$ 5,878	17-7	1
2	Jay Meystel	Relative	Administrative	0	See Attached	0.6	0.02%	Alloc Salary	907	17-7	2
3	Joel Meystel	Relative	Clerical	0	See Attached	0.6	0.03%	Alloc Salary	2,169	21-7	3
4	Cynthia Meystel	Relative	Clerical	0	See Attached	0.1	0.03%	Alloc Salary	886	21-7	4
5	Meir Mystel	Relative	Clerical	0	See Attached	0.2	0.03%	Alloc Salary	773	21-7	5
6	David Berkowitz	Owner	Administrative	0	See Attached	1.2	0.03%	Alloc Salary	5,878	17-7	6
7	Fred Frankel	Owner	Administrative	3.00%	See Attached	1.2	0.03%	Alloc Salary	5,423	17-7	7
8	Steve Turofsky	Owner	Administrative	3.00%	See Attached	1.2	0.03%	Alloc Salary	5,637	17-7	8
9	Nosson Factor	Relative	Clerical	0	See Attached	1	0.03%	Alloc Salary	2,494	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 30,045		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

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

Fax Number ()

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

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	APERION CARE, INC.
Street Address	4655 W CHASE AVENUE
City / State / Zip Code	LINCOLNWOOD, ILLINOIS 60712
Phone Number	(847) 262-8300
Fax Number	(

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	2	FOOD	ACTUAL CENSUS	34	\$ 6,946	\$	30,963	\$ 204	1
2	5	UTILITIES	ACTUAL CENSUS	34	1,265		30,963	37	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	28,061	21,169	30,963	825	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	34	1,271		30,963	37	4
5	10	SALARY- NURSE	ACTUAL CENSUS	34	126,141	126,141	30,963	3,707	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	34	7,576		30,963	223	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	34	1,719,984	1,519,984	30,963	50,551	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	69,096		30,963	2,031	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	34	154,783		30,963	4,549	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	34	889,796	1,222,825	30,963	26,151	10
11	24	SEMINARS	ACTUAL CENSUS	34	48,189		30,963	1,416	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	34	173,887		30,963	5,111	12
13	26	INSURANCE	ACTUAL CENSUS	34	62,237		30,963	1,829	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	34	163,535		30,963	4,806	14
15	30	DEPRECIATION	ACTUAL CENSUS	34	41,232		30,963	1,212	15
16	32	INTEREST	ACTUAL CENSUS	34	146,102		30,963	4,294	16
17	34	RENT	ACTUAL CENSUS	34	17,963		30,963	528	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	2,801		30,963	82	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,660,864	\$ 2,890,119		\$ 107,593	25

Facility Name & ID Number Aperion Care Elgin

0054031

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	30,963	\$ 8,925	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	30,963	5,195	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		30,963	1,880	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	30,963	27,685	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		30,963	3,697	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		30,963	809	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		30,963	1,308	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		30,963	432	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		30,963	916	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		30,963	3,792	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		30,963	186	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		30,963	15	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		30,963	359	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,878,156	\$ 1,421,169		\$ 55,199	25

Ending: 12/31/16

7

Ending: 12/31/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	RENEWAL REHAB
Street Address	8131 N. MONTICELLO
City / State / Zip Code	SKOKIE, IL 60076
Phone Number	(847) 673-6767
Fax Number	(847) 673-6768

Fax Number (847) 673-6768

	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			\$	\$		\$ 356,662	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					\$	\$		\$ 356,662	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	<u>ProPay HR LLC</u>
Street Address	<u>2201 W. MAIN ST</u>
City / State / Zip Code	<u>EVANSTON, ILLINOIS 60202</u>
Phone Number	<u>(847) 905-3268</u>
Fax Number	<u>()</u>

	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	Payroll Services	Direct			\$	\$		\$ 10,306	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					\$	\$		\$ 10,306	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization	EcoBrite Linen
Street Address	3712 Jarvis Avenue
City / State / Zip Code	Skokie, IL 60076
Phone Number	(847) 582-4000
Fax Number	()

Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct			\$	\$		\$ 56,445	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					\$	\$		\$ 56,445	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

Fax Number ()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	Line of Credit				800,000				29,809	6
7	Note Payable		X	Note Payable				14,274					7
8					-								8
9	TOTAL Facility Related						\$	\$ 814,274			\$ 29,809	9	
	B. Non-Facility Related*												
10	Interest Income		X								(2,313)	10	
11	Insurance Expense		X								3,317	11	
12												12	
13					-						6,098	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 7,102	14	
15	TOTALS (line 9+line14)						\$	\$ 814,274			\$ 36,911	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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	Alloc. From Aperion Care		X				\$				\$	4,29415
16	Alloc from Aperion Consult		X									1516
17	Allocated from 8131 N. Monticello		X									73217
18	Allocated from Chase Office		X									1,05718
19												19
20	TOTAL Non-Facility Related											6,09820

* 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.			\$	88,127	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.)			\$	91,116	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,989	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	90,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	92,989	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013	45,570	10	
		2014	42,600	11	
		2015	88,712	12	
Beginning Accrual Adjusted					
2016 Accrual=\$88,712 x 1.01= 90,000 (rounded)					
Allocated from 8131 Monticello - \$1132					
Allocated from Chase- \$1273					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

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

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

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 ElginCOUNTYKane

FACILITY IDPH LICENSE NUMBER0054031

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
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:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

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		2016	\$1,825	1
2					2
3	TOTALS			\$1,825	3

Facility Name & ID Number Aperion Care Elgin

0054031

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)		100,896	3,046		2,586	(460)	8,517	68
69	Financial Statement Depreciation			11,008			(11,008)		69
70	TOTAL (lines 4 thru 69)		\$ 100,896	\$ 14,054		\$ 2,586	\$ (11,468)	\$ 8,517	70

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

Facility Name & ID Number Aperion Care Elgin

0054031

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	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		\$ 100,896	\$ 14,054		\$ 2,586	\$ (11,468)	\$ 8,517	1
2 32 Channel Security System With Cameras	2016	10,757		20	538	538	538	2
3 Seco Refrigeration (Compression)	2016	3,376		20	253	253	253	3
4 Alarm	2016	7,062		20	88	88	88	4
5 Roof Replacement (Total Invoice Amount \$94,220.00)	2016	74,848		20	1,178	1,178	1,178	5
6 Installation Of Cat5E Cable	2016	6,535		20	654	654	654	6
7 Landscaping-Side Of Courtyard	2016	6,974		20	349	349	349	7
8 Sprinkler System-Installed Compressor & Replaced Piping	2016	5,593		20	597	597	597	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)		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	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)		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

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		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	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)		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

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		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	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)		\$ 216,040	\$ 14,054		\$ 6,242	\$ (7,812)	\$ 12,174	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

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		349	35	304	(45)	3,148	3
4	Allocated from Chase Office	2016	16,424	175	35	175		175	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	876	141	20	44	(97)	306	9
10	Allocated from Aperion Care	2012	248	19	20	12	(7)	62	10
11	Allocated from Aperion Care	2013	106	12	20	5	(7)	21	11
12	Allocated from Chase	2016	83,242	1,734	20	1,734		1,734	12
13	Allocated from 8131 N. Monticello	2010		616	20	266	(350)	2,787	13
14	Allocated from 8131 N. Monticello	2013			20	46	46	284	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)		\$ 100,896	\$ 3,046		\$ 2,586	\$ (460)	\$ 8,517	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

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		\$ 100,896	\$ 3,046		\$ 2,586	\$ (460)	\$ 8,517	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 100,896	\$ 3,046		\$ 2,586	\$ (460)	\$ 8,517	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,285	\$ 600	\$ 387	\$ (213)	10	\$ 955	71
72	Current Year Purchases	59,688	1,852	3,789	1,937	10	3,789	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 62,973	\$ 2,452	\$ 4,176	\$ 1,724		\$ 4,744	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	\$ 983	\$ 199	\$ 197	\$ (2)	5	\$ 441
77		Allocated from Aperion Consult	2016	681	132	136	4	5	273
78									
79									
80	TOTALS			\$ 1,664	\$ 331	\$ 333	\$ 2		\$ 714

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)			\$	282,502
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	16,837
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	10,751
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(6,086)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	17,632

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	\$ 86,454
93	HC Construction- windows and	35,392
94	interior remodel	
95		\$ 121,846

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:SEGULA PROPERTIES/CHASE
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:		102		554,154			3
4	Additions							4
5	Allocated form 8131 N. Monticello				267			5
6								6
7	TOTAL		102		\$ 554,421			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: \$ 10,345
- 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		\$	359	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 359	21

10. Effective dates of current rental agreement:
Beginning10/01/14
Ending05/31/19
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12.12/31/2017\$ 554,154

13.12/31/2018\$ 554,154

14.12/31/2019\$ 554,154

* 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	\$		\$ 172,136	\$		\$ 172,136	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			68,261			68,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			145,059			145,059	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				112,874		112,874	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					77,755	7,570		85,325	13
14	TOTAL			\$		\$ 463,211	\$ 120,444		\$ 583,655	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	\$ 29,169	\$	1
2	Cash-Patient Deposits	255		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,808,222		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,808		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	100,820		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,040,274	\$	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	101,282		15
16	Equipment, at Historical Cost	47,727		16
17	Accumulated Depreciation (book methods)	(11,008)		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>	133,598		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 271,599	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,311,873	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 729,520	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	814,274		29
30	Accrued Salaries Payable	205,420		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,237		31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,000		32
33	Accrued Interest Payable	2,856		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	103,879		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,952,186	\$	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>	544,344		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 544,344	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,496,530	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (184,657)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,311,873	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	2015 Income	11,841	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(196,498)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (196,498)	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)	\$ (184,657)	24 *

* This must agree with page 17, line 47.

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

0054031

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	\$ 6,227,989	1
2	Discounts and Allowances for all Levels	(233,476)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,994,513	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,721	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,721	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	95,098	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,921	19
20	Radiology and X-Ray	1,320	20
21	Other Medical Services	1,516	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,855	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,313	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,313	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	25	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,130,427	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,152,900	31
32	Health Care	2,067,063	32
33	General Administration	1,559,303	33
	B. Capital Expense		
34	Ownership	728,095	34
	C. Ancillary Expense		
35	Special Cost Centers	597,571	35
36	Provider Participation Fee	221,993	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,326,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(196,498)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (196,498)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,530,715	44
45	Private Pay - Net Inpatient Revenue	118,825	45
46	Medicare - Net Inpatient Revenue	1,462,220	46
47	Other-(specify) <u>Insurance</u>	2,882,753	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,994,513	49

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,056	2,099	\$ 94,129	\$ 44.84	1
2	Assistant Director of Nursing	637	736	24,775	33.66	2
3	Registered Nurses	12,737	12,737	401,624	31.53	3
4	Licensed Practical Nurses	14,882	15,901	465,986	29.31	4
5	CNAs & Orderlies	39,865	42,447	502,799	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,751	6,137	126,676	20.64	8
9	Activity Director	1,760	1,839	36,839	20.03	9
10	Activity Assistants	6,313	6,760	65,038	9.62	10
11	Social Service Workers	3,864	4,065	107,009	26.32	11
12	Dietician					12
13	Food Service Supervisor	3,781	4,153	95,130	22.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,963	15,238	206,200	13.53	15
16	Dishwashers					16
17	Maintenance Workers	3,952	4,169	103,393	24.80	17
18	Housekeepers	12,347	13,860	168,371	12.15	18
19	Laundry	2,459	2,667	22,501	8.44	19
20	Administrator	2,080	2,080	107,346	51.61	20
21	Assistant Administrator	664	696	20,511	29.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,597	8,092	130,874	16.17	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	1,901	2,088	30,253	14.49	31
32	Other Health Care(specify)					32
33	Other(specify)	339	354	3,452	9.75	33
34	TOTAL (lines 1 - 33)	136,948	146,118	\$ 2,712,906 *	\$ 18.57	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	\$ 21,300	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	52,500	10-03	38
39	Pharmacist Consultant	Monthly	7,956	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	Monthly	2,860	11-03	44
45	Social Service Consultant	Monthly	1,284	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 97,900		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 Elgin

0054031

Report Period Beginning: 01/01/16

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Ending: 12/31/16

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	
Jamie Lloyd	Administrator	0	\$ 107,346	Workers' Compensation Insurance	\$ 75,162	IDPH License Fee	\$	
Zev Brody	Asst. Administrator	0	20,511	Unemployment Compensation Insurance	73,531	Advertising: Employee Recruitment	1,159	
				FICA Taxes	201,794	Health Care Worker Background Check		
				Employee Health Insurance	81,921	(Indicate # of checks performed <u>234</u>)	2,346	
				Employee Meals	2,449	Patient Background Checks	<u>47</u> 470	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,991	
				Employee Physicals	640	Licenses	11,962	
				Employee Meals	1,174	Allocated from Aperion Care	4,549	
				Employee Benefits-Other	1,352	Allocated from Aperion Financial	279	
TOTAL (agree to Schedule V, line 17, col. 1)						See Supplemental Schedule	1,402	
(List each licensed administrator separately.)			\$ 127,857			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Mangement Fees			\$ 269,893					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 269,893	TOTAL (agree to Schedule V, line 22, col.8)		\$ 438,023	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Aperion Care	Home Office Expense		\$ 72,593					
Aperion Financial	Home Office Expense		59,393					
ProPay HR	Payroll Processing		13,562					
Marcum	Accounting		6,950				In-State Travel	
See Attached	Legal Fees		694					
Personnel Planners	Unemployment Consulting		1,258					
Westcom Solutions	Data Processing		20,587					
Creative Technology Solutions	Data Processing		12,957				Seminar Expense	9,003
Aperion Care Inc	Data Processing		26,197				Allocated from Aperion Care	1,416
National Data Care	Data Processing		2,642				Allocated from Aperion Financial	40
E-Health Data Solutions	Data Processing		900				See Supplemental Schedule	916
See Supplemental Schedule			3,288				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 221,020				TOTAL 11,375	

* Attach copy of IMRF notifications

**See instructions.

(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