

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0052506</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																			
Facility Name: <u>Aperion Care Wilmington</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>555 West Kahler</u> <u>Wilmington</u> <u>60481</u>																																																																																					
Number City Zip Code																																																																																					
County: <u>Will</u>																																																																																					
Telephone Number: <u>(815) 476-7931</u> Fax # <u>(815) 476-7939</u>																																																																																					
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____ *</td></tr><tr><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>12/6/2006</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2">Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Date) _____	Paid Preparer	(Signed) _____ *	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>12/6/2006</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____					In the event there are further questions about this report, please contact:				Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>		Email Address: _____		Springfield, IL 62763-0001 Phone # (217) 782-1630	
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#	0052506	Report Period Beginning:	01/01/16	Ending:	12/31/16
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D. How many bed-hold days during this year were paid by the Department?

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

**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 12/6/2006

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

YES ☒ Date 12/6/2006 NO ☐

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

YES ☒ NO ☐ If YES, enter number
of beds certified 80 and days of care provided

Medicare Intermediary National Government Services

MODIFIED

ACCRUAL	X
---------	---

CASH*	
-------	--

CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2016 **Fiscal Year:** 12/31/2016

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

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	706	97	12,386	13,189	8
9	SNF/PED					9
10	ICF	21,488	2,619	20,868	44,975	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,194	2,716	33,254	58,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.93%

Facility Name & ID Number Aperion Care Wilmington # 0052506 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	255,522	28,758	28,390	312,670		312,670	(3,035)	309,635			1
2	Food Purchase		329,158		329,158		329,158	(6,521)	322,637			2
3	Housekeeping	30,136	22,516	130,215	182,867		182,867		182,867			3
4	Laundry	44,448	8,069	102,382	154,899		154,899		154,899			4
5	Heat and Other Utilities			159,572	159,572		159,572	(3,243)	156,329			5
6	Maintenance	76,024	28,788	77,236	182,048		182,048	1,139	183,187			6
7	Other (specify):*							3,937	3,937			7
8	TOTAL General Services	406,130	417,289	497,795	1,321,214		1,321,214	(7,723)	1,313,491			8
	B. Health Care and Programs											
9	Medical Director			20,250	20,250		20,250		20,250			9
10	Nursing and Medical Records	2,305,041	134,196	80,038	2,519,275		2,519,275	(4,929)	2,514,346			10
10a	Therapy	115,170		130	115,300		115,300		115,300			10a
11	Activities	170,708	8,532	1,479	180,719		180,719		180,719			11
12	Social Services	312,918		10,546	323,464		323,464		323,464			12
13	CNA Training											13
14	Program Transportation			5,160	5,160		5,160		5,160			14
15	Other (specify):*							7,362	7,362			15
16	TOTAL Health Care and Programs	2,903,837	142,728	117,603	3,164,168		3,164,168	2,433	3,166,601			16
	C. General Administration											
17	Administrative	110,768		544,038	654,806		654,806	(445,877)	208,929			17
18	Directors Fees											18
19	Professional Services			456,639	456,639		456,639	(322,689)	133,950			19
20	Dues, Fees, Subscriptions & Promotions			128,694	128,694		128,694	(83,877)	44,817			20
21	Clerical & General Office Expenses	115,672	5,586	217,412	338,670		338,670	15,623	354,293			21
22	Employee Benefits & Payroll Taxes			593,826	593,826		593,826		593,826			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,148	13,148		13,148	4,431	17,579			24
25	Other Admin. Staff Transportation			4,944	4,944		4,944	18,717	23,661			25
26	Insurance-Prop.Liab.Malpractice			168,824	168,824		168,824	3,797	172,621			26
27	Other (specify):*							24,505	24,505			27
28	TOTAL General Administration	226,440	5,586	2,127,525	2,359,551		2,359,551	(785,371)	1,574,180			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,536,407	565,603	2,742,923	6,844,933		6,844,933	(790,660)	6,054,273			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			108,942	108,942		108,942	194,270	303,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,327	64,327		64,327	523,044	587,371			32
33	Real Estate Taxes			160,065	160,065		160,065	4,557	164,622			33
34	Rent-Facility & Grounds			849,938	849,938		849,938	(849,436)	502			34
35	Rent-Equipment & Vehicles			14,859	14,859		14,859	2,784	17,643			35
36	Other (specify):*			7,431	7,431		7,431	(7,431)	0			36
37	TOTAL Ownership			1,205,562	1,205,562		1,205,562	(132,212)	1,073,350			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,267	535,978	722,245		722,245	(39,817)	682,428			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			424,476	424,476		424,476		424,476			42
43	Other (specify):*			48,498	48,498		48,498	(48,498)				43
44	TOTAL Special Cost Centers		186,267	1,008,952	1,195,219		1,195,219	(88,315)	1,106,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,536,407	751,870	4,957,437	9,245,714		9,245,714	(1,011,187)	8,234,527			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	(4,530)	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	(183,984)	30		9
10	Interest and Other Investment Income	(1,989)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(5,825)	21		18
19	Entertainment	(15,657)	21		19
20	Contributions	(89,150)	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	(134,033)	21		24
25	Fund Raising, Advertising and Promotional	(48,498)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(100,370)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (584,190)		\$	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)	(426,997)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (426,997)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,011,187)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (10,001)	21	1
2	Credit Card Processing	(417)	21	2
3	Amortization	(7,431)	36	3
4	Other Unclassified Income	(637)	21	4
5	Building Company - Amortization	(62,075)	36	5
6	Building Company - Bank Charges	(15,449)	21	6
7	Building Company - Accounting Fees	(7,575)	19	7
8	Building Company - Professional Fees	(1,750)	19	8
9	Additional R & M	12,079	06	9
10	PAC Dues	(6,431)	20	10
11	Non-Allowable Legal	(98)	19	11
12	Non-Allowable Seminar	(25)	24	12
13	Debt Collection	(561)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(100,370)		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
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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 Wilmington # 0052506 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				(3,035)								(3,035)	1
2	Food Purchase	(154)		383	(6,750)								(6,521)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,530)		70			420	797					(3,243)	5
6	Maintenance	12,079		1,549	(14,040)		755	796					1,139	6
7	Other (specify):*			70	3,532			335					3,937	7
8	TOTAL General Services	7,395		2,072	(20,293)		1,175	1,928					(7,723)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			6,964	(11,893)								(4,929)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			418	6,944								7,362	15
16	TOTAL Health Care and Programs			7,382	(4,949)								2,433	16
	C. General Administration													
17	Administrative			(449,078)		3,201							(445,877)	17
18	Directors Fees													18
19	Professional Services	(9,984)	9,325	(175,002)	1,521	(145,093)	1,433	96		(4,986)			(322,689)	19
20	Fees, Subscriptions & Promotions	(95,581)		8,545	2,458	524		177					(83,877)	20
21	Clerical & General Office Expenses	(182,019)	15,449	49,125	812	130,013	984	1,259					15,623	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(25)		2,660	1,720	75							4,431	24
25	Other Admin. Staff Transportation			9,600	7,123	1,994							18,717	25
26	Insurance-Prop.Liab.Malpractice			3,436				361					3,797	26
27	Other (specify):*			9,029		15,476							24,505	27
28	TOTAL General Administration	(287,609)	24,774	(541,685)	13,634	6,191	2,417	1,893		(4,986)			(785,371)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(280,214)	24,774	(532,231)	(11,608)	6,191	3,593	3,821		(4,986)			(790,660)	29

Summary B

12/31/16

													SUMMARY
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
Depreciation	(183,984)	367,303	2,276	349	136	1,823	6,367					194,270	30
Amortization of Pre-Op. & Org.													31
Interest	(1,989)	513,578	8,066	28		1,375	1,986					523,044	32
Real Estate Taxes		41				2,126	2,391					4,557	33
Rent-Facility & Grounds		(819,938)	992			(7,490)	(23,000)					(849,436)	34
Rent-Equipment & Vehicles			155	674	605	643	708					2,784	35
Other (specify):*	(69,506)	62,075										(7,431)	36
TOTAL Ownership	(255,479)	123,059	11,488	1,051	741	(1,523)	(11,549)					(132,212)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation													38
Ancillary Service Centers								(39,817)				(39,817)	39
Barber and Beauty Shops													40
Coffee and Gift Shops													41
Provider Participation Fee													42
Other (specify):*	(48,498)											(48,498)	43
TOTAL Special Cost Centers	(48,498)							(39,817)				(88,315)	44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(584,190)	147,833	(520,743)	(10,557)	6,931	2,070	(7,728)	(39,817)	(4,986)			(1,011,187)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supp		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	\$ 819,938	555 W. Kahler, LLC	100.00%	\$	(819,938)	1
2	V	32	Interest	7	555 W. Kahler, LLC	100.00%	513,585	513,578	2
3	V	36	Amortization		555 W. Kahler, LLC	100.00%	62,075	62,075	3
4	V	21	Bank Charges		555 W. Kahler, LLC	100.00%	15,449	15,449	4
5	V	19	Accounting Fees		555 W. Kahler, LLC	100.00%	7,575	7,575	5
6	V	33	Real Estate Tax	160,065	555 W. Kahler, LLC	100.00%	160,106	41	6
7	V	30	Depreciation		555 W. Kahler, LLC	100.00%	367,303	367,303	7
8	V	19	Professional Fees		555 W. Kahler, LLC	100.00%	1,750	1,750	8
9	V					100.00%			9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 980,010			\$ 1,127,843	\$ * 147,833	14

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

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

0052506

Report Period Beginning: 01/01/16

Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	100.00%	\$ 383	\$ 383	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	70	70	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	1,549	1,549	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	70	70	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	6,964	6,964	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	418	418	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	94,960	94,960	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	3,815	3,815	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	8,545	8,545	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	49,125	49,125	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	2,660	2,660	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	9,600	9,600	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	3,436	3,436	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	9,029	9,029	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	2,276	2,276	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	8,066	8,066	30
31	V	34	RENT		APERION CARE, INC.	100.00%	992	992	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	155	155	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	544,038	APERION CARE, INC.	100.00%		(544,038)	35
36	V	19	HOME OFFICE	178,817	APERION CARE, INC.	100.00%		(178,817)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			\$ 722,855			\$ 202,112	\$ * (520,743)	39

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

Facility Name & ID Number	<u>Aperion</u> Care Wilmington
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0052506

Report Period Beginning: 01/01/16

Ending: 12/31/16

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 16,765	\$ 16,765	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	9,760	9,760	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	3,532	3,532	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	52,007	52,007	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	6,944	6,944	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	1,521	1,521	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	2,458	2,458	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	812	812	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	1,720	1,720	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	7,123	7,123	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	349	349	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	28	28	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	674	674	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	63,900	APERION CONSULTING, LLC	100.00%		(63,900)	34
35	V	01	DIETICIAN	19,800	APERION CONSULTING, LLC	100.00%		(19,800)	35
36	V	02	FOOD SERVICE	6,750	APERION CONSULTING, LLC	100.00%		(6,750)	36
37	V	06	PAINTER	3,000	APERION CONSULTING, LLC	100.00%		(3,000)	37
38	V	06	PROJECT MANAGER	20,800	APERION CONSULTING, LLC	100.00%		(20,800)	38
39	Total			\$ 114,250			\$ 103,693	\$ * (10,557)	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%	\$ 3,201	\$ 3,201	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	2,513	2,513	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	524	524	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	130,013	130,013	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	75	75	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,994	1,994	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	15,476	15,476	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	136	136	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	605	605	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	147,606	APERION FINANCIAL, LLC	100.00%		(147,606)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 147,606			\$ 154,537	\$ * 6,931	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%	\$ 420	\$ 420	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		755	755	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		1,433	1,433	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		984	984	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,823	1,823	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,375	1,375	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		502	502	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		643	643	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,126	2,126	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	992				(992)	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			\$ 7,992			\$ 10,062	\$ * 2,070	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%	\$ 797	\$ 797	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		796	796	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		335	335	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		96	96	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		177	177	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		1,259	1,259	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		361	361	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		6,367	6,367	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		1,986	1,986	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		2,391	2,391	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		708	708	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC			(23,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 23,000			\$ 15,272	\$ * (7,728)	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	\$ 533,024	RENEWAL REHAB	100.00%	\$ 493,207	\$ (39,817)	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			\$ 533,024			\$ 493,207	\$ * (39,817)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PAYROLL SERVICES	\$ 20,777	PROPAY HR LLC	24.00%	\$ 15,791	\$ (4,986)	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			\$ 20,777			\$ 15,791	\$ * (4,986)	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	04	Laundry Services	\$ 102,382	EcoBrite Linen	100.00%	\$ 102,382	\$	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			\$ 102,382			\$ 102,382	\$ *	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 Wilmington

0052506

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	Morris Esformes	16.6700%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	The Rajchenbach Family Trust	16.6700%	Aperion Care Bloomington	Jacksonville	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Rita Lipshitz	16.6600%	Aperion Care Bridgeport	Galesburg	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Delcaration of Trust Yosef Meystel	24.0000%	Aperion Care Burbank	Dolton	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	David A. Berkowitz Revocable Trust	24.0000%	Aperion Care Chicago Heights	East Moline	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Steven Turofsky	1.0000%	Aperion Care Colfax	Bridgeport	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Fredrick S. Frankel	1.0000%	Aperion Care Demotte	Litchfield	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Dolton	Springfield	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	St. Elmo	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Midlothian	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Burbank	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Chicago Heights	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	Forest Park	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Oak Lawn	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Highwood	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Decatur	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Plum Grove	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Evanston	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Chicago Heights	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	Spring Valley	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Elgin	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Toluca	555 W. KAHLER, LLC	WILMINGTON	BUILDING COMPANY	22
23			Aperion Care Plum Grove	Colfax				23
24			Aperion Care Spring Valley	Bloomington				24
25			Aperion Care Springfield	Michigan City, IN				25
26			Aperion Care St. Elmo	Demotte, IN				26
27			Aperion Care Tolleston Park	Kokomo, IN				27
28			Aperion Care Toluca	Gary, IN				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30								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			Burgin Manor	Olney				1
2			Baypointe Rehab Center	Brockton, MA				2
3			Eastpointe Rehab Center	Chelsea, MA				3
4			Southpointe Rehab Center	Falls River, MA				4
5			The Arbors at Michigan City	Michigan City, IN				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 Wilmington # 0052506 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	2.2	5.50%	Alloc Salary	\$ 11,042	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	1.1	2.75%	Alloc Salary	1,705	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	1.1	5.50%	Alloc Salary	4,074	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.2	6.06%	Alloc Salary	1,665	21-7	4
5	Meir Meystel	Relative	Clerical	0%	See Attached	0.4	5.80%	Alloc Salary	1,452	21-7	5
6	David Berkowitz	Relative	Administrative	0%	See Attached	2.2	5.50%	Alloc Salary	11,042	17-7	6
7	Fred Frankel	Owner	Administrative	1.00%	See Attached	2.2	5.50%	Alloc Salary	10,187	17-7	7
8	Steve Turofsky	Owner	Administrative	1.00%	See Attached	2.2	5.50%	Alloc Salary	10,589	17-7	8
9	Nosson Factor	Relative	Clerical	0%	See Attached	1.8	5.47%	Alloc Salary	4,685	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	\$ 56,441		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

Ending: 12/31/16

Ending: 12/31/16

Facility Name & ID Number	Aperion Care Wilmington
--------------------------------------	--------------------------------

0052506

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

APERION FINANCIAL, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

7

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 57,979	58,164	\$ 3,201	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525		58,164	2,513	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485		58,164	524	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	58,164	130,013	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360		58,164	75	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125		58,164	1,994	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317		58,164	15,476	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458		58,164	136	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954		58,164	605	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		\$ 154,537	25

Ending: 12/31/16

Ending: 12/31/16

(847 673-6768

Fax NumberIL478-2471

Ending: 12/31/16

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IL478-2471

Ending: 12/31/16

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IL478-2471

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	1st Midwest Bank		X	Mortgage			\$	12,300,000			\$	513,585	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Auto Loan		X					10,249					6
7	The Private Bank		X	Line of Credit				1,722,685				60,537	7
8					-								8
9	TOTAL Facility Related						\$	14,032,934			\$	574,122	9
	B. Non-Facility Related*												
10	Interest - Insurance Policies		X									3,790	10
11	Interest Income		X									(1,989)	11
12	Interest Income - Bldg Co		X									(7)	12
13	See Supplemental Schedule				-							11,455	13
14	TOTAL Non-Facility Related						\$				\$	13,249	14
15	TOTALS (line 9+line14)						\$	14,032,934			\$	587,371	15

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

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15	Allocated from Aperion Care		X				\$					\$ 8,066	15
16	Allocated from Aperion Consulting		X									28	16
17	Allocated from 8131 N. Monticello LLC		X									1,375	17
18	Allocated from Chase Office, LLC		X									1,986	18
19													19
20	TOTAL Non-Facility Related											11,455	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	156,702	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.)			\$	161,259	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,557	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	160,065	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.			\$	164,622	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	126,617	8	
		2012	139,234	9	
		2013	148,572	10	
		2014	156,702	11	
		2015	156,743	12	
2016 accrual = \$156,743 x 1.02 = \$160,065 (ROUNDED)					
Allocated from 8131 N. Monticello LLC: \$2,126					
Allocated from Chase Office, LLC: \$2,391					

		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 Wilmington</u>	COUNTY	<u>Will</u>
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CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Aperion Care Wilmington

COUNTY

Will

FACILITY IDPH LICENSE NUMBER

0052506

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:40,500

B. General Construction Type:ExteriorBrickFrameNumber of Stories

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	40,500	2006	\$145,000	1
2	Allocated from Chase Office, LLC			3,428	2
3	TOTALS	40,500		\$148,428	3

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

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)		2,531,359			126,568	126,568	360,811	67
68	Related Party Allocations (Pages 12H & 12I)		189,531	5,724		4,860	(864)	16,002	68
69	Financial Statement Depreciation			108,942			(108,942)		69
70	TOTAL (lines 4 thru 69)		\$ 5,840,628	\$ 481,969		\$ 213,773	\$ (268,196)	\$ 2,665,428	70

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

Facility Name & ID Number Aperion Care Wilmington

0052506

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		\$ 5,840,628	\$ 481,969		\$ 213,773	\$ (268,196)	\$ 2,665,428	1
2	Security System - New Camera & Installation	2013	14,787		20	1,479	1,479	4,806	2
3	Installation Of Cat5E Cable For Data & Voice	2013	11,195		20	1,120	1,120	3,638	3
4	New 7' X 10' Overall Aluminum Sign	2014	5,420		20	361	361	903	4
5	Framing & Drywall, Vinyl Floor, Millwork Labor, Tile Labor, Plu	2014	148,500		20	7,425	7,425	19,181	5
6	Solutions Cleaning Services Post-Construction Cleaning	2014	3,575		20	179	179	462	6
7	Abatement Of Acm Vinyl Tile & Mastic In Nw Resident Wing	2014	20,200		20	1,010	1,010	2,862	7
8	Alpha Adjusting Company Adjusting Fee, Building - Building Los	2014	20,096		20	1,005	1,005	2,596	8
9	Insurance Check For Building Losses	2014	(200,957)		20	(10,048)	(10,048)	(25,957)	9
10	Ec2 Inc. Prv, Mold Sample, Travel	2014	2,860		20	143	143	381	10
11	Dg Tell Cable Installation, Wall Mount Rack	2014	4,616		20	231	231	615	11
12	Water Damage Demolition, Restoration, Service & Remodel In Th	2014	81,290		20	4,064	4,064	10,500	12
13	Cubicle Track	2014	3,129		20	626	626	1,721	13
14	Thermostat Mixing Valve To Hot Water System	2014	4,875		20	244	244	691	14
15	Alpha Adjusting Co. Inc. Adj. For Insurance Proceeds	2014	1,635		20	82	82	232	15
16	Insurance Check For Building Losses	2014	(50,000)		20	(2,500)	(2,500)	(6,458)	16
17	Compressor Repair	2014	4,964		20	248	248	517	17
18	Water Heater	2014	6,005		20	300	300	901	18
19	Window Treatments, Roller Shades, Cubicle Curtains	2014	21,448		20	1,072	1,072	2,592	19
20	Alpha Adjusting Company Adjusting Fee - Building Loss	2014	5,000		20	250	250	708	20
21	New Bath/Shower Room Electric Heating Installed	2015	4,240		20	424	424	848	21
22	Remove Pvs Floor Drain In Kitchen, Install New Cleanout & Drai	2015	5,950		20	595	595	1,091	22
23	Electrical Work: Life Safety Receptacles, Transformer, 125 Amp I	2015	15,869		20	793	793	1,455	23
24	Paving Work: Removal & 4' Replacement, 1.5" Resurfacing	2015	52,620		20	2,631	2,631	4,604	24
25	Cubicle Curtains, Track, Window Treatments	2015	24,215		20	1,211	1,211	2,119	25
26	Heat Exchanger And Defective Compressor	2015	7,500		20	375	375	594	26
27	New Vs2 Fire Alarm System	2015	23,901		20	1,195	1,195	1,892	27
28	Resident Room Bathroom - Flooring	2015	4,666		20	233	233	253	28
29	Power Opener Replacment	2015	3,130		20	157	157	170	29
30	Fridge Roof	2015	8,035		20	402	402	435	30
31	Dining/Therapy/Office-Ceiling,Lights,Wallcover,Cove Base,Signs,	2015	44,992		20	2,250	2,250	2,437	31
32	Dining/Resident Rm/Corridors-Cove Base,Flooring,Tile	2015	134,459		20	6,723	6,723	7,283	32
33	Cooler/Freezer With Installation	2016	37,900		20	1,105	1,105	1,105	33
34	TOTAL (lines 1 thru 33)		\$ 6,316,743	\$ 481,969		\$ 239,158	\$ (242,812)	\$ 2,710,604	34

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

Facility Name & ID Number Aperion Care Wilmington

0052506

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		\$ 6,316,743	\$ 481,969		\$ 239,158	\$ (242,812)	\$ 2,710,604	1
2	Dining Rooms (Replace Tiles), Therapy Room (Cove Base), Therap	2016	16,481		20	824	824	824	2
3	Removal/Installation Of Cove Base 2 Dining Rooms, Resident Roo	2016	32,612		20	1,631	1,631	1,631	3
4	5 Ion Carrier	2016	8,500		20	213	213	213	4
5	Dining Rooms Removal Of Coval Base, Tv Lounge Chairs, Therap	2016	46,838		20	2,168	2,168	2,168	5
6	Swing Door Operator	2016	3,384		20	28	28	28	6
7	Shower Room Remodel-Demo/Plumbing/Electric/Tile (149,200)	2016	118,524		20	1,243	1,243	1,243	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)		\$ 6,543,082	\$ 481,969		\$ 245,264	\$ (236,705)	\$ 2,716,710	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,543,082	\$ 481,969		\$ 245,264	\$ (236,705)	\$ 2,716,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 6,543,082	\$ 481,969		\$ 245,264	\$ (236,705)	\$ 2,716,710	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,543,082	\$ 481,969		\$ 245,264	\$ (236,705)	\$ 2,716,710	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)		\$ 6,543,082	\$ 481,969		\$ 245,264	\$ (236,705)	\$ 2,716,710	34

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

Facility Name & ID Number Aperion Care Wilmington

0052506

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Plumbing System Repair	2014	24,700		20	1,235	1,235	3,705	9
10	18 New Wooden Doors	2014	9,067		20	453	453	1,359	10
11	Furnish and Install New 25 KW Kohler Generator	2014	20,487		20	1,024	1,024	3,072	11
12	Water Softener	2014	10,196		20	510	510	1,530	12
13	Facility Renovation: new water service,asphalt patching,lighting	2015	2,089,059		20	104,453	104,453	313,359	13
14	interior demo,millwork,roofing,painting,plumbing,fire protection								14
15	Resident/Dining/Therapy Rm/Corridors - cove base/flooring/tile	2015	165,514		20	8,276	8,276	16,552	15
16	Lobby/Conf Rm/Guest Bath/Dining Rms/Corridor/Therapy Rm/								16
17	Tiling/millwork base/wallcovering/light fixtures/windows/stations	2015	212,336		20	10,617	10,617	21,234	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)		\$ 2,531,359	\$		\$ 126,568	\$ 126,568	\$ 360,811	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,531,359	\$		\$ 126,568	\$ 126,568	\$ 360,811	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 2,531,359	\$		\$ 126,568	\$ 126,568	\$ 360,811	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 Chase Office, LLC	2016	30,852	330	35	330		330	3
4	Allocated from 8131 N. Monticello	2010		656	35	571	(85)	5,914	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office, LLC	2016	156,370	3,258	20	3,258		3,258	9
10									10
11	Allocated from 8131 N. Monticello	2010		1,158	20	499	(659)	5,234	11
12	Allocated from 8131 N. Monticello	2013			20	87	87	533	12
13									13
14	Allocated from Aperion Care	2010	1,645	264	20	82	(182)	576	14
15	Allocated from Aperion Care	2012	466	36	20	23	(13)	117	15
16	Allocated from Aperion Care	2013	198	22	20	10	(12)	40	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)		\$ 189,531	\$ 5,724		\$ 4,860	\$ (864)	\$ 16,002	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		\$ 189,531	\$ 5,724		\$ 4,860	\$ (864)	\$ 16,002	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 189,531	\$ 5,724		\$ 4,860	\$ (864)	\$ 16,002	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 286,973	\$ 1,126	\$ 44,044	\$ 42,918	10	\$ 101,977	71
72	Current Year Purchases	100,673	3,477	4,955	1,478	10	4,955	72
73	Fully Depreciated Assets	1,038,561				10	1,038,561	73
74								74
75	TOTALS	\$ 1,426,207	\$ 4,603	\$ 48,999	\$ 44,396		\$ 1,145,493	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		Various	2016	\$ 77,795	\$	\$ 8,324	\$ 8,324	5	\$ 47,270
77		Allocated from Aperion Care	2016	1,847	375	369	(6)	5	829
78		Allocated from Aperion Consulti	2016	1,280	249	256	7	5	512
79									
80	TOTALS			\$ 80,922	\$ 624	\$ 8,949	\$ 8,325		\$ 48,611

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)			\$	8,198,639
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	487,196
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	303,212
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(183,984)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,910,814

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?
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 LLC				505			5
6								6
7	TOTAL				\$ 505			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: \$ 16,969
- 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		\$	\$ 674	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 674	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 240,117	\$		\$ 240,117	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			43,977			43,977	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,891			237,891	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				175,373		175,373	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					13,993	10,894		24,887	13
14	TOTAL			\$		\$ 535,978	\$ 186,267		\$ 722,245	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	\$ 11,896	\$ 436,981	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,268,814	2,268,814	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	180,196	180,196	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	51,144	66,108	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,512,050	\$ 2,952,099	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,064,500	14
15	Leasehold Improvements, at Historical Cost	782,993	2,951,275	15
16	Equipment, at Historical Cost	235,827	600,882	16
17	Accumulated Depreciation (book methods)	(228,947)	(1,133,545)	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>	5,772,050	12,095,981	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,561,923	\$ 18,079,093	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,073,973	\$ 21,031,192	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 606,352	\$ 606,351	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,732,934	1,732,934	29
30	Accrued Salaries Payable	175,428	175,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,265	10,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)		160,065	32
33	Accrued Interest Payable	5,941	59,728	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	71,074	71,074	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,601,994	\$ 2,815,845	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,300,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	4,782,650	4,787,650	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,782,650	\$ 17,087,650	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,384,644	\$ 19,903,495	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,689,329	\$ 1,127,697	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,073,973	\$ 21,031,192	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,235,148	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,235,148	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,654,181	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	(1,200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 454,181	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)	\$ 1,689,329	24 *

* This must agree with page 17, line 47.

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

0052506

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	\$ 11,552,174	1
2	Discounts and Allowances for all Levels	(787,637)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,764,537	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	100,544	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 100,544	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	28,172	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,895	19
20	Radiology and X-Ray	942	20
21	Other Medical Services	179	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,188	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,989	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,989	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	637	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 637	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,899,895	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,321,214	31
32	Health Care	3,164,168	32
33	General Administration	2,359,551	33
	B. Capital Expense		
34	Ownership	1,205,562	34
	C. Ancillary Expense		
35	Special Cost Centers	770,743	35
36	Provider Participation Fee	424,476	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,245,714	40
41	Income before Income Taxes (line 30 minus line 40)**	1,654,181	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,654,181	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,416,800	44
45	Private Pay - Net Inpatient Revenue	524,988	45
46	Medicare - Net Inpatient Revenue	1,182,923	46
47	Other-(specify) <u>Insurance</u>	7,639,826	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,764,537	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,183	\$ 101,265	\$ 46.39	1
2	Assistant Director of Nursing	872	960	36,972	38.51	2
3	Registered Nurses	16,931	18,293	526,810	28.80	3
4	Licensed Practical Nurses	25,621	28,739	727,445	25.31	4
5	CNAs & Orderlies	64,633	69,963	884,694	12.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,298	6,206	115,170	18.56	8
9	Activity Director	1,848	2,080	34,074	16.38	9
10	Activity Assistants	13,267	14,063	136,634	9.72	10
11	Social Service Workers	13,263	13,986	294,616	21.07	11
12	Dietician					12
13	Food Service Supervisor	1,496	1,528	29,657	19.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,180	18,521	225,865	12.20	15
16	Dishwashers					16
17	Maintenance Workers	4,896	5,064	76,024	15.01	17
18	Housekeepers	3,318	3,422	30,136	8.81	18
19	Laundry	3,176	4,122	44,448	10.78	19
20	Administrator	1,880	2,080	108,012	51.93	20
21	Assistant Administrator	192	200	2,756	13.78	21
22	Other Administrative					22
23	Office Manager	912	920	18,309	19.90	23
24	Clerical	6,671	7,412	97,363	13.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,850	2,092	27,855	13.32	31
32	Other Health Care(specify)					32
33	Other(specify)	1,665	1,841	18,302	9.94	33
34	TOTAL (lines 1 - 33)	186,993	203,675	\$ 3,536,407 *	\$ 17.36	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	580	\$ 28,390	01-03	35
36	Medical Director	Monthly	20,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	893	66,700	10-03	38
39	Pharmacist Consultant	Monthly	13,338	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	130	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,479	11-03	44
45	Social Service Consultant	29	1,771	12-03	45
46	Other(specify) <u>Psychiatric Consult</u>	Monthly	8,775	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,528	\$ 140,833		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

Facility Name & ID Number

Aperion Care Wilmington

#

0052506

Report Period Beginning:

01/01/16

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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		
Jodi Jude		Administrator	0	\$ 108,012	Workers' Compensation Insurance		\$ 160,711	IDPH License Fee		\$		
Amanda Darey		Assisant Administrator	0	2,756	Unemployment Compensation Insurance		80,582	Advertising: Employee Recruitment		5,002		
					FICA Taxes		269,135	Health Care Worker Background Check				
					Employee Health Insurance		51,717	(Indicate # of checks performed 275)		2,751		
					Employee Meals			Patient Background Checks		71		
					Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions		21,620		
					401K Expense		26,085	License and Permits		1,690		
					Employee Physicals		1,600	Allocated from Aperion Care		8,545		
					Employee Meals		32	Allocated from Aperion Consulting		2,458		
					Employee Benefits- Other		3,964	See Supplemental Schedule		2,042		
								Less: Public Relations Expense		()		
								Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 110,767	TOTAL (agree to Schedule V, line 22, col.8)				\$ 593,825	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 44,818
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	
Aperion Care, Inc.			\$ 544,038						Out-of-State Travel		\$	
									In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 544,038						Seminar Expense		13,124
C. Professional Services										Allocated from Aperion Care		2,660
Vendor/Payee	Type		Amount							Allocated from Aperion Consulting		1,720
Point Click Care	Data Processing		\$ 7,925							See Supplemental Schedule		75
Aperion Care Inc.	Data Processing		8,276							Entertainment Expense		()
Creative Technology Solutions	Data Processing		20,405							(agree to Sch. V,		
Ability Network	Data Processing		325							line 24, col. 8)		
Galaxy Hosted Software	Data Processing		7,650							TOTAL		\$ 17,579
Wescom Solutions	Data Processing		30,785									
National Datacare Corportation	Data Processing		1,788									
Aperion Financial	Home Office Expense		147,606									
Aperion Care	Home Office Expense		178,817									
ProPay HR	Payroll Processing		20,777									
See Supplemental Schedule			32,286									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 456,640	TOTAL				\$			

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Aperion Care Wilmington	STATE OF ILLINOIS # 0052506	Report Period Beginning: 01/01/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. ICLTC \$19,488.81

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,504 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. \$ 424,476
 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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
 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