

		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>0049858</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																
Facility Name: <u>Aperion Care Midlothian</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>3249 West 147th St</u> <u>Midlothian</u> <u>60445</u>																																																																																		
Number City Zip Code																																																																																		
County: <u>Cook</u>																																																																																		
Telephone Number: <u>(708) 389-3141</u> Fax # <u>(773) 396-1626</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>(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>1/1/2008</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>1/1/2008</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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Facility Name & ID Number

Aperion Care Midlothian

#

0049858

Report Period Beginning:

01/01/16

Ending:

12/31/16

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,568	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,738	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,306	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	156	3	17,435	17,594	8
9	SNF/PED					9
10	ICF	13,287	69	106	13,462	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,443	72	17,541	31,056	14

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

93.24%

D. How many bed-hold days during this year were paid by the Department?

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

01/01/2008

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

01/01/2008

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

48

and days of care provided

2,525

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/16

Fiscal Year:

12/31/16

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

Facility Name & ID Number Aperion Care Midlothian # 0049858 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	146,808	12,481	14,972	174,261		174,261	(1,489)	172,772			1
2	Food Purchase		154,518		154,518		154,518	(4,331)	150,187			2
3	Housekeeping	128,399	25,930	13,000	167,329		167,329		167,329			3
4	Laundry		6,629	62,727	69,356		69,356		69,356			4
5	Heat and Other Utilities			68,568	68,568		68,568	(4,342)	64,226			5
6	Maintenance	43,236	18,634	69,757	131,627		131,627	(4,169)	127,458			6
7	Other (specify):*							2,102	2,102			7
8	TOTAL General Services	318,443	218,192	229,024	765,659		765,659	(12,229)	753,430			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,423,348	69,079	114,507	1,606,934		1,606,934	(72,013)	1,534,921			10
10a	Therapy	87,752	129		87,881		87,881		87,881			10a
11	Activities	96,165	10,487	2,888	109,540		109,540		109,540			11
12	Social Services	161,658		915	162,573		162,573		162,573			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,931	3,931			15
16	TOTAL Health Care and Programs	1,768,923	79,695	136,310	1,984,928		1,984,928	(68,083)	1,916,845			16
	C. General Administration											
17	Administrative	93,351		264,443	357,794		357,794	(212,032)	145,762			17
18	Directors Fees											18
19	Professional Services			306,387	306,387	(2,880)	303,507	(181,207)	122,300			19
20	Dues, Fees, Subscriptions & Promotions			102,381	102,381		102,381	(78,155)	24,226			20
21	Clerical & General Office Expenses	86,075		247,283	333,358		333,358	(108,512)	224,846			21
22	Employee Benefits & Payroll Taxes			371,087	371,087		371,087		371,087			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,378	2,378		2,378	2,379	4,757			24
25	Other Admin. Staff Transportation			6,738	6,738		6,738	9,994	16,732			25
26	Insurance-Prop.Liab.Malpractice			152,453	152,453		152,453	2,028	154,481			26
27	Other (specify):*							13,084	13,084			27
28	TOTAL General Administration	179,426		1,453,150	1,632,576	(2,880)	1,629,696	(552,421)	1,077,275			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,266,792	297,887	1,818,484	4,383,163	(2,880)	4,380,283	(632,733)	3,747,550			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			65,904	65,904		65,904	80,662	146,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,164	32,164		32,164	104,535	136,699			32
33	Real Estate Taxes			171,395	171,395	2,880	174,275	2,411	176,686			33
34	Rent-Facility & Grounds			464,778	464,778		464,778	(190,732)	274,046			34
35	Rent-Equipment & Vehicles			8,099	8,099		8,099	1,486	9,585			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			748,818	748,818	2,880	751,698	(8,116)	743,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,806	379,083	482,889		482,889	(27,814)	455,075			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,800	224,800		224,800		224,800			42
43	Other (specify):*			7,265	7,265		7,265	(7,265)				43
44	TOTAL Special Cost Centers		103,806	611,148	714,954		714,954	(35,079)	679,875			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,266,792	401,693	3,178,450	5,846,935		5,846,935	(675,928)	5,171,007			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	(5,029)	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	20,338	30		9
10	Interest and Other Investment Income	(5,815)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,852)	21		18
19	Entertainment	(6,750)	21		19
20	Contributions	(81,350)	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	(187,093)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(613)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(41,420)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (310,588)		\$	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)	(365,340)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (365,340)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (675,928)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (5,236)	43	1
2	Promotional Products	(2,029)	43	2
3	Bank Charges	(8,098)	21	3
4	Theft & Damage Loss	(387)	21	4
5	Amortization	(6,478)	36	5
6	Additional R&M	8,166	06	6
7	Non Allowable Legal Fees	(2,790)	19	7
8	PAC Dues	(3,054)	20	8
9	Bldg Co. - Amortization	(9,369)	36	9
10	Bldg Co. - Bank Charges	(2,494)	21	10
11	Capitalized R&M	(9,651)	06	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(41,420)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
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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 Midlothian # 0049858 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				(1,489)								(1,489)	1
2	Food Purchase	(4)		205	(4,532)								(4,331)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,029)		37			224	425					(4,342)	5
6	Maintenance	(1,485)		827	(4,339)		403	425					(4,169)	6
7	Other (specify):*			37	1,886			179					2,102	7
8	TOTAL General Services	(6,518)		1,106	(8,474)		628	1,029					(12,229)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,718	(75,731)								(72,013)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			223	3,708								3,931	15
16	TOTAL Health Care and Programs			3,941	(72,024)								(68,083)	16
	C. General Administration													
17	Administrative			(213,741)		1,709							(212,032)	17
18	Directors Fees													18
19	Professional Services	(2,790)		(96,683)	812	(79,626)	765	52		(3,738)			(181,207)	19
20	Fees, Subscriptions & Promotions	(84,404)		4,563	1,312	280		94					(78,155)	20
21	Clerical & General Office Expenses	(208,287)	2,494	26,230	434	69,419	526	672					(108,512)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,421	918	40							2,379	24
25	Other Admin. Staff Transportation			5,126	3,803	1,065							9,994	25
26	Insurance-Prop.Liab.Malpractice			1,835				193					2,028	26
27	Other (specify):*			4,821		8,263							13,084	27
28	TOTAL General Administration	(295,481)	2,494	(266,427)	7,279	1,150	1,291	1,011		(3,738)			(552,421)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(301,999)	2,494	(261,380)	(73,218)	1,150	1,918	2,040		(3,738)			(632,733)	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	20,338	54,478	1,215	186	72	973	3,399					80,662	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,815)	104,233	4,307	15		734	1,060					104,535	32
33	Real Estate Taxes						1,135	1,276					2,411	33
34	Rent-Facility & Grounds		(160,000)	530			(7,262)	(24,000)					(190,732)	34
35	Rent-Equipment & Vehicles			83	360	323	343	378					1,486	35
36	Other (specify):*	(15,847)	9,369										(6,478)	36
37	TOTAL Ownership	(1,324)	8,080	6,134	561	395	(4,076)	(17,886)					(8,116)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(27,814)				(27,814)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,265)											(7,265)	43
44	TOTAL Special Cost Centers	(7,265)							(27,814)				(35,079)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(310,588)	10,574	(255,246)	(72,658)	1,545	(2,158)	(15,846)	(27,814)	(3,738)			(675,928)	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 PG6 - supplemental		See PG6 - supplemental		See PG6 - 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 Income	\$ 160,000	Plaza Nursing Realty LLC	100.00%	\$	(160,000)	1
2	V	36	Amortization Expense		Plaza Nursing Realty LLC	100.00%	9,369	9,369	2
3	V	21	Bank Charges		Plaza Nursing Realty LLC	100.00%	2,494	2,494	3
4	V	30	Depreciation Expense		Plaza Nursing Realty LLC	100.00%	54,478	54,478	4
5	V	32	Interest Expense		Plaza Nursing Realty LLC	100.00%	104,234	104,234	5
6	V	33	Real Estate Tax	70,105	Plaza Nursing Realty LLC	100.00%	70,105		6
7	V	32	Interest Income	1	Plaza Nursing Realty LLC	100.00%		(1)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 230,106			\$ 240,680	\$ * 10,574	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%	\$ 205	\$ 205	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	37	37	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	827	827	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%	3,718	3,718	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%	50,703	50,703	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,037	2,037	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,563	4,563	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	26,230	26,230	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,421	1,421	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,126	5,126	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,835	1,835	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,821	4,821	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,215	1,215	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	4,307	4,307	30
31	V	34	RENT		APERION CARE, INC.	100.00%	530	530	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	83	83	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	264,443	APERION CARE, INC.	100.00%		(264,443)	35
36	V	19	HOME OFFICE	98,720	APERION CARE, INC.	100.00%		(98,720)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 363,163			\$ 107,917	\$ * (255,246)	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%	\$ 8,951	\$ 8,951	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,211	5,211	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,886	1,886	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	27,769	27,769	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,708	3,708	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	812	812	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,312	1,312	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	434	434	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	918	918	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,803	3,803	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%	360	360	27
28	V				APERION CONSULTING, LLC	100.00%			28
29	V				APERION CONSULTING, LLC	100.00%			29
30	V				APERION CONSULTING, LLC	100.00%			30
31	V				APERION CONSULTING, LLC	100.00%			31
32	V				APERION CONSULTING, LLC	100.00%			32
33	V				APERION CONSULTING, LLC	100.00%			33
34	V	10	CONSULTING	103,500	APERION CONSULTING, LLC	100.00%		(103,500)	34
35	V	01	DIETICIAN	10,440	APERION CONSULTING, LLC	100.00%		(10,440)	35
36	V	02	FOOD SERVICE	4,532	APERION CONSULTING, LLC	100.00%		(4,532)	36
37	V	06	PAINTER	5,000	APERION CONSULTING, LLC	100.00%		(5,000)	37
38	V	06	PROJECT MANAGER	4,550	APERION CONSULTING, LLC	100.00%		(4,550)	38
39	Total			\$ 128,022			\$ 55,364	\$ * (72,658)	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%	\$ 1,709	\$ 1,709	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,342	1,342	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	280	280	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	69,419	69,419	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	40	40	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,065	1,065	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,263	8,263	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	72	72	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	323	323	23
24	V				APERION FINANCIAL, LLC	100.00%			24
25	V				APERION FINANCIAL, LLC	100.00%			25
26	V				APERION FINANCIAL, LLC	100.00%			26
27	V				APERION FINANCIAL, LLC	100.00%			27
28	V				APERION FINANCIAL, LLC	100.00%			28
29	V				APERION FINANCIAL, LLC	100.00%			29
30	V				APERION FINANCIAL, LLC	100.00%			30
31	V				APERION FINANCIAL, LLC	100.00%			31
32	V				APERION FINANCIAL, LLC	100.00%			32
33	V				APERION FINANCIAL, LLC	100.00%			33
34	V	19	HOME OFFICE EXPENSE	80,968	APERION FINANCIAL, LLC	100.00%		(80,968)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 80,968			\$ 82,513	\$ * 1,545	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	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 224	\$ 224	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		403	403	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		765	765	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		526	526	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		973	973	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		734	734	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		268	268	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		343	343	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,135	1,135	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	530	8131 N. MONTICELLO, LLC			(530)	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			\$ 7,530			\$ 5,372	\$ * (2,158)	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%	\$ 425	\$ 425	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		425	425	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		179	179	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		52	52	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		94	94	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		672	672	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		193	193	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		3,399	3,399	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,060	1,060	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,276	1,276	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		378	378	25
26	V	34	RENT	24,000	CHASE OFFICE,LLC			(24,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 24,000			\$ 8,154	\$ * (15,846)	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	\$ 372,336	Renewal Rehab	100.00%	\$ 344,522	\$ (27,814)	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			\$ 372,336			\$ 344,522	\$ * (27,814)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 15,575	ProPay HR LLC	24.00%	\$ 11,837	\$ (3,738)	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			\$ 15,575			\$ 11,837	\$ * (3,738)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	4	Laundry Services	\$ 68,503	EcoBrite	100.00%	\$ 68,503	\$	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			\$ 68,503			\$ 68,503	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

Facility Name & ID Number

Aperion Care Midlothian

0049858

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	50.000%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz Trust	43.000%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	George Lowinger	7.000%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4			Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5			Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Oak Lawn	Oak Lawn	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Peru	Peru, IN	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Plum Grove	Palatine	PLAZA NURSING REALTY	MIDLOTHIAN	BUILDING CO	22
23			Aperion Care Spring Valley	Spring Valley				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aperion Care Midlothian # 0049858 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	\$ 5,896	17-7	1
2	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	889	21-7	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	5,896	17-7	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	910	17-7	4
5	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.6	3.00%	Alloc. Salary	2,175	21-7	5
6	Meir Meystel	Relative	Clerical	0.00%	See Attached	0.2	2.90%	Alloc. Salary	775	21-7	6
7	Nosson Factor	Relative	Clerical	0.00%	See Attached	1	3.04%	Alloc. Salary	2,502	21-7	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 19,043		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

7

IL478-2471

Ending: 12/31/16

$$\frac{1}{2}$$

Facility Name & ID Number	Aperion Care Midlothian
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0049858

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 FINANCIAL, 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	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 57,979	31,056	\$ 1,709	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525		31,056	1,342	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485		31,056	280	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	31,056	69,419	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360		31,056	40	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125		31,056	1,065	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317		31,056	8,263	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458		31,056	72	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954		31,056	323	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					\$ 2,799,102	\$ 2,378,479		\$ 82,513	25

Ending: 12/31/16

Ending: 12/31/16

7

Facility Name & ID Number	Aperion Care Midlothian
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0049858

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Renewal Rehab

Street Address

4655 W Chase Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 673-6767

Fax Number

(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	91	\$	\$		\$ 344,522	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				\$	\$		\$ 344,522	25

Ending: 12/31/16

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Ending: 12/31/16

()

Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage			\$	4,425,000			\$	104,234	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				706,665				28,674	6
7	Insurance Policies		X									3,490	7
8					-								8
9	TOTAL Facility Related						\$	5,131,665			\$	136,398	9
	B. Non-Facility Related*												
10	Interest Income		X									(5,815)	10
11	Allocated from Aperion Care	X										4,307	11
12	Allocated from Aperion Consult	X										15	12
13	See Supplemental Schedule				-							1,793	13
14	TOTAL Non-Facility Related						\$				\$	300	14
15	TOTALS (line 9+line14)						\$	5,131,665			\$	136,698	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 Financial	X		Interest Expense			\$					\$ 734	15
16	Allocated from Chase Office, LLC	X		Interest Expense								1,060	16
17	Building Co	X										(1)	17
18													18
19													19
20	TOTAL Non-Facility Related											1,793	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.			\$	160,211	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.)			\$	167,517	2
3. Under or (over) accrual (line 2 minus line 1).			\$	7,306	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	166,500	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.)			\$	2,880	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 \$ <u>8,644</u> For <u>2013</u> 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.			\$	176,686	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	<u>129,219</u>	8	
		2012	<u>137,501</u>	9	
		2013	<u>143,985</u>	10	
		2014	<u>160,232</u>	11	
		2015	<u>165,106</u>	12	
2016 Accrual = 2015 Tax (Rounded)					
Beginning Accrual Adjusted					
Allocated from 8131 N Monticello = \$1135					
Allocated from Chase Office, LLC = \$1276					
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

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

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

FACILITY NAME	<u>Aperion Care Midlothian</u>	COUNTY	<u>Cook</u>
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CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEAperion Care MidlothianCOUNTYCook

FACILITY IDPH LICENSE NUMBER0049858

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:19,780

B. General Construction Type:ExteriorBrickFrameNumber of Stories1

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	Land		2016	\$383,883	1
2	Allocated from Chase Office, LLC			1,830	2
3	TOTALS			\$385,713	3

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Midlothian# 0049858

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)		101,468	3,055		2,593	(462)	8,543	68
69	Financial Statement Depreciation			65,904			(65,904)		69
70	TOTAL (lines 4 thru 69)		\$ 4,051,142	\$ 123,437		\$ 130,011	\$ 6,574	\$ 298,853	70

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

Facility Name & ID Number Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,051,142	\$ 123,437		\$ 130,011	\$ 6,574	\$ 298,853	1
2	Engineering Services	2013	6,210		20	414	414	1,449	2
3	Repavement	2013	3,860		20	257	257	858	3
4	Special Order Doors & Frames	2014	6,272		20	314	314	758	4
5	2 Coats Of Seal Coating On Pavement; Replace Concrete	2014	6,669		20	333	333	806	5
6	Service For Outlet Installation	2014	5,673		20	284	284	638	6
7	Sign-Fabricate & Install 2 New Lexan Faces Into Existing Display	2014	4,295		20	215	215	501	7
8	Boiler	2015	6,003		20	300	300	375	8
9	Repaired And Corrected Panels Feeding A/C And Heating For Re	2015	3,000		20	150	150	150	9
10	Full Depth Removal & Replace	2016	7,881		20	230	230	230	10
11	Concrete	2016	10,250		20	299	299	299	11
12	Replaced Vinyl Double Hung In Kitchen, Dishwasher And Garage	2016	3,496		20	175	175	175	12
13	Removed And Replaced Damaged Retainers, Skirts And Bumber	2016	3,155		20	158	158	158	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)		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	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)		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	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)		\$ 4,117,907	\$ 123,437		\$ 133,140	\$ 9,703	\$ 305,251	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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 Midlothian

0049858

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
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 Midlothian

0049858

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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		350	39	305	(45)	3,158	3
4	Allocated from Chase Office, LLC	2016	16,743	176	39	176		176	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	878	141	10	44	(97)	307	9
10	Allocated from Aperion Care	2012	249	19	15	12	(7)	62	10
11	Allocated from Aperion Care	2013	106	12	10	5	(7)	21	11
12									12
13	Allocated from 8131 N Monticello	2010		618	20	266	(352)	2,795	13
14	Allocated from 8131 N Monticello	2013							14
15					20	46	46	285	15
16									16
17	Allocated Chase Office, LLC	2016	83,492	1,739	20	1,739		1,739	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)		\$ 101,468	\$ 3,055		\$ 2,593	\$ (462)	\$ 8,543	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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		\$ 101,468	\$ 3,055		\$ 2,593	\$ (462)	\$ 8,543	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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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)		\$ 101,468	\$ 3,055		\$ 2,593	\$ (462)	\$ 8,543	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	\$ 34,856	\$ 602	\$ 5,834	\$ 5,232	10	\$ 22,834	71
72	Current Year Purchases	276,011	1,857	4,375	2,518	10	4,375	72
73	Fully Depreciated Assets	26,095				10	26,095	73
74								74
75	TOTALS	\$ 336,962	\$ 2,459	\$ 10,209	\$ 7,750		\$ 53,305	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		2009 GMC SAVANA	2011	\$ 23,542	\$	\$ 2,884	\$ 2,884	5	\$ 19,216
77		Allocated from Aperion Care	2016	986	200	197	(3)	5	197
78		Allocated from Aperion Consulti	2016	683	133	137	4	5	137
79									
80	TOTALS			\$ 25,211	\$ 333	\$ 3,218	\$ 2,885		\$ 19,550

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)			\$	4,865,792
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	126,229
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	146,567
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	20,338
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	378,106

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

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Plaza Terrace Property, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒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:		91		\$273,778			3
4	Additions							4
5								5
6	Allocated from 8131 N Monticello				268			6
7	TOTAL		91		\$274,046			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:\$9,226Description: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 Care		\$	\$360	17
18					18
19					19
20					20
21	TOTAL		\$-	\$360	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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 158,430	\$		\$ 158,430	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			48,845			48,845	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			165,177			165,177	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				90,448		90,448	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					6,631	13,358		19,989	13
14	TOTAL			\$		\$ 379,083	\$ 103,806		\$ 482,889	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	\$	\$ 44,686	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	759,958	759,958	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,512	68,512	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	250,000	250,000	8
9	Other(specify): <u>See Attached Schedule</u>	5,900	97,989	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,084,370	\$ 1,221,145	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		383,883	13
14	Buildings, at Historical Cost		3,454,948	14
15	Leasehold Improvements, at Historical Cost	578,905	578,905	15
16	Equipment, at Historical Cost	148,056	373,870	16
17	Accumulated Depreciation (book methods)	(415,690)	(470,168)	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>	536,279	989,614	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 847,550	\$ 5,311,052	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,931,920	\$ 6,532,197	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 321,310	\$ 321,310	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	706,665	706,665	29
30	Accrued Salaries Payable	78,237	78,237	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,830	2,830	31
32	Accrued Real Estate Taxes(Sch.IX-B)		166,500	32
33	Accrued Interest Payable	2,767	22,117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	49,868	49,868	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,161,677	\$ 1,347,527	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,425,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	326,390	326,390	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 326,390	\$ 4,751,390	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,488,067	\$ 6,098,917	46
47	TOTAL EQUITY(page 18, line 24)	\$ 443,853	\$ 433,280	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,931,920	\$ 6,532,197	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 326,098	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 326,100	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	164,543	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	(46,790)	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)	\$ 117,753	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)	\$ 443,853	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Midlothian**# **0049858**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	\$ 6,290,113	1
2	Discounts and Allowances for all Levels	(386,766)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,903,347	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	81,292	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 81,292	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	833	19
20	Radiology and X-Ray	160	20
21	Other Medical Services	2,880	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,380	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,815	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,815	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,644	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,644	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,011,478	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	765,659	31
32	Health Care	1,984,928	32
33	General Administration	1,632,576	33
	B. Capital Expense		
34	Ownership	748,818	34
	C. Ancillary Expense		
35	Special Cost Centers	490,154	35
36	Provider Participation Fee	224,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,846,935	40
41	Income before Income Taxes (line 30 minus line 40)**	164,543	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 164,543	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,051,104	44
45	Private Pay - Net Inpatient Revenue	9,273	45
46	Medicare - Net Inpatient Revenue	1,396,264	46
47	Other-(specify) <u>Managed Care</u>	2,446,706	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,903,347	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	2,048	2,175	\$ 97,940	\$ 45.03	1
2	Assistant Director of Nursing	1,767	1,931	56,162	29.08	2
3	Registered Nurses	3,361	3,607	109,193	30.27	3
4	Licensed Practical Nurses	23,230	24,847	682,702	27.48	4
5	CNAs & Orderlies	41,845	46,081	477,351	10.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,942	4,151	87,752	21.14	8
9	Activity Director	1,630	1,745	24,444	14.01	9
10	Activity Assistants	4,831	5,181	50,393	9.73	10
11	Social Service Workers	7,982	8,522	161,658	18.97	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,111	27,919	13.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,420	12,390	118,889	9.60	15
16	Dishwashers					16
17	Maintenance Workers	2,025	2,113	43,236	20.46	17
18	Housekeepers	11,433	12,195	128,399	10.53	18
19	Laundry					19
20	Administrator	2,032	2,136	93,351	43.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	232	259	2,829	10.92	23
24	Clerical	4,880	5,281	83,246	15.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,960	2,080	21,328	10.25	33
34	TOTAL (lines 1 - 33)	126,515	136,805	\$ 2,266,792 *	\$ 16.57	34

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

** See instructions.

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	\$ 14,972	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	103,500	10-03	38
39	Pharmacist Consultant	Monthly	6,507	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	2,888	11-03	44
45	Social Service Consultant	17	915	12-03	45
46	Other(specify) Psychiatric Consultant	Monthly	4,500	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	17	\$ 151,282		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Moshe Weinberger	Administrator	0	\$ 17,828	Workers' Compensation Insurance		\$ 49,240	IDPH License Fee	\$ 3,980	
Michael Brown	Administrator	0	75,523	Unemployment Compensation Insurance		62,083	Advertising: Employee Recruitment	698	
				FICA Taxes		171,677	Health Care Worker Background Check	1,150	
				Employee Health Insurance		66,014	(Indicate # of checks performed <u>120</u>)		
				Employee Meals			Patient Background Checks <u>36</u>	360	
				Illinois Municipal Retirement Fund (IMRF)*			Licenses and Permits	795	
				Union Pension Fund		15,985	Dues and Subscriptions	10,994	
				Employee Meals		227	Allocated from Aperion Care	4,563	
				Employee Benefits Other		5,701	Allocated from Aperion Consulting	1,312	
				Employee Physicals		160	See Supplemental Schedule	374	
							Less: Public Relations Expense ()		
							Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 371,087	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,226
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attachment	Legal Fees		\$ 5,507			\$	Out-of-State Travel	\$	
Aperion Care	Accounting Fees		517						
Marcum, LLP	Accounting Fees		23,125						
Creative Technology Solutions	Data Processing		16,277				In-State Travel		
Galaxy Hosted Software	Data Processing		3,000						
National Datacare Corp	Data Processing		2,835						
Wescom Solutions	Data Processing		19,934						
Aperion Care	Data Processing		7,703				Seminar Expense	2,378	
E-Health Data Solutions	Data Processing		900				Allocated from Aperion Care	1,421	
Ability Network	Data Processing		2,161				Allocated from Aperion Financial	40	
Point Click Care	Data Processing		4,124				See Supplemental Schedule	918	
See Supplemental Schedule			220,307				Entertainment Expense ()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			(agree to Sch. V, line 24, col. 8)		
							TOTAL		
\$ 306,390							\$ 4,757		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Aperion Care Midlothian</u>	STATE OF ILLINOIS # <u>0049858</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$9253

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,945 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 224,800
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees