

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0052761

Facility Name: Aperion Care Galesburg

Address: 1145 Frank Street Galesburg 61401
Number City Zip Code

County: Knox

Telephone Number: (309) 342-2103 Fax # (309) 342-1819

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2013

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

#	0052761	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 / 11/1/2013 /

YES ☒ Date 11/1/2013 NO ☐

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

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.**

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	3,655	1,051	2,725	7,431	8
9	SNF/PED					9
10	ICF	16,226	121	10,228	26,575	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,881	1,172	12,953	34,006	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.03%

Facility Name & ID Number Aperion Care Galesburg # 0052761 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	140,191	18,221	14,700	173,112		173,112	(4,898)	168,214			1
2	Food Purchase		188,956		188,956		188,956	159	189,115			2
3	Housekeeping	142,021	26,983		169,004		169,004		169,004			3
4	Laundry	31,165	10,411		41,576		41,576		41,576			4
5	Heat and Other Utilities			104,684	104,684		104,684	(6,746)	97,938			5
6	Maintenance	67,655	24,531	20,958	113,144		113,144	8,899	122,043			6
7	Other (specify):*							2,302	2,302			7
8	TOTAL General Services	381,032	269,102	140,342	790,476		790,476	(284)	790,192			8
	B. Health Care and Programs											
9	Medical Director			23,727	23,727		23,727		23,727			9
10	Nursing and Medical Records	1,432,407	184,209	59,652	1,676,268		1,676,268	(8,922)	1,667,346			10
10a	Therapy	187,343			187,343		187,343		187,343			10a
11	Activities	58,828	3,097	462	62,387		62,387		62,387			11
12	Social Services	141,509		4,444	145,953		145,953		145,953			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,305	4,305			15
16	TOTAL Health Care and Programs	1,820,087	187,306	88,285	2,095,678		2,095,678	(4,617)	2,091,061			16
	C. General Administration											
17	Administrative	71,173		269,417	340,590		340,590	(212,027)	128,563			17
18	Directors Fees											18
19	Professional Services			277,431	277,431		277,431	(191,137)	86,294			19
20	Dues, Fees, Subscriptions & Promotions			96,573	96,573		96,573	(70,742)	25,831			20
21	Clerical & General Office Expenses	53,003		275,000	328,003		328,003	(116,834)	211,169			21
22	Employee Benefits & Payroll Taxes			317,177	317,177		317,177		317,177			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,024	4,024		4,024	2,605	6,629			24
25	Other Admin. Staff Transportation			15,116	15,116		15,116	10,943	26,059			25
26	Insurance-Prop.Liab.Malpractice			137,569	137,569		137,569	2,220	139,789			26
27	Other (specify):*							14,327	14,327			27
28	TOTAL General Administration	124,176		1,392,307	1,516,483		1,516,483	(560,644)	955,839			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,325,295	456,408	1,620,934	4,402,637		4,402,637	(565,544)	3,837,093			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			79,829	79,829		79,829	61,437	141,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,612	39,612		39,612	149,486	189,098			32
33	Real Estate Taxes			27,008	27,008		27,008	2,641	29,649			33
34	Rent-Facility & Grounds			426,750	426,750		426,750	(426,456)	294			34
35	Rent-Equipment & Vehicles			8,060	8,060		8,060	1,627	9,687			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			587,737	587,737		587,737	(217,742)	369,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,513	327,227	334,740		334,740	(21,204)	313,536			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,957	261,957		261,957		261,957			42
43	Other (specify):*			17,286	17,286		17,286	(17,286)				43
44	TOTAL Special Cost Centers		7,513	606,470	613,983		613,983	(38,490)	575,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,325,295	463,921	2,815,141	5,604,357		5,604,357	(821,776)	4,782,581			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	(7,498)	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	(32,287)	30		9
10	Interest and Other Investment Income	(8,708)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(65)	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	(1,917)	21		18
19	Entertainment	(3,052)	21		19
20	Contributions	(74,847)	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	(210,120)	21		24
25	Fund Raising, Advertising and Promotional	(17,286)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(457)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(94,334)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (450,571)		\$	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)	(371,206)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (371,206)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (821,777)		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

Aperion Care Galesburg

ID# 0052761

Report Period Beginning: 01/01/16

Ending: 12/31/16

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (7,333)	21	1
2	Theft & Damage	(475)	21	2
3	Amortization	(6,478)	36	3
4	Building Co - Amortization	(58,624)	36	4
5	Building Co - Bank Charges	(4,390)	21	5
6	Building Co - State Replacement Tax	(2,354)	20	6
7	Building Co - Professional Fees	(14,325)	19	7
8	Chamber of Commerce	(254)	20	8
9	PAC Dues	(2,483)	20	9
10	Additional R&M	2,480	06	10
11	Non-allowable Legal	(98)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(94,334)		49

ID#

0052761

Report Period Beginning:

01/01/16

Ending:

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Galesburg # 0052761 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				(4,898)								(4,898)	1
2	Food Purchase	(65)		224									159	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,498)		41			246	466					(6,746)	5
6	Maintenance	2,480		906	4,606		441	465					8,899	6
7	Other (specify):*			41	2,065			196					2,302	7
8	TOTAL General Services	(5,083)		1,212	1,773		687	1,127					(284)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			4,072	(12,994)								(8,922)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			245	4,060								4,305	15
16	TOTAL Health Care and Programs			4,317	(8,934)								(4,617)	16
	C. General Administration													
17	Administrative			(213,898)		1,871							(212,027)	17
18	Directors Fees													18
19	Professional Services	(14,423)	14,325	(103,687)	(5,292)	(79,150)	838	56		(3,805)			(191,137)	19
20	Fees, Subscriptions & Promotions	(79,938)	2,354	4,996	1,437	306		103					(70,742)	20
21	Clerical & General Office Expenses	(227,744)	4,390	28,721	475	76,013	575	736					(116,834)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,555	1,006	44							2,605	24
25	Other Admin. Staff Transportation			5,613	4,164	1,166							10,943	25
26	Insurance-Prop.Liab.Malpractice			2,009				211					2,220	26
27	Other (specify):*			5,279		9,048							14,327	27
28	TOTAL General Administration	(322,105)	21,069	(269,412)	1,790	9,299	1,413	1,107		(3,805)			(560,644)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(327,188)	21,069	(263,883)	(5,370)	9,299	2,101	2,234		(3,805)			(565,544)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Galesburg # 0052761 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	(32,287)	87,322	1,331	204	79	1,066	3,722					61,437	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,708)	151,497	4,716	16		804	1,161					149,486	32
33	Real Estate Taxes		1				1,243	1,398					2,641	33
34	Rent-Facility & Grounds		(396,750)	580			(7,286)	(23,000)					(426,456)	34
35	Rent-Equipment & Vehicles			90	394	354	376	414					1,627	35
36	Other (specify):*	(65,102)	58,624										(6,478)	36
37	TOTAL Ownership	(106,097)	(99,306)	6,717	614	433	(3,798)	(16,305)					(217,742)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(21,204)				(21,204)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(17,286)											(17,286)	43
44	TOTAL Special Cost Centers	(17,286)							(21,204)				(38,490)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(450,571)	(78,237)	(257,166)	(4,756)	9,731	(1,697)	(14,071)	(21,204)	(3,805)			(821,776)	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	Rent	\$ 396,750	1145 Frank St. LLC	100.00%	\$	\$ (396,750)	1
2	V	33	Rent Income - RE Tax	27,008	1145 Frank St. LLC	100.00%		(27,008)	2
3	V	32	Interest	5	1145 Frank St. LLC	100.00%	151,502	151,497	3
4	V	19	Professional Fees		1145 Frank St. LLC	100.00%	14,325	14,325	4
5	V	36	Amortization		1145 Frank St. LLC	100.00%	58,624	58,624	5
6	V	21	Bank Charges		1145 Frank St. LLC	100.00%	4,390	4,390	6
7	V	30	Depreciation		1145 Frank St. LLC	100.00%	87,322	87,322	7
8	V	33	Real Estate Tax		1145 Frank St. LLC	100.00%	26,345	26,345	8
9	V	33	Real Estate Tax - Prior Year		1145 Frank St. LLC	100.00%	664	664	9
10	V	20	State Replacement Tax		1145 Frank St. LLC	100.00%	2,354	2,354	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 423,763			\$ 345,526	\$ * (78,237)	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%	\$ 224	\$ 224	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	41	41	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	906	906	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	41	41	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	4,072	4,072	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	245	245	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	55,519	55,519	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,230	2,230	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,996	4,996	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	28,721	28,721	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,555	1,555	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,613	5,613	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	2,009	2,009	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	5,279	5,279	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,331	1,331	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,716	4,716	30
31	V	34	RENT		APERION CARE, INC.	100.00%	580	580	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	90	90	32
33	V								33
34	V								34
35	V	17	MANAGEMENT FEE	269,417	APERION CARE, INC.	100.00%		(269,417)	35
36	V	19	HOME OFFICE	98,582	APERION CARE, INC.	100.00%		(98,582)	36
37	V	19	DATA PROCESSING	7,335	APERION CARE, INC.			(7,335)	37
38	V								38
39	Total			\$ 375,334			\$ 118,168	\$ * (257,166)	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%	\$ 9,802	\$	9,802 15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,706		5,706 16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	2,065		2,065 17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	30,406		30,406 18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	4,060		4,060 19
20	V	19	PROFESSIONAL FEES	6,181	APERION CONSULTING, LLC	100.00%	889		(5,292) 20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,437		1,437 21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	475		475 22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	1,006		1,006 23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	4,164		4,164 24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	204		204 25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	16		16 26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	394		394 27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	10	CONSULTING	43,400	APERION CONSULTING, LLC	100.00%			(43,400) 34
35	V	01	DIETICIAN	14,700	APERION CONSULTING, LLC	100.00%			(14,700) 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	1,100	APERION CONSULTING, LLC	100.00%			(1,100) 38
39	Total			\$ 65,381			\$ 60,625	\$ *	(4,756) 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%	\$ 1,871	\$ 1,871	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,469	1,469	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	306	306	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	76,013	76,013	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	44	44	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,166	1,166	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	9,048	9,048	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	79	79	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	354	354	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	80,619	APERION FINANCIAL, LLC	100.00%		(80,619)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 80,619			\$ 90,350	\$ * 9,731	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%	\$ 246	\$ 246	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC	100.00%	441	441	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	838	838	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	575	575	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,066	1,066	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	804	804	20
21	V	34	RENT		8131 N. MONTICELLO, LLC	100.00%	294	294	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC	100.00%	376	376	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,243	1,243	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC	100.00%		(7,000)	26
27	V	34	RENT	580	8131 N. MONTICELLO, LLC	100.00%		(580)	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			\$ 7,580			\$ 5,883	\$ * (1,697)	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%	\$ 466	\$ 466	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC	100.00%	465	465	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC	100.00%	196	196	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC	100.00%	56	56	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC	100.00%	103	103	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC	100.00%	736	736	20
21	V	26	INSURANCE		CHASE OFFICE,LLC	100.00%	211	211	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC	100.00%	3,722	3,722	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC	100.00%	1,161	1,161	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC	100.00%	1,398	1,398	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC	100.00%	414	414	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC	100.00%		(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			\$ 8,929	\$ * (14,071)	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	\$ 283,852	RENEWAL REHAB	100.00%	\$ 262,648	\$ (21,204)	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			\$ 283,852			\$ 262,648	\$ * (21,204)	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	\$ 15,854	ProPay HR LLC	24.00%	\$ 12,049	\$ (3,805)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 15,854			\$ 12,049	\$ * (3,805)	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.

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	MICHAEL ROSEN	29.50%	Aperion Care Amboy	Amboy	1145 Frank St. LLC	Galesburg	Building Company	1
2	YOSEF MEYSEL TRUST	32.00%	Aperion Care Bloomington	Bloomington	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	2
3	FREDRICK S. FRANKEL	1.00%	Aperion Care Bridgeport	Bridgeport	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	DAVID BERKOWITZ TRUST	32.00%	Aperion Care Burbank	Burbank	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	4
5	STEVEN TUROFSKY	1.00%	Aperion Care Chicago Heights	Chicago Heights	PROPAY	EVANSTON	PAYROLL SERVICES	5
6	HOWARD BORENSTEIN	4.50%	Aperion Care Colfax	Colfax	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7			Aperion Care Demotte	Demotte,IN	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	7
8			Aperion Care Dolton	Dolton	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	8
9			Aperion Care Elgin	Elgin	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	9
10			Aperion Care Evanston	Evanston	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Hidden Lake	St. Louis, MO	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	12
13			Aperion Care Highwood	Highwood	ECO-BRITE	SKOKIE	LAUNDRY	13
14			Aperion Care International	Chicago	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	14
15			Aperion Care Jacksonville	Jacksonville	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	15
16			Aperion Care Kokomo	Kokomo, IN	APERION ESTATES PERU	PERU, IN	ALF	16
17			Aperion Care Litchfield	Litchfield	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	17
18			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	19
20			Aperion Care Oak Lawn	Oak Lawn	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	20
21			Aperion Care Peru	Peru, IN	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	21
22			Aperion Care Plum Grove	Palatine	PHARMORE	SKOKIE	PHARMACY	22
23			Aperion Care Spring Valley	Spring Valley				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aperion Care Galesburg # 0052761 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.3	3.25%	Alloc. Salary	\$ 6,456	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	997	17-7	2
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.6	3.00%	Alloc. Salary	2,382	21-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	973	21-7	4
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.3	3.25%	Alloc. Salary	6,456	17-7	5
6	Fredrick Frankel	Owner	Administrative	1.00%	See Attached	1.3	3.25%	Alloc. Salary	5,956	17-7	6
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.3	3.25%	Alloc. Salary	6,191	17-7	7
8	Michael Rosen	Owner	Administrative	29.50%	See Attached	1.3	3.25%	Alloc. Salary	6,456	17-7	8
9	Meir Meystel	Relative	Clerical	0.00%	See Attached	0.2	2.90%	Alloc. Salary	849	21-7	9
10	Nosson Factor	Relative	Clerical	0.00%	See Attached	1.1	3.34%	Alloc. Salary	2,739	21-7	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	\$ 39,455		13

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

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

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

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	1,053,513	34	\$ 6,946	\$	34,006	\$ 224	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		34,006	41	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	34,006	906	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		34,006	41	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	34,006	4,072	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		34,006	245	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	34,006	55,519	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		34,006	2,230	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		34,006	4,996	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	34,006	28,721	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		34,006	1,555	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		34,006	5,613	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		34,006	2,009	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		34,006	5,279	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		34,006	1,331	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		34,006	4,716	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		34,006	580	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		34,006	90	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,660,864	\$ 2,890,119		\$ 118,168	25

Ending: 12/31/16

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	1	DIETARY	PATIENT DAYS	34	\$ 303,659	\$ 303,659	34,006	\$ 9,802	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	34	176,775	175,516	34,006	5,706	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	34	63,982		34,006	2,065	3
4	10	SALARY NURSE	PATIENT DAYS	34	941,995	941,995	34,006	30,406	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	34	125,781		34,006	4,060	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	34	27,541		34,006	889	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	34	44,521		34,006	1,437	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	34	14,707		34,006	475	8
9	24	SEMINARS	PATIENT DAYS	34	31,152		34,006	1,006	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	34	129,014		34,006	4,164	10
11	30	DEPRECIATION	PATIENT DAYS	34	6,318		34,006	204	11
12	32	INTEREST	PATIENT DAYS	34	508		34,006	16	12
13	35	AUTO LEASE	PATIENT DAYS	34	12,204		34,006	394	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		\$ 60,625	25

Ending: 12/31/16

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	5	UTILITIES	ACTUAL CENSUS	34	\$ 7,614	\$	34,006	\$ 246	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	13,676		34,006	441	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	25,960		34,006	838	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	34	17,828		34,006	575	4
5	30	DEPRECIATION	ACTUAL CENSUS	34	33,024		34,006	1,066	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	34	24,903		34,006	804	6
7	34	RENT	ACTUAL CENSUS	34	9,100		34,006	294	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	11,640		34,006	376	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	34	38,500		34,006	1,243	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				\$ 182,245	\$		\$ 5,883	25

Ending: 12/31/16

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$	34,006	\$ 466	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		34,006	465	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		34,006	196	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		34,006	56	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		34,006	103	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		34,006	736	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		34,006	211	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		34,006	3,722	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		34,006	1,161	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		34,006	1,398	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		34,006	414	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 276,616	\$		\$ 8,929	25

Ending: 12/31/16

(847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	THERAPY SERVICES	DIRECT		\$	\$		\$ 262,648	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				\$	\$		\$ 262,648	25

Ending: 12/31/16

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 12,049	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				\$	\$		\$ 12,049	25

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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			\$	3,337,500			\$	151,502	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	First Midwest Bank		X	Line of Credit				1,067,378				39,612	6	
7	Auto Loan		X					12,527					7	
8					-								8	
9	TOTAL Facility Related						\$	4,417,405				\$	191,114	9
	B. Non-Facility Related*													
10	Interest Income		X									(8,708)	10	
11	Interest Income - Bldg Co		X									(5)	11	
12	Allocated from Aperion Care		X									4,716	12	
13	See Supplemental Schedule				-							1,981	13	
14	TOTAL Non-Facility Related						\$					\$	(2,016)	14
15	TOTALS (line 9+line14)						\$	4,417,405				\$	189,098	15

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

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from Aperion Consulting		X				\$		\$			\$	16
16	Allocated from 8131 N. Monticello LLC		X										804
17	Allocated from Chase Office, LLC		X										1,161
18													18
19													19
20	TOTAL Non-Facility Related												1,981

* 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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Aperion Care Galesburg

COUNTY

Knox

FACILITY IDPH LICENSE NUMBER

0052761

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. <u>99-09-202-017</u>	<u>Long Term Care Facility</u>	\$ <u>25,972.54</u>	\$ <u>25,972.54</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>65,893.19</u>	\$ <u>1,084.31</u>
3. <u>10-27-307-027-0000</u>	<u>Home Office Allocation</u>	\$ <u>40,836.48</u>	\$ <u>551.03</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>132,702.21</u>	\$ <u>27,607.88</u>

B. Real Estate Tax Cost Allocations

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

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.

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.

FACILITY NAME Aperion Care Galesburg COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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.

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?

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.)

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

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.

D. Does the Operating Entity?

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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	\$ 308,847	1
2	Allocated from Chase Office LLC		2016	2,004	2
3	TOTALS			\$ 310,851	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	108		2015	1972	\$ 2,758,153	\$ 87,322	35	\$ 78,804	\$ (8,518)	\$ 138,338	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		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)		110,812	3,348		2,843	(505)	9,356	68
69	Financial Statement Depreciation			79,829			(79,829)		69
70	TOTAL (lines 4 thru 69)		\$ 2,868,965	\$ 170,499		\$ 81,647	\$ (88,852)	\$ 147,694	70

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

Facility Name & ID Number Aperion Care Galesburg

0052761

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,868,965	\$ 170,499		\$ 81,647	\$ (88,852)	\$ 147,694	1
2	Fire Sprinklers	2013	68,730		20	3,437	3,437	12,887	2
3	New White Alucabond Face Panel Mounted Sign	2014	4,141		20	276	276	690	3
4	Entrance Sign & 2 Formed Pan Faces	2014	5,450		20	1,090	1,090	3,270	4
5	100 Gallon Natural Gas Water Heater	2014	8,740		20	1,748	1,748	4,370	5
6	Security Camera System Installation	2014	13,842		20	2,768	2,768	6,690	6
7	Drain, Remove & Replace Old 100 Gallon Gas Tank	2014	5,168		20	258	258	624	7
8	New Landscape Design	2014	9,494		20	633	633	1,582	8
9	Vestibule-New Ceramic Tile & Walk Off Carpet Tile, Dumpster	2014	14,132		20	707	707	1,590	9
10	Lounge / Dining Room-New Vinyl Plankwood Tile, Wallcovering	2014	35,072		20	1,754	1,754	3,946	10
11	Admissions Office / Activiry Room-New Carpet Tile, Wallcovering	2014	4,620		20	231	231	520	11
12	Conference Room-New Carpet Tile, Wallcovering	2014	4,498		20	225	225	506	12
13	Therapy Room - Replace Carpet With Vinyl Tile, Wallcovering	2014	10,288		20	514	514	1,157	13
14	2 North Corridors - New Vct & Pure Vinyl Tile	2014	10,864		20	543	543	1,222	14
15	2 South Corridors - New Vct & Pure Vinyl Tile	2014	7,917		20	396	396	891	15
16	Corridors - Wallcovering, Handrails, Bumper & Corner Guards	2014	34,495		20	1,725	1,725	3,881	16
17	Nurse Call System Annunciator Panet	2014	5,956		20	298	298	620	17
18	10 Windows Near Egress	2015	4,841		20	242	242	383	18
19	B-Wing Corridor - Install Wallcovering & Paint	2015	17,689		20	884	884	1,769	19
20	Guest Bathroom-Replace Flr & Wall Tile,Toilet,Sink,Faucet,Fixtu	2015	4,260		20	213	213	426	20
21	Nurses Station-2 Custom Nurse Stations With Sink & Faucet	2015	28,376		20	1,419	1,419	2,838	21
22	Vestibule & Dining-Wallcovering, New Divider Wall, Light Fixtur	2015	21,725		20	1,086	1,086	2,172	22
23	Therapy Room-Laminate Workstation; Admissions Office-Shades	2015	9,970		20	499	499	997	23
24	Paint Library, Activity Rm, Doorframes, Therapy Rm, Dining Rm	2015	28,018		20	1,401	1,401	2,802	24
25	2 N & 2 S Corridors - Millwork Base, Signage, Lighting	2015	43,324		20	2,166	2,166	4,332	25
26	Guest Bathrm & Vestibule- Tile,Mirror,Remove Windows	2015	2,561		20	128	128	245	26
27	Nurse Station- Demo, Electrical Power To New Station	2015	4,243		20	212	212	407	27
28	Library/Group & Conference Rm- Cove Base & Shades	2015	3,374		20	169	169	323	28
29	Lounge - New Vinyl Tile, Light Fixtures	2015	8,402		20	420	420	805	29
30	Therapy Rm & Misc - New Workstation, Dumpster	2015	5,563		20	278	278	533	30
31	Corridors- Reroute Power & New Light Fixtures, 6 Outlets	2015	39,362		20	1,968	1,968	3,772	31
32	Fence	2015	4,340		20	217	217	380	32
33	Corridors-Signage,Cornice-Dining Room & Resident Rooms...	2016	16,578		20	86	86	86	33
34	TOTAL (lines 1 thru 33)		\$ 3,354,996	\$ 170,499		\$ 109,638	\$ (60,861)	\$ 214,412	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		\$ 3,354,996	\$ 170,499		\$ 109,638	\$ (60,861)	\$ 214,412	1
2	Heat Pump	2016	4,150		20	104	104	104	2
3	Installation Of Entrance Sign And Cabinet Faces	2016	4,722		20	59	59	59	3
4	Heat Exchanger	2016	3,714		20	186	186	186	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
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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)		\$ 3,367,582	\$ 170,499		\$ 109,986	\$ (60,513)	\$ 214,760	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,367,582	\$ 170,499		\$ 109,986	\$ (60,513)	\$ 214,760	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
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)		\$ 3,367,582	\$ 170,499		\$ 109,986	\$ (60,513)	\$ 214,760	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,367,582	\$ 170,499		\$ 109,986	\$ (60,513)	\$ 214,760	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
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)		\$ 3,367,582	\$ 170,499		\$ 109,986	\$ (60,513)	\$ 214,760	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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	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 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from 8131 N. Monticello LLC	2010		384	20	334	(50)	3,458	3
4 Allocated from Chase Office, LLC	2016	18,038	193	20	193		193	4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Aperion Care	2010	962	155	20	48	(107)	337	9
10 Allocated from Aperion Care	2012	273	21	20	14	(7)	68	10
11 Allocated from Aperion Care	2013	116	13	20	6	(7)	23	11
12								12
13								13
14 Allocated from 8131 N. Monticello LLC	2010		677	20	292	(385)	3,060	14
15 Allocated from 8131 N. Monticello LLC	2013			20	51	51	312	15
16								16
17 Allocated from Chase Office, LLC	2016	91,423	1,905	20	1,905		1,905	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)		\$ 110,812	\$ 3,348		\$ 2,843	\$ (505)	\$ 9,356	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 110,812	\$ 3,348		\$ 2,843	\$ (505)	\$ 9,356	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 110,812	\$ 3,348		\$ 2,843	\$ (505)	\$ 9,356	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	\$ 143,268	\$ 658	\$ 18,099	\$ 17,441	10	\$ 39,467	71
72	Current Year Purchases	122,805	2,033	5,778	3,745	10	5,778	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 266,073	\$ 2,691	\$ 23,877	\$ 21,186		\$ 45,246	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 SAVANA	2013	\$ 54,662	\$	\$ 7,037	\$ 7,037	5	\$ 28,858	76
77		Allocation from Aperion Care	2016	1,080	219	216	(3)	5	485	77
78		Allocation from Aperion Consulti	2016	748	145	150	5	5	299	78
79										79
80	TOTALS			\$ 56,490	\$ 364	\$ 7,403	\$ 7,039		\$ 29,642	80

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)	\$ 4,000,995	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,554	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,267	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,287)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 289,648	85

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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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?

☐ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from 8131 N. Monticello LLC				294			5
6								6
7	TOTAL				\$294			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

9. Option to Buy:

☐ YES

☐ NO

Terms:

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

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$9,294
- 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		\$	\$394	17
18					18
19					19
20					20
21	TOTAL		\$-	\$394	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)	\$			

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	\$		\$ 139,325	\$		\$ 139,325	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,276			5,276	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			139,175			139,175	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			32,001			32,001	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					11,450	7,513		18,963	13
14	TOTAL			\$		\$ 327,227	\$ 7,513		\$ 334,740	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	\$ 129,620	\$ 298,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,431,826	1,431,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,993	82,993	6
7	Other Prepaid Expenses	1,117	1,117	7
8	Accounts Receivable (owners or related parties)	600,000	600,000	8
9	Other(specify): <u>See Attached Schedule</u>	2,462	1,091,211	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,248,018	\$ 3,505,679	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		308,847	13
14	Buildings, at Historical Cost		2,758,153	14
15	Leasehold Improvements, at Historical Cost	339,546	339,546	15
16	Equipment, at Historical Cost	248,890	331,890	16
17	Accumulated Depreciation (book methods)	(176,402)	(311,715)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,049,988	1,102,944	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,462,022	\$ 4,529,665	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,710,040	\$ 8,035,344	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 343,227	\$ 343,228	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,079,905	1,079,905	29
30	Accrued Salaries Payable	159,751	159,751	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	6,009	6,009	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,345	32
33	Accrued Interest Payable	3,706	18,301	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	49,722	49,722	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,642,320	\$ 1,683,261	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,337,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,462,623	1,462,623	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,462,623	\$ 4,800,123	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,104,943	\$ 6,483,384	46
47	TOTAL EQUITY(page 18, line 24)	\$ 605,097	\$ 1,551,960	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,710,040	\$ 8,035,344	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 563,626	1
2	Restatements (describe):		2
3	<u>Rounding</u>	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 563,628	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	374,802	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	(333,333)	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)	\$ 41,469	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)	\$ 605,097	24 *

* This must agree with page 17, line 47.

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	\$ 5,550,249	1
2	Discounts and Allowances for all Levels	186,598	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,736,847	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216,116	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 216,116	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	12,074	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	430	19
20	Radiology and X-Ray	163	20
21	Other Medical Services	4,821	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 17,488	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,708	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,708	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,979,159	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	790,476	31
32	Health Care	2,095,678	32
33	General Administration	1,516,483	33
	B. Capital Expense		
34	Ownership	587,737	34
	C. Ancillary Expense		
35	Special Cost Centers	352,026	35
36	Provider Participation Fee	261,957	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,604,357	40
41	Income before Income Taxes (line 30 minus line 40)**	374,802	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 374,802	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,603,834	44
45	Private Pay - Net Inpatient Revenue	248,598	45
46	Medicare - Net Inpatient Revenue	300,721	46
47	Other-(specify) Insurance	3,583,694	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,736,847	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	688	790	\$ 26,629	\$ 33.71	1
2	Assistant Director of Nursing	1,928	2,157	44,068	20.43	2
3	Registered Nurses	8,280	8,831	234,987	26.61	3
4	Licensed Practical Nurses	23,500	25,251	487,203	19.29	4
5	CNAs & Orderlies	55,723	58,285	614,649	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,378	9,131	187,343	20.52	8
9	Activity Director	656	664	14,341	21.60	9
10	Activity Assistants	3,725	4,062	42,556	10.48	10
11	Social Service Workers	6,270	6,867	141,509	20.61	11
12	Dietician					12
13	Food Service Supervisor	2,336	2,456	30,661	12.48	13
14	Head Cook	1,831	1,886	18,191	9.65	14
15	Cook Helpers/Assistants	9,070	9,446	91,339	9.67	15
16	Dishwashers					16
17	Maintenance Workers	4,876	5,192	67,655	13.03	17
18	Housekeepers	14,611	15,474	142,021	9.18	18
19	Laundry	3,054	3,219	31,165	9.68	19
20	Administrator	1,968	2,082	71,173	34.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	816	895	13,073	14.61	23
24	Clerical	2,502	2,639	39,930	15.13	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	1,741	1,852	24,871	13.43	31
32	Other Health Care(specify)					32
33	Other(specify)	161	161	1,931	11.96	33
34	TOTAL (lines 1 - 33)	152,114	161,340	\$ 2,325,295 *	\$ 14.41	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	231	\$ 14,700	01-03	35
36	Medical Director	Monthly	23,727	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	519	43,401	10-03	38
39	Pharmacist Consultant	Monthly	10,251	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	12	462	11-03	44
45	Social Service Consultant	71	4,444	12-03	45
46	Other(specify) <u>Psychiatric MD</u>	89	6,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	922	\$ 102,985		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.

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

0052761

Report Period Beginning: 01/01/16

Ending: 12/31/16

Facility Name & ID Number		Aperion Care Galesburg		STATE OF ILLINOIS	#	0052761	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>IL Council on LTC \$7,524</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>5,134</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>261,957</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ <u>Yes</u> Indicate the amount. \$ <u>1,118</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% ln 14</u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>N/A</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							