

		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: 0053611

Facility Name: Aperion Care Spring Valley

Address: 1300 N Greenwood St Spring Valley 61362
Number City Zip Code

County: Bureau

Telephone Number: (815) 664-4708 Fax # (815) 663-2527

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2015

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

Facility Name & ID Number Aperion Care Spring Valley

0053611 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	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,868</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,868</u>	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	<u>1,701</u>	<u>509</u>	<u>4,216</u>	<u>6,426</u>	8
9	SNF/PED					9
10	ICF	<u>15,345</u>	<u>3,682</u>		<u>19,027</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,046</u>	<u>4,191</u>	<u>4,216</u>	<u>25,453</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.96%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 05/01/15

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 05/01/15 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 98 and days of care provided 3,140

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 Spring Valley # 0053611 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	186,033	12,948	12,842	211,823		211,823	(4,724)	207,099			1
2	Food Purchase		151,806		151,806	(123)	151,683	(544)	151,139			2
3	Housekeeping	109,892	22,930		132,822		132,822		132,822			3
4	Laundry	42,692	10,731		53,423		53,423		53,423			4
5	Heat and Other Utilities			96,457	96,457		96,457	(5,442)	91,015			5
6	Maintenance	44,925	29,183	67,491	141,599		141,599	5,507	147,106			6
7	Other (specify):*							1,724	1,724			7
8	TOTAL General Services	383,542	227,598	176,790	787,930	(123)	787,807	(3,480)	784,327			8
	B. Health Care and Programs											
9	Medical Director			28,900	28,900		28,900		28,900			9
10	Nursing and Medical Records	1,376,417	153,390	70,811	1,600,618		1,600,618	(37,993)	1,562,625			10
10a	Therapy	57,431	303	390	58,124		58,124		58,124			10a
11	Activities	84,861	1,593	1,170	87,624		87,624		87,624			11
12	Social Services	65,119		1,885	67,004		67,004		67,004			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,222	3,222			15
16	TOTAL Health Care and Programs	1,583,828	155,286	103,156	1,842,270		1,842,270	(34,771)	1,807,499			16
	C. General Administration											
17	Administrative	106,212		211,472	317,684		317,684	(168,516)	149,168			17
18	Directors Fees											18
19	Professional Services			163,915	163,915		163,915	(74,049)	89,866			19
20	Dues, Fees, Subscriptions & Promotions			77,639	77,639		77,639	(56,325)	21,314			20
21	Clerical & General Office Expenses	58,384		203,888	262,272		262,272	(79,568)	182,704			21
22	Employee Benefits & Payroll Taxes			253,607	253,607	123	253,730		253,730			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,947	6,947		6,947	1,950	8,897			24
25	Other Admin. Staff Transportation			11,231	11,231		11,231	8,191	19,422			25
26	Insurance-Prop.Liab.Malpractice			70,730	70,730		70,730	1,662	72,392			26
27	Other (specify):*							10,723	10,723			27
28	TOTAL General Administration	164,596		999,429	1,164,025	123	1,164,148	(355,932)	808,217			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,131,966	382,884	1,279,375	3,794,225		3,794,225	(394,183)	3,400,042			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			9,219	9,219		9,219	5,929	15,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,062	23,062		23,062	4,937	27,999			32
33	Real Estate Taxes			54,093	54,093		54,093	1,976	56,069			33
34	Rent-Facility & Grounds			441,355	441,355		441,355	(29,780)	411,575			34
35	Rent-Equipment & Vehicles			5,288	5,288		5,288	1,218	6,506			35
36	Other (specify):*			8,667	8,667		8,667	(8,667)				36
37	TOTAL Ownership			541,684	541,684		541,684	(24,387)	517,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,660	481,318	559,978		559,978	(35,253)	524,725			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,736	179,736		179,736		179,736			42
43	Other (specify):*			17,978	17,978		17,978	(17,978)				43
44	TOTAL Special Cost Centers		78,660	679,032	757,692		757,692	(53,231)	704,461			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,131,966	461,544	2,500,091	5,093,601		5,093,601	(471,801)	4,621,800			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	(62)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,006)	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	1,137	30		9
10	Interest and Other Investment Income	(76)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(250)	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	(676)	21		18
19	Entertainment	(3,533)	21		19
20	Contributions	(59,797)	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	(145,541)	21		24
25	Fund Raising, Advertising and Promotional	(17,228)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,834)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (248,866)		\$	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)	(222,935)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (222,935)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (471,801)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (9,151)	21	1
2	Amortization	(8,667)	36	2
3	Non-Allowable Legal	(98)	19	3
4	Additional R&M	3,879	06	4
5	Credit Card Processing	(174)	21	5
6	Theft, Damage and Loss	(223)	21	6
7	PAC Dues	(1,650)	20	7
8	Marketing Fees	(750)	43	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
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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	(16,834)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
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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 Spring Valley # 0053611 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				(4,724)								(4,724)	1
2	Food Purchase	(312)		168	(400)								(544)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,006)		31			184	349					(5,442)	5
6	Maintenance	3,879		678	271		330	348					5,507	6
7	Other (specify):*			31	1,546			147					1,724	7
8	TOTAL General Services	(2,439)		908	(3,307)		514	844					(3,480)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,048	(41,041)								(37,993)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			183	3,039								3,222	15
16	TOTAL Health Care and Programs			3,231	(38,002)								(34,771)	16
	C. General Administration													
17	Administrative			(169,917)		1,401							(168,516)	17
18	Directors Fees													18
19	Professional Services	(98)		(5,127)	665	(66,641)	627	42		(3,517)			(74,049)	19
20	Fees, Subscriptions & Promotions	(61,447)		3,740	1,076	229		77					(56,325)	20
21	Clerical & General Office Expenses	(159,298)		21,498	355	56,895	431	551					(79,568)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,164	753	33							1,950	24
25	Other Admin. Staff Transportation			4,201	3,117	873							8,191	25
26	Insurance-Prop.Liab.Malpractice			1,504				158					1,662	26
27	Other (specify):*			3,951		6,772							10,723	27
28	TOTAL General Administration	(220,843)		(138,985)	5,966	(439)	1,058	828		(3,517)			(355,932)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(223,282)		(134,846)	(35,343)	(439)	1,572	1,672		(3,517)			(394,183)	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	1,137		996	153	59	798	2,786					5,929
31	Amortization of Pre-Op. & Org.												31
32	Interest	(76)		3,530	12		602	869					4,937
33	Real Estate Taxes						930	1,046					1,976
34	Rent-Facility & Grounds			434			(7,214)	(23,000)					(29,780)
35	Rent-Equipment & Vehicles			68	295	265	281	310					1,218
36	Other (specify):*	(8,667)											(8,667)
37	TOTAL Ownership	(7,606)		5,028	460	324	(4,603)	(17,989)					(24,387)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers								(35,253)				(35,253)
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(17,978)											(17,978)
44	TOTAL Special Cost Centers	(17,978)							(35,253)				(53,231)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(248,866)		(129,819)	(34,884)	(115)	(3,031)	(16,317)	(35,253)	(3,517)			(471,801)

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning: 01/01/16

Ending: 12/31/16

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%	\$ 168	\$ 168	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	31	31	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	678	678	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	31	31	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	3,048	3,048	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	183	183	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	41,555	41,555	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,669	1,669	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,740	3,740	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	21,498	21,498	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,164	1,164	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	4,201	4,201	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,504	1,504	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,951	3,951	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	996	996	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	3,530	3,530	30
31	V	34	RENT		APERION CARE, INC.	100.00%	434	434	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	68	68	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	211,472	APERION CARE, INC.	100.00%		(211,472)	35
36	V	19	HOME OFFICE	6,796	APERION CARE, INC.	100.00%		(6,796)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 218,268			\$ 88,449	\$ * (129,819)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 7,336	\$	7,336 15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	4,271		4,271 16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,546		1,546 17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	22,759		22,759 18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,039		3,039 19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	665		665 20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,076		1,076 21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	355		355 22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	753		753 23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,117		3,117 24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	153		153 25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	12		12 26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	295		295 27
28	V				APERION CONSULTING, LLC	100.00%			
29	V				APERION CONSULTING, LLC	100.00%			
30	V				APERION CONSULTING, LLC	100.00%			
31	V				APERION CONSULTING, LLC	100.00%			
32	V				APERION CONSULTING, LLC	100.00%			
33	V				APERION CONSULTING, LLC	100.00%			
34	V	10	CONSULTING	63,800	APERION CONSULTING, LLC	100.00%			(63,800) 34
35	V	01	DIETICIAN	12,060	APERION CONSULTING, LLC	100.00%			(12,060) 35
36	V	02	FOOD SERVICE	400	APERION CONSULTING, LLC	100.00%			(400) 36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			
38	V	06	PROJECT MANAGER	4,000	APERION CONSULTING, LLC	100.00%			(4,000) 38
39	Total			\$ 80,260			\$ 45,376	\$ *	(34,884) 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%	\$ 1,401	\$ 1,401	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,100	1,100	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	229	229	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	56,895	56,895	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	33	33	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	873	873	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,772	6,772	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	59	59	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	265	265	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	67,741	APERION FINANCIAL, LLC	100.00%		(67,741)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 67,741			\$ 67,626	\$ * (115)	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%	\$ 184	\$ 184	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		330	330	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		627	627	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		431	431	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		798	798	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		602	602	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		220	220	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		281	281	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		930	930	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	434				(434)	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			\$ 7,434			\$ 4,403	\$ * (3,031)	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%	\$ 349	\$ 349	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		348	348	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		147	147	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		42	42	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		77	77	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		551	551	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		158	158	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,786	2,786	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		869	869	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,046	1,046	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		310	310	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC			(23,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 23,000			\$ 6,683	\$ * (16,317)	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	\$ 471,919	Renewal Rehab	100.00%	\$ 436,666	\$ (35,253)	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			\$ 471,919			\$ 436,666	\$ * (35,253)	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	\$ 14,653	ProPay HR LLC	24.00%	\$ 11,136	\$ (3,517)	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			\$ 14,653			\$ 11,136	\$ * (3,517)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

Facility Name & ID Number

Aperion Care Spring Valley

0053611

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 Delta Trust	24.00%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz Delta Trust	24.00%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Michael Rosen	24.00%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Jeremy Boshes	1.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Steven Turofsky	1.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Michelle Koder	1.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Frederick Frankel	1.25%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Morris Esformes	4.75%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Delecia Wirtenberg Revocable Trust	4.75%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	Sylvia Yolinsky Revocable Trust	4.75%	Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11	Jack Yolinsky	4.75%	Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12	David J. Wirtenberg	4.75%	Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care 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 Spring Valley # 0053611 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1	2.50%	Alloc Salary	\$ 4,832	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc Salary	746	17-7	2
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.5	2.50%	Alloc Salary	1,783	21-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc Salary	729	21-7	4
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1	2.50%	Alloc Salary	4,832	17-7	5
6	Frederick Frankel	Owner	Administrative	1.25%	See Attached	1	2.50%	Alloc Salary	4,458	17-7	6
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1	2.50%	Alloc Salary	4,634	17-7	7
8	Michael Rosen	Relative	Administrative	24.00%	See Attached	1	2.50%	Alloc. Fee	4,832	17-7	8
9	Nosson Factor	Relative	Clerical	0%	See Attached	0.8	2.43%	Alloc Salary	2,050	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 28,896		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

Facility Name & ID Number Aperion Care Spring Valley

0053611

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

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

Facility Name & ID Number	Aperion Care Spring Valley
--------------------------------------	-----------------------------------

0053611

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 CARE, INC.

Street Address

4655 W CHASE AVENUE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-8300

Fax Number

7

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$	25,453	\$ 168	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		25,453	31	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	25,453	678	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		25,453	31	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	25,453	3,048	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		25,453	183	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	25,453	41,555	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		25,453	1,669	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		25,453	3,740	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	25,453	21,498	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		25,453	1,164	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		25,453	4,201	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		25,453	1,504	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		25,453	3,951	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		25,453	996	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		25,453	3,530	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		25,453	434	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		25,453	68	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,660,864	\$ 2,890,119		\$ 88,449	25

Ending: 12/31/16

Facility Name & ID Number Aperion Care Spring Valley# 0053611

Report Period Beginning:

01/01/16Ending: 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

(

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE	ACTUAL CENSUS	34	\$ 57,979	\$ 57,979	25,453	\$ 1,401	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	45,525		25,453	1,100	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	34	9,485		25,453	229	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	34	2,354,900	2,320,500	25,453	56,895	4
5	24	SEMINARS	ACTUAL CENSUS	34	1,360		25,453	33	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	34	36,125		25,453	873	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	34	280,317		25,453	6,772	7
8	30	DEPRECIATION	ACTUAL CENSUS	34	2,458		25,453	59	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	10,954		25,453	265	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		\$ 67,626	25

Ending: 12/31/16

Facility Name & ID Number	Aperion Care Spring Valley
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0053611

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

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 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	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$	25,453	\$ 349	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		25,453	348	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		25,453	147	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		25,453	42	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		25,453	77	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		25,453	551	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		25,453	158	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		25,453	2,786	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		25,453	869	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		25,453	1,046	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		25,453	310	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	\$		\$ 6,683	25

Ending: 12/31/16

(847) 673-6768

IL478-2471

Ending: 12/31/16

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Ending: 12/31/16

Name of Related Organization

Fax NumberNO ☒

()

	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	The Private Bank		X	Line of Credit				750,000				21,586	6
7	GM Financial		X	Line of Credit - Auto				57,963					7
8					-								8
9	TOTAL Facility Related						\$	\$ 807,963			\$ 21,586	9	
	B. Non-Facility Related*												
10	Interest Insurance Policies		X									1,476	10
11	Interest Income		X									(76)	11
12	Allocated from Aperion Care	X										3,530	12
13	See Supplemental Schedule				-							1,483	13
14	TOTAL Non-Facility Related						\$	\$			\$ 6,413	14	
15	TOTALS (line 9+line14)						\$	\$ 807,963			\$ 27,999	15	

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

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from 8131 N Montice	X		Interest Expense			\$					\$	602
16	Allocated from Chase Office	X		Interest Expense									869
17	Allocated from Aperion Consul	X											12
18													18
19													19
20	TOTAL Non-Facility Related												1,483

* 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.			\$	58,031	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.)			\$	58,038	2
3. Under or (over) accrual (line 2 minus line 1).			\$	7	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	56,062	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	56,069	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	49,009	8	
		2012	48,947	9	
		2013	47,790	10	
		2014	54,229	11	
		2015	56,062	12	
2016 Accrual = 2015 Tax					
Beginning Accrual Adjusted					
Allocated from Chase Office = \$1046					
Allocated from 8131 N Monticello = \$930					
		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 Spring Valley</u>	COUNTY	<u>Bureau</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 NAME

Aperion Care Spring Valley

COUNTY

Bureau

FACILITY IDPH LICENSE NUMBER

0053611

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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:24,107

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	Allocated from Chase Office, LLC			\$1,500	1
2					2
3	TOTALS			\$1,500	3

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		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)	82,941	2,506		2,132	(374)	7,002	68
69	Financial Statement Depreciation		9,219			(9,219)		69
70	TOTAL (lines 4 thru 69)	\$ 82,941	\$ 11,725		\$ 2,132	\$ (9,593)	\$ 7,002	70

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

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		\$ 82,941	\$ 11,725		\$ 2,132	\$ (9,593)	\$ 7,002	1
2	Data Cable Installation	2015	7,643		20	382	382	573	2
3	Data And Voice Cable Installation	2015	7,866		20	393	393	590	3
4	Install Outlets-Hall/Nurse Station/Dining/Laundry/Admin Office	2015	2,520		20	126	126	189	4
5	Compressor Replacement And Piping	2015	2,865		20	143	143	215	5
6	Signage For Road Sign / Glass Door / Awning	2015	5,837		20	292	292	438	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)		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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)		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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)		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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)		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

0053611

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		287	39	250	(37)	2,588	3
4	Allocated from Chase Office, LLC	2016	13,501	144	39	144		144	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	720	116	10	36	(80)	252	9
10	Allocated from Aperion Care	2012	204	16	15	10	(6)	51	10
11	Allocated from Aperion Care	2013	87	10	4	10		17	11
12									12
13	Allocated from 8131 N Monticello	2010		507	20	218	(289)	2,291	13
14	Allocated from 8131 N Monticello	2013			20	38	38	233	14
15									15
16									16
17	Allocated Chase Office, LLC	2016	68,429	1,426	10	1,426		1,426	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)		\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

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		\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	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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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)		\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	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	\$ 2,701	\$ 493	\$ 319	\$ (174)	10	\$ 785	71
72	Current Year Purchases	40,086	1,521	2,497	976	10	2,497	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 42,787	\$ 2,014	\$ 2,816	\$ 802		\$ 3,282	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		Car 9/1/16 place in service	2016	\$ 57,278	\$	\$ 8,592	\$ 8,592	5	\$ 8,592
77		Allocated from Aperion Care	2016	808	164	162	(2)	5	363
78		Allocated from Aperion Consulti	2016	560	109	111	2	5	224
79									
80	TOTALS			\$ 58,646	\$ 273	\$ 8,865	\$ 8,592		\$ 9,179

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)			\$	212,605
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	14,012
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	15,149
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	1,137
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	21,468

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	Lobby, Offices, Dining Room	\$ 84,472
93	Bathrooms, Cove Bases, walls	
94	floors, lighting	
95		\$ 84,472

* 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:Spring Valley Real Estate
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

☒ YES

☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		98		\$411,355			3
4	Additions							4
5	Allocated from 8131 N Monticello				220			5
6								6
7	TOTAL		98		\$411,575			7

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

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:

☐ YES☐ NO

Terms:

*

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$6,212
- 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		\$	\$295	17
18					18
19					19
20					20
21	TOTAL		\$-	\$295	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	\$		\$ 185,308	\$		\$ 185,308	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,142			71,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			205,570			205,570	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				73,519		73,519	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					19,298	5,141		24,439	13
14	TOTAL			\$		\$ 481,318	\$ 78,660		\$ 559,978	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	\$ 106,189	\$	1
2	Cash-Patient Deposits	380		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,418,565		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	144,477		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,736,602	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	19,629		15
16	Equipment, at Historical Cost	78,998		16
17	Accumulated Depreciation (book methods)	(11,092)		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>	438,014		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 525,549	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,262,151	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 296,636	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	807,963		29
30	Accrued Salaries Payable	96,969		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,772		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,062		32
33	Accrued Interest Payable	2,552		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	82,832		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,346,786	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	726,176		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 726,176	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,072,962	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 189,189	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,262,151	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 310,132	1
2	Restatements (describe):		2
3	Rounding Equity	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 310,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(120,945)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	50,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (120,945)	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)	\$ 189,189	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Spring Valley# 0053611Report Period Beginning: 01/01/16Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,368,535	1
2	Discounts and Allowances for all Levels	(600,920)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,767,615	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,395	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 184,395	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	62	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	18,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,856	19
20	Radiology and X-Ray	12	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,570	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	76	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 76	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)	\$ 4,972,656	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	787,930	31
32	Health Care	1,842,270	32
33	General Administration	1,164,025	33
	B. Capital Expense		
34	Ownership	541,684	34
	C. Ancillary Expense		
35	Special Cost Centers	577,956	35
36	Provider Participation Fee	179,736	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,093,601	40
41	Income before Income Taxes (line 30 minus line 40)**	(120,945)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (120,945)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,184,754	44
45	Private Pay - Net Inpatient Revenue	873,875	45
46	Medicare - Net Inpatient Revenue	1,440,433	46
47	Other-(specify) <u>Managed Care</u>	268,553	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,767,615	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	2,040	2,195	\$ 80,049	\$ 36.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,095	7,508	200,756	26.74	3
4	Licensed Practical Nurses	19,197	20,268	504,004	24.87	4
5	CNAs & Orderlies	45,796	47,808	591,608	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,056	3,314	57,431	17.33	8
9	Activity Director	1,824	2,080	37,123	17.85	9
10	Activity Assistants	3,432	3,724	47,738	12.82	10
11	Social Service Workers	3,510	3,786	64,251	16.97	11
12	Dietician					12
13	Food Service Supervisor	2,149	2,261	43,820	19.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,142	14,182	142,213	10.03	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,273	44,925	19.76	17
18	Housekeepers	10,531	11,387	109,892	9.65	18
19	Laundry	4,387	4,732	42,692	9.02	19
20	Administrator	1,864	2,259	106,212	47.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,848	2,080	32,933	15.83	23
24	Clerical	1,813	1,989	25,451	12.80	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)	42	42	868	20.67	33
34	TOTAL (lines 1 - 33)	123,784	131,888	\$ 2,131,966 *	\$ 16.16	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 12,842	01-03	35
36	Medical Director	Monthly	28,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	63,800	10-03	38
39	Pharmacist Consultant	Monthly	7,011	10-03	39
40	Physical Therapy Consultant	8	390	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,170	11-03	44
45	Social Service Consultant	38	1,885	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 115,998		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

Facility Name & ID Number

Aperion Care Spring Valley

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Koehler (01/01-6/2/16)	Administrator	0	\$ 36,112
Jennifer Diaz (6/7-12/31/16)	Administrator	0	70,100
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,212

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	\$ 211,472
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 211,472

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consulting	\$ 486
Aperion Consulting	Compliance Consulting	2,008
Aperion Care	Compliance Consulting	3,477
Legal Services	Legal Services	659
Creative Technology Solutions	Data Processing	11,603
National Datacare Corp.	Data Processing	2,968
Wescom Solutions	Data Processing	13,179
Aperion Care	Data Processing	7,066
World Trade Office Solutions	Data Processing	2,000
Aperion Care	Home Office	6,796
Aperion Financial	Home Office	67,741
See Supplemental Schedule		45,932
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 163,915

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 56,931
Unemployment Compensation Insurance	17,261
FICA Taxes	159,563
Employee Health Insurance	16,312
Employee Meals	123
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	880
Employee Meals	227
Employee Benefits - Other	2,433
TOTAL (agree to Schedule V, line 22, col.8)	\$ 253,730

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,642
Advertising: Employee Recruitment	1,023
Health Care Worker Background Check	3,935
(Indicate # of checks performed 394)	
Patient Background Checks 75	745
Dues and Subscriptions	6,669
Licenses and Permits	178
Allocated from Aperion Care	3,740
Allocated from Aperion Consulting	1,076
See Supplemental Schedule	306
Less: Public Relations Expense (	
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,314

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	6,947
Allocated From Aperion Care	1,164
Allocated from Aperion Consulting	753
See Supplemental Schedule	33
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 8,897

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Aperion Care Spring Valley</u>	STATE OF ILLINOIS # <u>0053611</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? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. ICLTC \$5000

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(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. \$ 9,112 Line 10-02

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,736
 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. \$ 123 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 62

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