

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0052696

Facility Name: Aperion Care St Elmo

Address: 221 East Cumberland St Elmo 62458
Number City Zip Code

County: Fayette

Telephone Number: (618) 829-5551 Fax # (618) 829-5569

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2014

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

Facility Name & ID Number Aperion Care St Elmo

0052696 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,372</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>18</u>	Intermediate (ICF)	<u>18</u>	<u>6,588</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>480</u>		<u>1,282</u>	<u>1,762</u>	8
9	SNF/PED					9
10	ICF	<u>7,089</u>	<u>4,529</u>		<u>11,618</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,569</u>	<u>4,529</u>	<u>1,282</u>	<u>13,380</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 60.93%

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)

Meals on Wheels

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 02/01/14

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

YES

☒

Date 02/01/14

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

42

and days of care provided

1,184

Medicare Intermediary National Government Services

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 St Elmo # 0052696 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	109,853	9,732	5,578	125,163		125,163	3,857	129,020			1
2	Food Purchase		83,444		83,444		83,444	(1,274)	82,170			2
3	Housekeeping	57,287	11,052		68,339		68,339		68,339			3
4	Laundry	37,061	7,521	142	44,724		44,724		44,724			4
5	Heat and Other Utilities			54,641	54,641		54,641	(5,868)	48,773			5
6	Maintenance	35,647	21,021	33,267	89,935		89,935	2,454	92,389			6
7	Other (specify):*							906	906			7
8	TOTAL General Services	239,848	132,770	93,628	466,246		466,246	75	466,321			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	828,201	48,721	21,465	898,387		898,387	(6,034)	892,353			10
10a	Therapy											10a
11	Activities	44,503	3,997	4,135	52,635		52,635		52,635			11
12	Social Services	37,039		4,000	41,039		41,039		41,039			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,693	1,693			15
16	TOTAL Health Care and Programs	909,743	52,718	46,600	1,009,061		1,009,061	(4,341)	1,004,720			16
	C. General Administration											
17	Administrative	93,723		115,918	209,641		209,641	(93,338)	116,303			17
18	Directors Fees											18
19	Professional Services			156,315	156,315		156,315	(81,085)	75,230			19
20	Dues, Fees, Subscriptions & Promotions			95,594	95,594		95,594	(74,856)	20,738			20
21	Clerical & General Office Expenses	16,768		90,826	107,594		107,594	(18,036)	89,558			21
22	Employee Benefits & Payroll Taxes			192,117	192,117		192,117		192,117			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,168	1,168		1,168	1,025	2,193			24
25	Other Admin. Staff Transportation			3,135	3,135		3,135	4,306	7,441			25
26	Insurance-Prop.Liab.Malpractice			42,859	42,859		42,859	873	43,732			26
27	Other (specify):*							5,637	5,637			27
28	TOTAL General Administration	110,491		697,932	808,423		808,423	(255,474)	552,949			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,260,082	185,488	838,160	2,283,730		2,283,730	(259,741)	2,023,989			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			37,586	37,586		37,586	26,634	64,220			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,825	14,825		14,825	91,330	106,155			32
33	Real Estate Taxes			24,069	24,069		24,069	1,039	25,108			33
34	Rent-Facility & Grounds			218,500	218,500		218,500	(218,384)	116			34
35	Rent-Equipment & Vehicles			8,694	8,694		8,694	640	9,334			35
36	Other (specify):*			4,224	4,224		4,224	(4,224)				36
37	TOTAL Ownership			307,898	307,898		307,898	(102,965)	204,933			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			256,688	256,688		256,688	(16,258)	240,430			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,617	110,617		110,617		110,617			42
43	Other (specify):*			21,850	21,850		21,850	(21,850)				43
44	TOTAL Special Cost Centers			389,155	389,155		389,155	(38,108)	351,047			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,260,082	185,488	1,535,213	2,980,783		2,980,783	(400,813)	2,579,970			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	(668)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,164)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,695)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(282)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,569)	21		18
19	Entertainment	(2,777)	21		19
20	Contributions	(74,047)	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	(45,532)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(61,736)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,482)		\$	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)	(174,331)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (174,331)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (400,813)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (18,295)	43	1
2	Promotional Products	(3,555)	43	2
3	Bank Charges	(8,331)	21	3
4	Meals on Wheels	(412)	02	4
5	Bldg Co - Amortization	(16,299)	36	5
6	Bldg Co - Bank Fees	(2,065)	21	6
7	Bldg Co - Professional Fees	(2,000)	19	7
8	Additional R&M	3,633	06	8
9	PAC Dues	(3,501)	20	9
10	Non Allowable Legal Fees	(98)	19	10
11	Amortization	(4,224)	36	11
12	Credit Card Charges	(727)	21	12
13	Bldg Co - Accounting Fees	(1,725)	19	13
14	Capitalized R&M	(4,137)	06	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	(61,736)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
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 St Elmo # 0052696 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				3,857								3,857	1
2	Food Purchase	(1,362)		88									(1,274)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,164)		16			97	183					(5,868)	5
6	Maintenance	(504)		356	2,245		174	183					2,454	6
7	Other (specify):*			16	813			77					906	7
8	TOTAL General Services	(8,030)		476	6,915		270	443					75	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			1,602	(7,636)								(6,034)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			96	1,597								1,693	15
16	TOTAL Health Care and Programs			1,698	(6,039)								(4,341)	16
	C. General Administration													
17	Administrative			(94,074)		736							(93,338)	17
18	Directors Fees													18
19	Professional Services	(3,823)	3,725	(43,684)	350	(35,349)	330	22		(2,657)			(81,085)	19
20	Fees, Subscriptions & Promotions	(77,548)		1,966	565	120		41					(74,856)	20
21	Clerical & General Office Expenses	(62,013)	2,065	11,301	187	29,908	226	290					(18,036)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			612	396	17							1,025	24
25	Other Admin. Staff Transportation			2,208	1,639	459							4,306	25
26	Insurance-Prop.Liab.Malpractice			790				83					873	26
27	Other (specify):*			2,077		3,560							5,637	27
28	TOTAL General Administration	(143,384)	5,790	(118,803)	3,137	(548)	556	435		(2,657)			(255,474)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(151,414)	5,790	(116,629)	4,013	(548)	827	879		(2,657)			(259,741)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,695)	56,810	524	80	31	419	1,465					26,634	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		88,695	1,856	6		316	457					91,330	32
33	Real Estate Taxes						489	550					1,039	33
34	Rent-Facility & Grounds		(177,500)	228			(7,112)	(34,000)					(218,384)	34
35	Rent-Equipment & Vehicles			36	155	139	148	163					640	35
36	Other (specify):*	(20,523)	16,299										(4,224)	36
37	TOTAL Ownership	(53,218)	(15,696)	2,644	241	170	(5,740)	(31,366)					(102,965)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(16,258)				(16,258)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(21,850)											(21,850)	43
44	TOTAL Special Cost Centers	(21,850)							(16,258)				(38,108)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(226,482)	(9,906)	(113,985)	4,254	(378)	(4,913)	(30,487)	(16,258)	(2,657)			(400,813)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 177,500	221 East Cumberland, LLC	100.00%	\$	\$ (177,500)	1
2	V	19	Accounting Fees		221 East Cumberland, LLC	100.00%	1,725	1,725	2
3	V	36	Amortization		221 East Cumberland, LLC	100.00%	16,299	16,299	3
4	V	21	Bank Fees		221 East Cumberland, LLC	100.00%	2,065	2,065	4
5	V	30	Depreciation		221 East Cumberland, LLC	100.00%	56,810	56,810	5
6	V	32	Interest Expense		221 East Cumberland, LLC	100.00%	88,695	88,695	6
7	V	19	Professional Fees		221 East Cumberland, LLC	100.00%	2,000	2,000	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 177,500			\$ 167,594	\$ * (9,906)	14

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

Facility Name & ID Number	Aperion Care St Elmo	#	0052696	Report Period Beginning:	01/01/16	Ending:	12/31/16
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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%	\$ 88	\$ 88	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	16	16	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	356	356	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	16	16	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	1,602	1,602	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	96	96	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	21,844	21,844	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	878	878	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	1,966	1,966	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	11,301	11,301	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	612	612	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	2,208	2,208	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	790	790	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	2,077	2,077	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	524	524	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	1,856	1,856	30
31	V	34	RENT		APERION CARE, INC.	100.00%	228	228	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	36	36	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	115,918	APERION CARE, INC.	100.00%		(115,918)	35
36	V	19	HOME OFFICE	44,562	APERION CARE, INC.	100.00%		(44,562)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 160,480			\$ 46,495	\$ * (113,985)	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%	\$ 3,857	\$ 3,857	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	2,245	2,245	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	813	813	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	11,964	11,964	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	1,597	1,597	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	350	350	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	565	565	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	187	187	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	396	396	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	1,639	1,639	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	80	80	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	6	6	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	155	155	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	19,600	APERION CONSULTING, LLC	100.00%		(19,600)	34
35	V	01	DIETICIAN		APERION CONSULTING, LLC	100.00%			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		APERION CONSULTING, LLC	100.00%			38
39	Total			\$ 19,600			\$ 23,854	\$ * 4,254	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%	\$ 736	\$ 736	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	578	578	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	120	120	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	29,908	29,908	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	17	17	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	459	459	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	3,560	3,560	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	31	31	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	139	139	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	35,927	APERION FINANCIAL, LLC	100.00%		(35,927)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 35,927			\$ 35,548	\$ * (378)	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 97	\$ 97	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		174	174	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		330	330	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		226	226	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		419	419	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		316	316	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		116	116	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		148	148	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		489	489	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	228	8131 N. MONTICELLO, LLC			(228)	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			\$ 7,228			\$ 2,315	\$ * (4,913)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 183	\$ 183	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		183	183	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		77	77	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		22	22	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		41	41	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		290	290	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		83	83	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		1,465	1,465	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		457	457	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		550	550	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		163	163	25
26	V	34 RENT	34,000	CHASE OFFICE,LLC			(34,000)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 34,000			\$ 3,513	\$ * (30,487)	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	39	Therapy Services	217,655	Renewal Rehab	100.00%	\$ 201,397	\$ (16,258)	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			\$ 217,655			\$ 201,397	\$ * (16,258)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 11,071	ProPay HR LLC	24.00%	\$ 8,414	\$ (2,657)	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			\$ 11,071			\$ 8,414	\$ * (2,657)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES☒ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐ YES☒ NO

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

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

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

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Fred Frankel	1.50%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	Steve Turofsky	1.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Trust	48.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Yosef Meystel Trust	48.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5			Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care 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	221 EAST CUMBERLAND LLC	ST ELMO	BUILDING CO.	22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				24
25			Aperion Care Springfield	Springfield				25
26			Aperion Care 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 St Elmo # 0052696 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	0.5	1.25%	Alloc Salary	\$ 2,540	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.3	0.75%	Alloc Salary	392	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.3	1.50%	Alloc Salary	937	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.04	1.26%	Alloc Salary	383	21-7	4
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.5	1.25%	Alloc Salary	2,540	17-7	5
6	Fred Frankel	Owner	Administrative	1.50%	See Attached	0.5	1.25%	Alloc Salary	2,343	17-7	6
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.5	1.25%	Alloc Salary	2,436	17-7	7
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.4	1.22%	Alloc Salary	1,078	21-7	8
9	Meir Meystel	Relative	Clerical	0%	See Attached	0.1	1.45%	Alloc Salary	334	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	\$ 12,983		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

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IL478-2471

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

APERION CARE, INC.

Street Address

4655 W CHASE AVENUE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-8300

Fax Number

7

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$	13,380	\$ 88	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		13,380	16	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	13,380	356	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		13,380	16	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	13,380	1,602	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		13,380	96	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	13,380	21,844	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		13,380	878	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		13,380	1,966	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	13,380	11,301	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		13,380	612	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		13,380	2,208	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		13,380	790	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		13,380	2,077	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		13,380	524	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		13,380	1,856	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		13,380	228	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		13,380	36	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,660,864	\$ 2,890,119		\$ 46,495	25

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

Ending: 12/31/16

(847) 673-6768

Ending: 12/31/16

()

Ending: 12/31/16

Name of Related Organization

Fax Number

NO ☒

()

	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			\$	2,160,000			\$	88,695	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	Bank Leumi		X	Line of Credit				372,916				14,061	6	
7	Insurance Policies		X									764	7	
8					-								8	
9	TOTAL Facility Related						\$	2,532,916				\$	103,520	9
	B. Non-Facility Related*													
10	Allocated from Aperion Consult	X										6	10	
11	Allocated from Aperion Care	X										1,856	11	
12	Allocated from 8131 N Monticello	X										316	12	
13	See Supplemental Schedule				-							457	13	
14	TOTAL Non-Facility Related						\$					\$	2,635	14
15	TOTALS (line 9+line14)						\$	2,532,916				\$	106,155	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

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

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

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

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from Chase Office, LI	X					\$					\$	457
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											457	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care St Elmo COUNTY Fayette
 FACILITY IDPH LICENSE NUMBER 0052696
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

14,076

B. General Construction Type:

Exterior

Brick

Frame

Reinforced Concrete

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	Facility	51,830	2014	\$ 90,000	1
2	Allocated from Chase, LLC			789	2
3	TOTALS	51,830		\$ 90,789	3

Facility Name & ID Number Aperion Care St Elmo

0052696

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	60		2014	1968	\$ 1,108,000	\$ 56,810	39	\$ 28,410	\$ (28,400)	\$ 85,231	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		43,599	1,316		1,137	(179)	3,804	68
69	Financial Statement Depreciation			37,586			(37,586)		69
70	TOTAL (lines 4 thru 69)		\$ 1,151,599	\$ 95,712		\$ 29,547	\$ (66,165)	\$ 89,035	70

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,151,599	\$ 95,712		\$ 29,547	\$ (66,165)	\$ 89,035	1
2	Labor & Materials To Install New Light Fixtures & Exit Signs	2014	20,758		20	1,038	1,038	2,595	2
3	Furnish & Install New Sign With Lexan Face Panels	2014	3,220		20	215	215	537	3
4	New Ceiling In Kitchen & Replace Front Roof Area	2014	9,000		20	450	450	1,275	4
5	New Cat5E Lines For New & Existing Computers	2014	4,800		20	960	960	2,640	5
6	Computer Back Up On Generator	2014	4,025		20	805	805	1,878	6
7	Light Fixtures	2014	2,818		20	141	141	329	7
8	New Architectural 30 Year Shingle Roof	2014	86,290		20	4,315	4,315	9,708	8
9	Soffit & Fascia	2014	9,200		20	460	460	997	9
10	Cabling For Vip System	2014	4,000		20	800	800	1,733	10
11	New Windows, Paint 28 Rms, New Vct Tile In 5 Rms, 25 Ptac Unit	2014	116,700		20	5,835	5,835	12,156	11
12	Electrical Work For 28 New Ptac Units; Includes New 400 Amp M	2014	33,460		20	1,673	1,673	3,485	12
13	Don Office Floor Tile, 4 Resident Rooms-Remove Wallpaper, New	2015	10,507		20	525	525	832	13
14	Corridor Handrails, End Caps, Bumper Guards & End Caps	2015	8,756		20	438	438	730	14
15	New Condensing Unit	2016	4,692		20	78	78	78	15
16	Repaired Windows, Soffits And Timbers For Front Entry	2016	3,134		20	78	78	78	16
17	Patched Parking Lot, Seal Coated And Re-Striped	2016	4,137		20	207	207	207	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)		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	34

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	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 12C, Carried Forward		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	34

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 1,477,096	\$ 95,712		\$ 47,565	\$ (48,147)	\$ 128,293	34

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		151	39	131	(20)	1,361	3
4	Allocated from Chase Office, LLC	2016	7,097	76	39	76		76	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	378	61	10	19	(42)	132	9
10	Allocated from Aperion Care	2012	107	8	15	5	(3)	27	10
11	Allocated from Aperion Care	2013	46	5	10	2	(3)	9	11
12									12
13	Allocated from 8131 N Monticello	2010		266	20	135	(131)	1,327	13
14	Allocated from 8131 N Monticello	2013			20	20	20	123	14
15									15
16	Allocated Chase Office, LLC	2016	35,971	749	20	749		749	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)		\$ 43,599	\$ 1,316		\$ 1,137	\$ (179)	\$ 3,804	34

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

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 43,599	\$ 1,316		\$ 1,137	\$ (179)	\$ 3,804	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)		\$ 43,599	\$ 1,316		\$ 1,137	\$ (179)	\$ 3,804	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	\$ 151,832	\$ 259	\$ 15,791	\$ 15,532	10	\$ 46,381	71
72	Current Year Purchases	16,171	799	718	(81)	10	718	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 168,003	\$ 1,058	\$ 16,509	\$ 15,451		\$ 47,099	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Allocated from Aperion Consulti	2016	\$ 294	\$ 57	\$ 59	\$ 2	5	\$ 118
77		Allocated from Aperion Care	2016	425	86	85	(1)	5	191
78									78
79									79
80	TOTALS			\$ 719	\$ 143	\$ 144	\$ 1		\$ 309

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)			\$	1,736,607
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	96,913
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	64,218
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(32,695)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	175,701

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	Parking Lot	\$ 3,497
93		
94		
95		\$ 3,497

* 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?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from 8131 N Monticello				116			5
6								6
7	TOTAL				\$ 116			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 9,180
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Consulting		\$	\$ 155	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 155	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)	\$			

(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.

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	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 110,880	\$		\$ 110,880	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,443			12,443	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			94,333			94,333	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			30,895			30,895	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					8,137			8,137	13
14	TOTAL			\$		\$ 256,688	\$		\$ 256,688	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	\$	\$ 5,075	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	591,166	591,166	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,956	40,956	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	410,000	960,000	8
9	Other(specify): <u>See Attached Schedule</u>	6,777	143,987	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,048,899	\$ 1,741,184	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,000	13
14	Buildings, at Historical Cost		1,108,000	14
15	Leasehold Improvements, at Historical Cost	326,944	326,944	15
16	Equipment, at Historical Cost	22,665	164,665	16
17	Accumulated Depreciation (book methods)	(81,696)	(246,208)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	538,579	1,867,672	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 806,492	\$ 3,311,073	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,855,391	\$ 5,052,257	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,621	\$ 121,621	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	372,916	372,916	29
30	Accrued Salaries Payable	78,142	78,142	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,637	3,637	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,751	32
33	Accrued Interest Payable	1,277	10,722	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	24,529	24,529	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 602,122	\$ 635,318	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,160,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,564,376	2,564,376	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,564,376	\$ 4,724,376	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,166,498	\$ 5,359,694	46
47	TOTAL EQUITY(page 18, line 24)	\$ (311,107)	\$ (307,437)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,855,391	\$ 5,052,257	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (21,867)	1
2	Restatements (describe):		2
3	Equity Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (21,866)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(294,691)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	30,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(24,550)	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)	\$ (289,241)	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)	\$ (311,107)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care St Elmo

0052696

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,156,576	1
2	Discounts and Allowances for all Levels	389,565	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,546,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	124,236	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 124,236	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	668	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,011	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	665	19
20	Radiology and X-Ray	1,198	20
21	Other Medical Services	3,761	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,303	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	412	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 412	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,686,092	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	466,246	31
32	Health Care	1,009,061	32
33	General Administration	808,423	33
	B. Capital Expense		
34	Ownership	307,898	34
	C. Ancillary Expense		
35	Special Cost Centers	278,538	35
36	Provider Participation Fee	110,617	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,980,783	40
41	Income before Income Taxes (line 30 minus line 40)**	(294,691)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (294,691)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,179,580	44
45	Private Pay - Net Inpatient Revenue	746,376	45
46	Medicare - Net Inpatient Revenue	597,358	46
47	Other-(specify) <u>Insurance/Managed Care</u>	22,827	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,546,141	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,080	\$ 71,847	\$ 34.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,172	6,919	173,182	25.03	3
4	Licensed Practical Nurses	10,746	12,037	225,188	18.71	4
5	CNAs & Orderlies	33,214	35,737	357,984	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,865	2,037	23,928	11.75	9
10	Activity Assistants	1,883	2,052	20,377	9.93	10
11	Social Service Workers	1,943	2,134	23,628	11.07	11
12	Dietician					12
13	Food Service Supervisor	1,361	1,633	27,483	16.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,222	8,803	82,370	9.36	15
16	Dishwashers					16
17	Maintenance Workers	1,958	2,062	35,647	17.29	17
18	Housekeepers	5,521	6,043	57,287	9.48	18
19	Laundry	3,575	4,019	37,061	9.22	19
20	Administrator	1,944	2,456	93,723	38.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,224	1,427	16,768	11.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,207	1,384	13,609	9.83	33
34	TOTAL (lines 1 - 33)	82,755	90,823	\$ 1,260,082 *	\$ 13.87	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	112	\$ 5,578	01-03	35
36	Medical Director	Monthly	17,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	19,600	10-03	38
39	Pharmacist Consultant	Monthly	1,865	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	83	4,135	11-03	44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatric Consult</u>	Monthly	4,000	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	\$ 52,178		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

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Aperion Care St Elmo

0052696

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles Hutson (01/01-08/17/16)	Administrator	0	\$ 68,418
Amanda Von Burg (8/22-12/31/16)	Administrator	0	25,305
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,723

B. Administrative - Other

Description	Amount
Aperion Care - Management Fee	\$ 115,918
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 115,918

C. Professional Services

Vendor/Payee	Type	Amount
Creative Technology Solutions	Data Processing	\$ 7,055
National Datacare Corporation	Data Processing	1,892
Wescom Solutions	Data Processing	10,895
Galaxy Hosted Software	Data Processing	3,000
Aperion Care	Data Processing	6,274
Malka Designs	Data Processing	215
Ability Network	Data Processing	3,025
Point Click Care	Data Processing	3,142
Propay HR	Payroll Processing	11,071
Marcum, LLP	Accounting Fees	21,975
Aperion Care	Accounting Fees	517
See Supplemental Schedule		87,255
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 156,316

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 40,607
Unemployment Compensation Insurance	26,980
FICA Taxes	94,771
Employee Health Insurance	25,373
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	640
Employee Benefits Other	3,746
TOTAL (agree to Schedule V, line 22, col.8)	\$ 192,117

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	716
Health Care Worker Background Check (Indicate # of checks performed 50)	503
Patient Background Checks 16	160
Dues & Subscriptions	11,434
Licenses & Permits	1,253
Allocated from Aperion Consulting	565
Allocated from Aperion Financial	120
See Supplemental Schedule	2,007
Less: Public Relations Expense ()	
Non-allowable advertising ()	
Yellow page advertising ()	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 20,738

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,168
Allocated from Aperion Consulting	396
Allocated from Aperion Care	612
See Supplemental Schedule	17
Entertainment Expense ()	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,193

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0052696

Report Period Beginning:

01/01/16

Ending:

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12/31/16

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. ICLTC \$10609 INHAA \$125
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,646 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 110,617
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 668
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees