

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: <u>0051086</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Aperion Care Springfield, Llc</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>525 S. Martin Luther King Dr.</u> <u>Springfield</u> <u>62703</u>			
NumberCityZip Code			
County: <u>Sangamon</u>			
Telephone Number: <u>(217)789-1680</u> Fax # <u>(217)789-0842</u>			
HFS ID Number: <u></u>		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>9/1/2010</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code <u></u> ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other <u></u>			

☐ GOVERNMENTAL☐ State☐ County☐ Other

Facility Name & ID Number Aperion Care Springfield, Llc

0051086 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,790	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					8
9	SNF/PED					9
10	ICF	11,626	30	11,284	22,940	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,626	30	11,284	22,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.43%

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 09/01/2010

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

YES

☒

Date 09/01/2010

NO

☐

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

YES

☐

NO

☒

of beds certified

If YES, enter number

and days of care provided

N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

☒

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 Springfield, Llc # 0051086 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	142,809	12,556	9,600	164,965		164,965	(2,988)	161,977			1
2	Food Purchase		120,626		120,626		120,626	149	120,775			2
3	Housekeeping	71,347	10,274		81,621		81,621		81,621			3
4	Laundry	20,108	8,063		28,171		28,171		28,171			4
5	Heat and Other Utilities			73,016	73,016		73,016	(6,011)	67,005			5
6	Maintenance	41,179	25,067	33,838	100,084		100,084	9,324	109,408			6
7	Other (specify):*							1,553	1,553			7
8	TOTAL General Services	275,443	176,586	116,454	568,483		568,483	2,027	570,510			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	618,019	38,170	21,153	677,342		677,342	7,859	685,201			10
10a	Therapy											10a
11	Activities	59,490	4,626	2,852	66,968		66,968		66,968			11
12	Social Services	83,284		244	83,528		83,528		83,528			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,904	2,904			15
16	TOTAL Health Care and Programs	760,793	42,796	41,049	844,638		844,638	10,763	855,401			16
	C. General Administration											
17	Administrative	94,384		87,649	182,033		182,033	(48,934)	133,099			17
18	Directors Fees											18
19	Professional Services			190,473	190,473		190,473	(113,747)	76,726			19
20	Dues, Fees, Subscriptions & Promotions			99,168	99,168		99,168	(74,585)	24,583			20
21	Clerical & General Office Expenses	27,521		61,883	89,404		89,404	41,601	131,005			21
22	Employee Benefits & Payroll Taxes			172,376	172,376		172,376		172,376			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,260	4,260		4,260	1,757	6,017			24
25	Other Admin. Staff Transportation			10,839	10,839		10,839	7,382	18,221			25
26	Insurance-Prop.Liab.Malpractice			35,354	35,354		35,354	1,497	36,851			26
27	Other (specify):*							9,665	9,665			27
28	TOTAL General Administration	121,905		662,002	783,907		783,907	(175,364)	608,543			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,158,141	219,382	819,505	2,197,028		2,197,028	(162,574)	2,034,454			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			44,333	44,333		44,333	31,474	75,807			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,087	14,087		14,087	105,124	119,211			32
33	Real Estate Taxes			19,323	19,323		19,323	1,781	21,104			33
34	Rent-Facility & Grounds			240,267	240,267		240,267	(240,069)	198			34
35	Rent-Equipment & Vehicles			1,407	1,407		1,407	1,098	2,505			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			325,895	325,895		325,895	(107,070)	218,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		989		989		989		989			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,061	173,061		173,061		173,061			42
43	Other (specify):*			11,218	11,218		11,218	(11,218)				43
44	TOTAL Special Cost Centers		989	184,279	185,268		185,268	(11,218)	174,050			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,158,141	220,371	1,329,679	2,708,191		2,708,191	(280,862)	2,427,329			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,519)	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	16,002	30		9
10	Interest and Other Investment Income	(3,227)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,337)	21		18
19	Entertainment	(3,000)	21		19
20	Contributions	(76,047)	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	(18,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(881)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(97,238)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,249)		\$	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)	(90,613)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (90,613)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (280,862)		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

Report Period Beginning:

Ending:

ID#

0051086

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing / Advertising	\$ (11,218)	43	1
2	Bank Charges	(5,713)	21	2
3	Theft & Damage Loss	(1,325)	21	3
4	Amortization	(6,478)	36	4
5	Additional R&M	5,052	06	5
6	PAC Dues	(3,154)	20	6
7	Building Company - Home Office Expense	(11,350)	19	7
8	Building Company - Amortization	(37,539)	36	8
9	Building Company - Bank Charges	(2,713)	21	9
10	Building Company - Replacement Tax	(355)	21	10
11	Non-allowable Legal Fees	(3,001)	19	11
12	Non-allowable Professional Fees	(19,444)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(97,238)		49

ID#

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Springfield, Llc # 0051086 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				(2,988)								(2,988)	1
2	Food Purchase	(2)		151									149	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,519)		28			166	314					(6,011)	5
6	Maintenance	5,052		611	3,049		298	314					9,324	6
7	Other (specify):*			28	1,393			132					1,553	7
8	TOTAL General Services	(1,469)		818	1,454		464	760					2,027	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,747	5,112								7,859	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			165	2,739								2,904	15
16	TOTAL Health Care and Programs			2,912	7,851								10,763	16
	C. General Administration													
17	Administrative			(50,196)		1,262							(48,934)	17
18	Directors Fees													18
19	Professional Services	(33,795)	11,350	(49,533)	600	(40,841)	565	38	(2,131)				(113,747)	19
20	Fees, Subscriptions & Promotions	(79,201)		3,370	969	207		70					(74,585)	20
21	Clerical & General Office Expenses	(33,324)	3,068	19,375	320	51,277	388	496					41,601	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,049	678	30							1,757	24
25	Other Admin. Staff Transportation			3,786	2,809	787							7,382	25
26	Insurance-Prop.Liab.Malpractice			1,355				142					1,497	26
27	Other (specify):*			3,561		6,104							9,665	27
28	TOTAL General Administration	(146,320)	14,418	(67,233)	5,376	18,826	953	747	(2,131)				(175,364)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(147,789)	14,418	(63,503)	14,681	18,826	1,417	1,507	(2,131)				(162,574)	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	16,002	11,152	898	138	54	719	2,511					31,474
31	Amortization of Pre-Op. & Org.												31
32	Interest	(3,227)	103,833	3,181	11		542	783					105,124
33	Real Estate Taxes						838	943					1,781
34	Rent-Facility & Grounds		(210,267)	391			(7,193)	(23,000)					(240,069)
35	Rent-Equipment & Vehicles			61	266	239	253	279					1,098
36	Other (specify):*	(44,017)	37,539										(6,478)
37	TOTAL Ownership	(31,242)	(57,743)	4,531	415	293	(4,840)	(18,484)					(107,070)
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(11,218)											(11,218)
44	TOTAL Special Cost Centers	(11,218)											(11,218)
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,249)	(43,325)	(58,972)	15,096	19,119	(3,423)	(16,977)	(2,131)				(280,862)

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 210,267	525 South MLK Drive, LLC	100.00%	\$	(210,267)	1
2	V	19	Home Office Expense		525 South MLK Drive, LLC	100.00%	11,350	11,350	2
3	V	36	Amortization		525 South MLK Drive, LLC	100.00%	37,539	37,539	3
4	V	21	Bank Charges		525 South MLK Drive, LLC	100.00%	2,713	2,713	4
5	V	30	Depreciation		525 South MLK Drive, LLC	100.00%	11,152	11,152	5
6	V	32	Interest Expense	4	525 South MLK Drive, LLC	100.00%	103,837	103,833	6
7	V	33	Real Estate Taxes	19,323	525 South MLK Drive, LLC	100.00%	19,323		7
8	V	21	Replacement Tax		525 South MLK Drive, LLC	100.00%	355	355	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 229,594			\$ 186,269	\$ * (43,325)	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%	\$ 151	\$ 151	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	28	28	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	611	611	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	28	28	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	2,747	2,747	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	165	165	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	37,452	37,452	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,505	1,505	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,370	3,370	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	19,375	19,375	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,049	1,049	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	3,786	3,786	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,355	1,355	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,561	3,561	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	898	898	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	3,181	3,181	30
31	V	34	RENT		APERION CARE, INC.	100.00%	391	391	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	61	61	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	87,649	APERION CARE, INC.	100.00%		(87,649)	35
36	V	19	HOME OFFICE	51,038	APERION CARE, INC.	100.00%		(51,038)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 138,687			\$ 79,715	\$ * (58,972)	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%	\$ 6,612	\$ 6,612	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	3,849	3,849	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,393	1,393	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	20,512	20,512	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,739	2,739	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	600	600	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	969	969	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	320	320	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	678	678	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	2,809	2,809	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	138	138	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	11	11	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	266	266	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	15,400	APERION CONSULTING, LLC	100.00%		(15,400)	34
35	V	01	DIETICIAN	9,600	APERION CONSULTING, LLC	100.00%		(9,600)	35
36	V	02	FOOD SERVICE		APERION CONSULTING, LLC	100.00%			36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	800	APERION CONSULTING, LLC	100.00%		(800)	38
39	Total			\$ 25,800			\$ 40,896	\$ * 15,096	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%	\$ 1,262	\$ 1,262	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	991	991	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	207	207	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	51,277	51,277	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	30	30	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	787	787	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,104	6,104	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	54	54	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	239	239	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	41,832	APERION FINANCIAL, LLC	100.00%		(41,832)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 41,832			\$ 60,951	\$ * 19,119	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%	\$ 166	\$ 166	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		298	298	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		565	565	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		388	388	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		719	719	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		542	542	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		198	198	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		253	253	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		838	838	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	391	8131 N. MONTICELLO, LLC			(391)	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			\$ 7,391			\$ 3,968	\$ * (3,423)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 314	\$	314
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		314		314
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		132		132
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		38		38
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		70		70
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		496		496
21	V	26	INSURANCE		CHASE OFFICE,LLC		142		142
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,511		2,511
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		783		783
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		943		943
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		279		279
26	V	34	RENT	23,000	CHASE OFFICE,LLC				(23,000)
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 23,000			\$ 6,023	\$ *	(16,977)

* 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	\$ 8,881	ProPay HR LLC	24.00%	\$ 6,750	\$ (2,131)	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			\$ 8,881			\$ 6,750	\$ * (2,131)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meyetel Trust	47.00%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz	47.00%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Jay Meystel Trust	4.00%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Steve Turofsky	1.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Fred Frankel	1.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care 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	525 SOUTH MLK DRIVE	SPRINGFIELD	BUILDING CO.	22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				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 Springfield, Llc # 0051086 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attached	1	2.50%	Alloc Salary	\$ 4,832	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.4	1.00%	Alloc Salary	672	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.4	2.00%	Alloc Salary	1,607	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc Salary	657	21-7	4
5	David Berkowitz	Owner	Administrative	47.00%	See Attached	0.9	2.25%	Alloc Salary	4,355	17-7	5
6	Fred Frankel	Owner	Administrative	1.00%	See Attached	0.9	2.25%	Alloc Salary	4,018	17-7	6
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.9	2.25%	Alloc Salary	4,176	17-7	7
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.7	2.13%	Alloc Salary	1,848	21-7	8
9	Meir Meystel	Relative	Clerical	0%	See Attached	0.1	1.45%	Alloc Salary	573	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	\$ 22,738		13

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

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

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16

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	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$	22,940	\$ 151	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		22,940	28	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	22,940	611	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		22,940	28	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	22,940	2,747	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		22,940	165	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	22,940	37,452	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		22,940	1,505	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		22,940	3,370	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	22,940	19,375	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		22,940	1,049	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		22,940	3,786	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		22,940	1,355	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		22,940	3,561	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		22,940	898	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		22,940	3,181	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		22,940	391	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		22,940	61	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,660,864	\$ 2,890,119		\$ 79,715	25

Ending: 12/31/16

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 303,659	22,940	\$ 6,612	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	22,940	3,849	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		22,940	1,393	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	22,940	20,512	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		22,940	2,739	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		22,940	600	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		22,940	969	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		22,940	320	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		22,940	678	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		22,940	2,809	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		22,940	138	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		22,940	11	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		22,940	266	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,878,156	\$ 1,421,169		\$ 40,896	25

Ending: 12/31/16

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	22,940	\$ 1,262	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525		22,940	991	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485		22,940	207	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	22,940	51,277	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360		22,940	30	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125		22,940	787	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317		22,940	6,104	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458		22,940	54	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954		22,940	239	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		\$ 60,951	25

Ending: 12/31/16

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	ACTUAL CENSUS	34	\$ 7,614	\$	22,940	\$ 166	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	13,676		22,940	298	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	25,960		22,940	565	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	34	17,828		22,940	388	4
5	30	DEPRECIATION	ACTUAL CENSUS	34	33,024		22,940	719	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	34	24,903		22,940	542	6
7	34	RENT	ACTUAL CENSUS	34	9,100		22,940	198	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	11,640		22,940	253	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	34	38,500		22,940	838	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 182,245	\$		\$ 3,968	25

Ending: 12/31/16

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	\$	22,940	\$ 314	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		22,940	314	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		22,940	132	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		22,940	38	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		22,940	70	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		22,940	496	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		22,940	142	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		22,940	2,511	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		22,940	783	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		22,940	943	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		22,940	279	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	\$		\$ 6,023	25

Ending: 12/31/16

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	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	19	Payroll Services	Direct			\$	\$		6,750	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					\$	\$		6,750	25

Ending: 12/31/16

Fax Number

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

Ending: 12/31/16**Fax Number**

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

Ending: 12/31/16

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage			\$	2,700,000			\$	103,837	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Assurance		X	Insurance Financing								177	6
7	First Midwest Bank		X	Line of Credit				340,542	12/11/2017	3.7340		13,910	7
8					-								8
9	TOTAL Facility Related						\$	3,040,542			\$	117,924	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,227)	10
11	Building Co. Interest Income		X									(4)	11
12	Allocated Aperion Care	X										3,181	12
13	See Supplemental Schedule				-							1,336	13
14	TOTAL Non-Facility Related						\$				\$	1,286	14
15	TOTALS (line 9+line14)						\$	3,040,542			\$	119,210	15

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

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated Aperion Consulting	X					\$					\$	11
16	Allocated Chase Office	X											783
17	Allocated 8131 Monticello	X											542
18													18
19													19
20	TOTAL Non-Facility Related												1,336

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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.			\$	17,838	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.)			\$	19,890	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,052	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	19,052	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.			\$	21,104	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	16,491	8	
		2012	16,907	9	
		2013	17,236	10	
		2014	17,630	11	
		2015	18,109	12	
2016 Accrual = 18109 x 1.05 = 19052 (rounded)					
Allocated from 8131 Monticello = \$838					
Allocated from Chase Office, LLC =\$943					

		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 Springfield, Llc</u>	COUNTY	<u>Sangamon</u>
FACILITY IDPH LICENSE NUMBER	<u>0051086</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

FACILITY NAME	<u>Aperion Care Springfield, Llc</u>	COUNTY	<u>Sangamon</u>
FACILITY IDPH LICENSE NUMBER	<u>0051086</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-6300</u>	FAX #:	<u>(847) 236-6301</u>

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.

Page 10B

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	525 South MLK Drive, LLC		2011	\$183,518	1
2	Allocated from Chase Office, LLC			1,352	2
3	TOTALS			\$184,870	3

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65		2011	1972	\$ 639,905	\$ 11,170	35	\$ 18,283	\$ 7,113	\$ 115,792
5										
6										
7										
8										
	Improvement Type**									
9	Various		2011		19,082		20	1,908	1,908	13,340
10	Various		2012		161,607		20	20,189	20,189	89,697
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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)		74,752	2,258		1,916	(342)	6,311	68
69	Financial Statement Depreciation			44,315			(44,315)		69
70	TOTAL (lines 4 thru 69)		\$ 895,346	\$ 57,743		\$ 42,296	\$ (15,447)	\$ 225,141	70

**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 12A, Carried Forward	\$ 895,346	\$ 57,743		\$ 42,296	\$ (15,447)	\$ 225,141	1
2	Fire Door	2013	2,828	20	141	141	566	2
3	Installation Of New Cat 5 Cables In All Work Stations	2013	4,800	20	240	240	760	3
4	American Backflow Prevention New Backflow Preventer With Shut Off Valve	2014	7,200	20	360	360	900	4
5	Installed New Power Vent Hot Water Heater	2015	2,870	20	144	144	275	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)	\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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)		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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)		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1		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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		259	35	225	(34)	2,333	3
4	Allocated from Chase Office, LLC	2016	12,168	130	39	130		130	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	649	104	20	32	(72)	227	9
10	Allocated from Aperion Care	2012	184	14	20	9	(5)	46	10
11	Allocated from Aperion Care	2013	78	9	20	4	(5)	16	11
12									12
13	Allocated from 8131 N Monticello	2010		457	20	197	(260)	2,064	13
14	Allocated from 8131 N Monticello	2013			20	34	34	210	14
15	Allocated from 8131 N Monticello								15
16									16
17	Allocated Chase Office, LLC	2016	61,673	1,285	20	1,285		1,285	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)		\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	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 12H, Carried Forward		\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	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	\$ 211,966	\$ 445	\$ 23,963	\$ 23,518	10	\$ 120,593	71
72	Current Year Purchases	30,587	1,371	1,565	194	10	1,565	72
73	Fully Depreciated Assets	28,623				10	28,623	73
74								74
75	TOTALS	\$ 271,176	\$ 1,816	\$ 25,528	\$ 23,712		\$ 150,781	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		2010 FORD E350 - Transfer from	2012	\$ 47,641	\$	\$ 5,836	\$ 5,836	5	\$ 33,052
77		2005 DODGE CARAVAN USED	2014	5,626		1,004	1,004	5	3,283
78		Allocated from Aperion Care	2016	728	148	146	(2)	5	327
79		Allocated from Aperion Consulti	2016	505	98	112	14	5	202
80	TOTALS			\$ 54,500	\$ 246	\$ 7,098	\$ 6,852		\$ 36,864

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)			\$ 1,423,590	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 59,805	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 75,807	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 16,002	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 415,286	

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

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

YES

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from 8131 N Monticello		65		198			5
6								6
7	TOTAL		65		\$ 198			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: \$ 7,303Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Prior Period	\$	(5,064)	17
18	Allocated from Aperion Consulting			266	18
19					19
20					20
21	TOTAL		\$ -	\$ (4,798)	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				989		989	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									13
14	TOTAL			\$		\$	\$ 989		\$ 989	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	\$ 63,977	\$ 239,656	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	287,914	287,914	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,682	49,682	6
7	Other Prepaid Expenses		5,688	7
8	Accounts Receivable (owners or related parties)	200,000	1,319,256	8
9	Other(specify): See Attached Schedule	6,895	15,205	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 608,468	\$ 1,917,401	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,440	13
14	Buildings, at Historical Cost		342,849	14
15	Leasehold Improvements, at Historical Cost	92,053	115,665	15
16	Equipment, at Historical Cost	235,049	417,344	16
17	Accumulated Depreciation (book methods)	(236,717)	(489,276)	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): See Attached Schedule	1,122,433	1,552,538	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,212,818	\$ 2,124,560	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,821,286	\$ 4,041,961	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 124,257	\$ 124,257	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	340,542	340,542	29
30	Accrued Salaries Payable	86,043	86,043	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,364	2,364	31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,052	32
33	Accrued Interest Payable	1,014	12,821	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,122	1,122	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 555,342	\$ 586,201	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,700,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	930,251	1,013,959	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 930,251	\$ 3,713,959	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,485,593	\$ 4,300,160	46
47	TOTAL EQUITY(page 18, line 24)	\$ 335,693	\$ (258,199)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,821,286	\$ 4,041,961	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (41,938)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (41,938)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,964	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,333)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 377,631	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)	\$ 335,693	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,166,449	1
2	Discounts and Allowances for all Levels	(1,070,780)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,095,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 259	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,227	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,227	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)	\$ 3,099,155	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	568,483	31
32	Health Care	844,638	32
33	General Administration	783,907	33
	B. Capital Expense		
34	Ownership	325,895	34
	C. Ancillary Expense		
35	Special Cost Centers	12,207	35
36	Provider Participation Fee	173,061	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,708,191	40
41	Income before Income Taxes (line 30 minus line 40)**	390,964	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 390,964	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,570,539	44
45	Private Pay - Net Inpatient Revenue	5,400	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Insurance	1,519,730	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,095,669	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.

Facility Name & ID Number Aperia Care Springfield, LLC

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	2,016	2,120	\$ 80,156	\$ 37.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,419	4,815	108,832	22.60	3
4	Licensed Practical Nurses	7,922	8,648	167,550	19.37	4
5	CNAs & Orderlies	22,164	24,358	261,481	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,914	2,021	25,740	12.74	9
10	Activity Assistants	836	852	7,724	9.07	10
11	Social Service Workers	3,944	4,160	83,284	20.02	11
12	Dietician					12
13	Food Service Supervisor	1,776	1,848	33,934	18.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,315	11,275	108,875	9.66	15
16	Dishwashers					16
17	Maintenance Workers	3,031	3,159	41,179	13.04	17
18	Housekeepers	5,643	6,063	71,347	11.77	18
19	Laundry	2,158	2,369	20,108	8.49	19
20	Administrator	2,024	2,120	94,384	44.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,140	27,521	12.86	23
24	Clerical					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)	2,067	2,158	26,026	12.06	33
34	TOTAL (lines 1 - 33)	72,189	78,106	\$ 1,158,141 *	\$ 14.83	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	\$ 9,600	01-03	35
36	Medical Director	Monthly	16,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	15,400	10-03	38
39	Pharmacist Consultant	105	5,253	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	54	2,852	11-03	44
45	Social Service Consultant	5	244	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	164	\$ 50,649		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

Facility Name & ID Number		Aperion Care Springfield, Llc		STATE OF ILLINOIS		Page 21		
				# 0051086		Report Period Beginning: 01/01/16		
						Ending: 12/31/16		
XIX. SUPPORT SCHEDULES								
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jackie Liddell	Administrator	0	\$ 94,384	Workers' Compensation Insurance	\$ 10,032	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	13,847	Advertising: Employee Recruitment	1,088	
				FICA Taxes	85,590	Health Care Worker Background Check		
				Employee Health Insurance	57,323	(Indicate # of checks performed 71)	714	
				Employee Meals		Patient Background Checks 13	128	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	12,125	
				Other Employee Benefits	4,161	Licenses and Permits	1,932	
				Employee Physicals	320	Allocated from Aperion Care	3,370	
				401K	405	Allocated from Aperion Consulting	969	
				Employee Meals	698	See Supplemental Schedule	277	
						Less: Public Relations Expense (		
						Non-allowable advertising (		
						Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)			\$ 94,384	\$ 172,376		\$ 24,583		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Aperion Care, Inc			\$ 87,649			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 87,649	TOTAL		\$	In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Creative Technology Solutions	Data Processing		\$ 6,669					
National Datacare Corporation	Data Processing		2,050					
Wescom Solutions	Data Processing		10,782					
Galaxy Hosted Software	Data Processing		3,000					
Aperion Care Inc	Data Processing		6,993					
E-Health Data Solutions	Data Processing		1,800					
Relass from Equip to Data Proc	Data Processing		1,557					
Ability Network	Data Processing		3,211					
Point Click Care	Data Processing		2,460					
Aperion Care Inc	Home Office Expense		51,038				Seminar Expense	4,260
Aperion Financial	Home Office Expense		41,832				Allocated from Aperion Care	1,049
See Supplemental Schedule			59,082				Allocated from Aperion Consulting	678
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	See Supplemental Schedule	30
(For legal fee disclosure, see page 39 of instructions)			\$ 190,474				Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,017
				* Attach copy of IMRF notifications				**See instructions.

Facility Name & ID Number		Aperion Care Springfield, Llc		STATE OF ILLINOIS	#	0051086	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC \$9557</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>645</u> Line <u>10-02</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>173,061</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? (For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ <u>No</u> Indicate the amount. \$ <u>N/a</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% in 1</u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>Yes</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							