

Facility Name & ID Number Aperion Care Bloomington

0053983 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 _____

	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	117	Skilled (SNF)	117	42,822	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,822	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,693	1,693	8
9	SNF/PED					9
10	ICF	21,795	1,772	6,033	29,600	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,795	1,772	7,726	31,293	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.08%

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 12/01/15

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

YES Date 12/01/15 NO

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

YES NO If YES, enter number of beds certified 115 and days of care provided 1,693

Medicare Intermediary CGS

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 Bloomington # 0053983 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	230,141	21,385	32,080	283,606		283,606	(23,060)	260,546		1
2	Food Purchase		188,019		188,019		188,019	100	188,119		2
3	Housekeeping	75,565	25,512	67,959	169,036		169,036		169,036		3
4	Laundry	28,144	6,391	45,306	79,841		79,841		79,841		4
5	Heat and Other Utilities			123,558	123,558		123,558	(4,278)	119,280		5
6	Maintenance	38,714	25,170	110,606	174,490		174,490	(24,669)	149,821		6
7	Other (specify):*							2,118	2,118		7
8	TOTAL General Services	372,564	266,477	379,509	1,018,550		1,018,550	(49,789)	968,761		8
	B. Health Care and Programs										
9	Medical Director			17,900	17,900		17,900		17,900		9
10	Nursing and Medical Records	1,463,231	93,185	90,426	1,646,842		1,646,842	(49,572)	1,597,270		10
10a	Therapy	36,854			36,854		36,854		36,854		10a
11	Activities	94,410	6,094	585	101,089		101,089		101,089		11
12	Social Services	101,703		1,788	103,491		103,491		103,491		12
13	CNA Training										13
14	Program Transportation			723	723		723		723		14
15	Other (specify):*							3,961	3,961		15
16	TOTAL Health Care and Programs	1,696,198	99,279	111,422	1,906,899		1,906,899	(45,611)	1,861,288		16
	C. General Administration										
17	Administrative	90,617		229,434	320,051		320,051	(176,622)	143,429		17
18	Directors Fees										18
19	Professional Services			216,174	216,174		216,174	(115,227)	100,947		19
20	Dues, Fees, Subscriptions & Promotions			81,082	81,082		81,082	(35,325)	45,757		20
21	Clerical & General Office Expenses	57,135		153,886	211,021		211,021	(16,477)	194,544		21
22	Employee Benefits & Payroll Taxes			339,616	339,616		339,616		339,616		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,009	13,009		13,009	2,396	15,405		24
25	Other Admin. Staff Transportation			11,444	11,444		11,444	10,070	21,514		25
26	Insurance-Prop.Liab.Malpractice			96,554	96,554		96,554	2,043	98,597		26
27	Other (specify):*							13,184	13,184		27
28	TOTAL General Administration	147,752		1,141,199	1,288,951		1,288,951	(315,958)	972,993		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,216,514	365,756	1,632,130	4,214,400		4,214,400	(411,358)	3,803,042		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aperion Care Bloomington

#0053983

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			10,209	10,209		10,209	(1,181)	9,028			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,357	33,357		33,357	5,254	38,611			32
33	Real Estate Taxes			20,656	20,656		20,656	2,430	23,086			33
34	Rent-Facility & Grounds			633,716	633,716		633,716	(29,730)	603,986			34
35	Rent-Equipment & Vehicles			24,718	24,718		24,718	1,498	26,216			35
36	Other (specify):*			(208)	(208)		(208)	208				36
37	TOTAL Ownership			722,448	722,448		722,448	(21,521)	700,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,731	269,701	378,432		378,432	(19,989)	358,443			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,363	245,363		245,363		245,363			42
43	Other (specify):*			27,007	27,007		27,007	(27,007)				43
44	TOTAL Special Cost Centers		108,731	542,071	650,802		650,802	(46,996)	603,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,216,514	474,487	2,896,649	5,587,650		5,587,650	(479,875)	5,107,775			45

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

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning: 01/01/16

Ending: 12/31/16

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(4,971)	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	(7,073)	30		9
10	Interest and Other Investment Income	(909)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(106)	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	(857)	21		18
19	Entertainment	(3,129)	21		19
20	Contributions	(40,797)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,153)	21		24
25	Fund Raising, Advertising and Promotional				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	(38,696)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,691)		\$	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	2	
		Amount	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)	(278,184)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (278,184)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (479,875)		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	2	3	4	
		Yes	No	Amount	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

Aperion Care Bloomington

ID# 0053983

Report Period Beginning: 01/01/16

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (27,007)	43	1
2	Bank Charges	(5,361)	21	2
3	Cable TV Repairs	(640)	06	3
4	Additional R&M	13,708	06	4
5	Non Allowable legal fees	(98)	19	5
6	PAC Dues	(825)	20	6
7	Non Allowable Professional Fees	(4,576)	19	7
8	Amortization Exp	208	36	8
9	Capitalized R&M	(14,105)	06	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
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	(38,696)		49

Aperion Care Bloomington

ID# 0053983
 Report Period Beginning: 01/01/16
 Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Bloomington# 0053983

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				(23,060)								(23,060)	1
2	Food Purchase	(106)		206									100	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,971)		38			226	429					(4,278)	5
6	Maintenance	(1,037)		833	(25,299)		406	428					(24,669)	6
7	Other (specify):*			38	1,900			180					2,118	7
8	TOTAL General Services	(6,114)		1,115	(46,459)		632	1,037					(49,789)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			3,747	(53,319)								(49,572)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			225	3,736								3,961	15
16	TOTAL Health Care and Programs			3,972	(49,583)								(45,611)	16
	C. General Administration													
17	Administrative			(178,344)		1,722							(176,622)	17
18	Directors Fees													18
19	Professional Services	(4,674)		(59,580)	818	(49,074)	771	52		(3,540)			(115,227)	19
20	Fees, Subscriptions & Promotions	(41,622)		4,598	1,322	282		95					(35,325)	20
21	Clerical & General Office Expenses	(114,500)		26,430	437	69,949	530	677					(16,477)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,431	925	40							2,396	24
25	Other Admin. Staff Transportation			5,165	3,832	1,073							10,070	25
26	Insurance-Prop.Liab.Malpractice			1,849				194					2,043	26
27	Other (specify):*			4,858		8,326							13,184	27
28	TOTAL General Administration	(160,796)		(193,593)	7,334	32,318	1,301	1,019		(3,540)			(315,958)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(166,910)		(188,506)	(88,708)	32,318	1,933	2,056		(3,540)			(411,358)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bloomington# 0053983

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,073)		1,225	188	73	981	3,425					(1,181)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(909)		4,340	15		740	1,069					5,254	32
33	Real Estate Taxes						1,144	1,286					2,430	33
34	Rent-Facility & Grounds			534			(7,264)	(23,000)					(29,730)	34
35	Rent-Equipment & Vehicles			83	363	325	346	381					1,498	35
36	Other (specify):*	208											208	36
37	TOTAL Ownership	(7,774)		6,182	566	398	(4,054)	(16,839)					(21,521)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(19,989)				(19,989)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(27,007)											(27,007)	43
44	TOTAL Special Cost Centers	(27,007)							(19,989)				(46,996)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(201,691)		(182,324)	(88,143)	32,716	(2,121)	(14,784)	(19,989)	(3,540)			(479,875)	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 Sup.		See page 6 Sup.		See page 6 Sup.		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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%	\$ 206	\$ 206
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	38	38
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	833	833
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	38	38
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	3,747	3,747
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	225	225
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	51,089	51,089
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,052	2,052
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,598	4,598
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	26,430	26,430
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,431	1,431
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,165	5,165
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,849	1,849
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,858	4,858
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	1,225	1,225
30	V	32 INTEREST		APERION CARE, INC.	100.00%	4,340	4,340
31	V	34 RENT		APERION CARE, INC.	100.00%	534	534
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	83	83
33	V			APERION CARE, INC.	100.00%		
34	V			APERION CARE, INC.	100.00%		
35	V	17 MANAGEMENT FEE	229,434	APERION CARE, INC.	100.00%		(229,434)
36	V	19 HOME OFFICE	61,632	APERION CARE, INC.	100.00%		(61,632)
37	V			APERION CARE, INC.			
38	V						
39	Total		\$ 291,066			\$ 108,741	\$ * (182,324)

* 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		APERION CONSULTING, LLC	100.00%	\$ 9,020	\$ 9,020	15
16	V	6		APERION CONSULTING, LLC	100.00%	5,251	5,251	16
17	V	7		APERION CONSULTING, LLC	100.00%	1,900	1,900	17
18	V	10		APERION CONSULTING, LLC	100.00%	27,981	27,981	18
19	V	15		APERION CONSULTING, LLC	100.00%	3,736	3,736	19
20	V	19		APERION CONSULTING, LLC	100.00%	818	818	20
21	V	20		APERION CONSULTING, LLC	100.00%	1,322	1,322	21
22	V	21		APERION CONSULTING, LLC	100.00%	437	437	22
23	V	24		APERION CONSULTING, LLC	100.00%	925	925	23
24	V	25		APERION CONSULTING, LLC	100.00%	3,832	3,832	24
25	V	30		APERION CONSULTING, LLC	100.00%	188	188	25
26	V	32		APERION CONSULTING, LLC	100.00%	15	15	26
27	V	35		APERION CONSULTING, LLC	100.00%	363	363	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	81,300	APERION CONSULTING, LLC	100.00%		(81,300)	34
35	V	01	28,080	APERION CONSULTING, LLC	100.00%		(28,080)	35
36	V	01	4,000	APERION CONSULTING, LLC	100.00%		(4,000)	36
37	V	06		APERION CONSULTING, LLC	100.00%			37
38	V	06	30,550	APERION CONSULTING, LLC	100.00%		(30,550)	38
39	Total		\$ 143,930			\$ 55,787	\$ * (88,143)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE	\$	APERION FINANCIAL, LLC	100.00%	\$ 1,722	\$	1,722	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,352		1,352	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	282		282	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	69,949		69,949	18
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	40		40	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,073		1,073	20
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,326		8,326	21
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	73		73	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	325		325	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	50,426	APERION FINANCIAL, LLC	100.00%			(50,426)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 50,426			\$ 83,143	\$ *	32,716	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%	\$ 226	\$	226	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		406		406	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		771		771	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		530		530	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		981		981	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		740		740	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		270		270	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		346		346	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,144		1,144	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	534					(534)	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		\$ 7,534			\$ 5,413	\$ *	(2,121)	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%	\$ 429	\$	429	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		428		428	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		180		180	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		52		52	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		95		95	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		677		677	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		194		194	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		3,425		3,425	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		1,069		1,069	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,286		1,286	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		381		381	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			\$ 8,216	\$ *	(14,784)	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	\$ 267,588	Renewal Rehab	100.00%	\$ 247,599	\$ (19,989)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 267,588			\$ 247,599	\$ * (19,989)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 14,752	Propay HR LLC	24.00%	\$ 11,212	\$ (3,540)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 14,752			\$ 11,212	\$ * (3,540)

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	Yosef Meystel Trust	21.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Delta Trust	21.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	David Berkowitz Trust	21.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Yosef Meystel Delta Trust	21.50%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Fred Frankel	3.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Steve Turofsky	3.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Jeremy Boshes	3.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Michelle Koder	3.00%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	Naftali Wilhelm	2.00%	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				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 St. Elmo	St. Elmo				26
27			Aperion Care Tolleston Park	Gary, IN				27
28			Aperion Care Toluca	Toluca				28
29			Aperion Care Valparaiso	Valparaiso, IN				29
30			Aperion Care Wilmington	Wilmington				30

Facility Name & ID Number

Aperion Care Bloomington

0053983

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		See Attached	1.2	3.00%	Allocated Salary	\$ 5,941	17-7	1	
2	Jay Meystel	Relative	Administrative		See Attached	0.6	1.50%	Allocated Salary	917	17-7	2	
3	Joel Meystel	Relative	Administrative		See Attached	0.6	3.00%	Allocated Salary	2,192	21-7	3	
4	Cynthia Meystel	Relative	Clerical		See Attached	0.1	3.03%	Allocated Salary	896	21-7	4	
5	Meir Meystel	Relative	Clerical		See Attached	0.2	2.90%	Allocated Salary	781	21-7	5	
6	David Berkowitz	Relative	Administrative		See Attached	1.2	3.00%	Allocated Salary	5,941	17-7	6	
7	Fred Frankel	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Allocated Salary	5,480	17-7	7	
8	Steve Turofsky	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Allocated Salary	5,697	17-7	8	
9	Nosson Factor	Relative	Clerical		See Attached	1	3.04%	Allocated Salary	2,521	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	\$ 30,366		13	

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

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

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Bloomington

0053983

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

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

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$ 31,293	\$ 206	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	31,293	38	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	31,293	833
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	31,293	38	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	31,293	3,747
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	31,293	225	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	31,293	51,089
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	31,293	2,052	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	31,293	4,598	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	31,293	26,430
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	31,293	1,431	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	31,293	5,165	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	31,293	1,849	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	31,293	4,858	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	31,293	1,225	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	31,293	4,340	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	31,293	534	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	31,293	83	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 108,741	25

Facility Name & ID Number Aperion Care Bloomington

0053983

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

Name of Related Organization APERION CONSULTING, LLC
 Street Address 4655 W CHASE AVE
 City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712
 Phone Number (847) 262-3800
 Fax Number (

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 31,293	\$ 9,020	1	
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	31,293	5,251	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982	31,293	1,900	3	
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	31,293	27,981	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781	31,293	3,736	5	
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541	31,293	818	6	
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521	31,293	1,322	7	
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707	31,293	437	8	
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152	31,293	925	9	
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014	31,293	3,832	10	
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318	31,293	188	11	
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508	31,293	15	12	
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204	31,293	363	13	
14									14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,878,156	\$ 1,421,169	\$ 55,787	25	

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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 (

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 31,293	\$ 1,722	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	31,293	1,352	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	31,293	282	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	69,949	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	31,293	40	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	31,293	1,073	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	31,293	8,326	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	31,293	73	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	31,293	325	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	\$ 83,143	25

Facility Name & ID Number Aperion Care Bloomington

0053983

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 8131 N. MONTICELLO, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 262-3800
 Fax Number (

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 7,614	\$ 31,293	\$ 226	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	31,293	406	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	31,293	771	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	31,293	530	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	31,293	981	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	31,293	740	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	31,293	270	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	31,293	346	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	31,293	1,144	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 182,245	\$	\$ 5,413	25

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CHASE OFFICE, LLC
 Street Address 4655 W. CHASE AVE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 262-3800
 Fax Number (

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$ 31,293	\$ 429	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412	31,293	428	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076	31,293	180	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748	31,293	52	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201	31,293	95	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798	31,293	677	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544	31,293	194	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317	31,293	3,425	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973	31,293	1,069	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299	31,293	1,286	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821	31,293	381	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 276,616	\$	\$ 8,216	25

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Renewal Rehab
 Street Address 4655 W Chase Ave
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847-262-3800
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct Allocation		\$	\$		\$ 247,599	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				\$	\$		\$ 247,599	25

Facility Name & ID Number Aperion Care Bloomington

0053983

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 Propay HR LLC
 Street Address 2201 W Main
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847-905-3268
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll services	Direct Allocation		\$	\$		\$ 11,212	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				\$	\$		\$ 11,212	25

Facility Name & ID Number Aperion Care Bloomington

0053983 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Facility Name & ID Number

Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5				-																
Working Capital																				
6	Retirement Home TV Corp		X	Capitalized lease				11,995												
7	The Private Bank		X	Line of Credit				957,908		31,330										
8				-																
9	TOTAL Facility Related							969,903		31,330										
B. Non-Facility Related*																				
10	Interest Income		X							(909)										
11	Interest Ins. Policies		X							2,027										
12																				
13	See Supplemental Schedule				-					6,164										
14	TOTAL Non-Facility Related									7,282										
15	TOTALS (line 9+line14)							969,903		38,612										

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.)

Facility Name & ID Number

Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending:

12/31/16

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																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15	Aperion Care	X					\$	\$			\$	4,340	15							
16	Aperion Consulting	X										15	16							
17	8131 Monticello	X										740	17							
18	Chase Office	X										1,069	18							
19													19							
20	TOTAL Non-Facility Related																			

* 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.		\$	<u>28,468</u>	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.)		\$	<u>26,992</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,476)</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>24,562</u>	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.		\$	<u>23,086</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u> </u>	8
	2012	<u> </u>	9
	2013	<u> </u>	10
	2014	<u> </u>	11
	2015	<u> 24,562</u>	12

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

2016 accrual =2015 tax \$24,562

Allocated from 8131 Monticello:1144

Allocated from Chase Office:1286

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 & ID Number Aperion Care Bloomington

0053983 Report Period Beginning:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number 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).

N/A

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	<u>Allocated from Chase Office, LLC</u>			<u>\$ 1,844</u>	1
2					2
3	TOTALS			\$ 1,844	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			101,971	3,079	2,614	(465)	8,609	68
69				10,209		(10,209)		69
70		\$	101,971	\$ 13,288	\$ 2,614	\$ (10,674)	\$ 8,609	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 101,971	\$ 13,288		\$ 2,614	\$ (10,674)	\$ 8,609	1
2	Satellite	2015	16,989		20	849	849	920	2
3	Cameras, Cables, Monitors, Etc.	2016	10,318		20	516	516	516	3
4	Cable For Data	2016	6,506		20	325	325	325	4
5	Remove Old Flooring And Reset Framework	2016	2,540		20	64	64	64	5
6	New Doors	2016	5,030		20	105	105	105	6
7	Kitchen Door	2016	2,786		20	58	58	58	7
8	Parking Lot Done (56,000)	2016	44,486		20	700	700	700	8
9	Water Main Work, Replaced Main Gate Valve	2016	6,004		20	300	300	200	9
10	Heating/Cooling Thermostat Installation	2016	4,771		20	239	239	239	10
11	Roof Exhauster Installation	2016	3,330		20	167	167	167	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)		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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)	\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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)	\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	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)	\$ 204,731	\$ 13,288		\$ 5,936	\$ (7,352)	\$ 11,903	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Chase Office, LLC	2016	16,599	177	20	177		177	3
4	Allocated from 8131 N. Monticello	2010		353	20	307	(46)	3,182	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	885	142	20	44	(98)	310	9
10	Allocated from Aperion Care	2012	251	19	20	13	(6)	63	10
11	Allocated from Aperion Care	2013	107	12	20	5	(7)	21	11
12									12
13	Allocated from Chase Office, LLC	2016	84,129	1,753	20	1,753		1,753	13
14									14
15	Allocated from 8131 N Monticello	2010		623	20	268	(355)	2,816	15
16	Allocated from 8131 N Monticello	2013			20	47	47	287	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)		\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	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)	\$ 101,971	\$ 3,079		\$ 2,614	\$ (465)	\$ 8,609	34

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

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	\$ 3,320	\$ 606	\$ 392	\$ (214)	10	\$ 965	71
72	Current Year Purchases	47,912	1,871	2,363	492	10	2,363	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 51,232	\$ 2,477	\$ 2,755	\$ 278		\$ 3,328	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 Care	2016	\$ 993	\$ 202	\$ 199	\$ (3)	5	\$ 446	76
77		Allocated from Aperion consultin	2016	689	134	138	4	5	275	77
78										78
79										79
80	TOTALS			\$ 1,682	\$ 336	\$ 337	\$ 1		\$ 721	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	\$ 259,489	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,101	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,028	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,073)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 15,952	85

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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Architects project 15074	\$ 197,919	92
93	Project 155 roof replacement	260,950	93
94			94
95		\$ 458,869	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: Segula Properties, LLC

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:		<u>117</u>		<u>603,716</u>			<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6	<u>Allocated from Aperion</u>				<u>270</u>			<u>6</u>
7	TOTAL		117		\$ 603,986			7

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 \$ _____

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: \$ 13,383 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	<u>Facility</u>	<u>GM</u>	<u>\$ 1,039</u>	<u>\$ 12,470</u>	<u>17</u>
18	<u>Allocated from Aperion Consulting</u>			<u>363</u>	<u>18</u>
19					<u>19</u>
20					<u>20</u>
21	TOTAL		\$ 1,039	\$ 12,833	21

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs				\$	128,728	\$			\$	128,728		1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					9,739					9,739		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs					129,124					129,124		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							91,093			91,093		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): _____														12	
13	Other (specify): <u>See Supplemental</u>							2,110		17,638			19,748		13	
14	TOTAL				\$			\$ 269,701	\$	108,731	\$		\$ 378,432		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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,790,537		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,464		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	189,620		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,090,621	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	100,855		15
16	Equipment, at Historical Cost	23,115		16
17	Accumulated Depreciation (book methods)	(10,492)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	463,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 576,783	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,667,404	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 777,019	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	969,903		29
30	Accrued Salaries Payable	115,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,890		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,562		32
33	Accrued Interest Payable	3,349		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	37,402		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,932,993	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,150,046		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,150,046	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,083,039	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (415,635)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,667,404	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (42,266)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (42,266)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,369)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (373,369)	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)	\$ (415,635)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Bloomington# 0053983Report Period Beginning: 01/01/16Ending: 12/31/16**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,259,765	1
2	Discounts and Allowances for all Levels	(1,193,684)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,066,081	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,973	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 59,973	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	73,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,918	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,765	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 87,318	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	909	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 909	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,214,281	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,018,550	31
32	Health Care	1,906,899	32
33	General Administration	1,288,951	33
B. Capital Expense			
34	Ownership	722,448	34
C. Ancillary Expense			
35	Special Cost Centers	405,439	35
36	Provider Participation Fee	245,363	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,587,650	40
41	Income before Income Taxes (line 30 minus line 40)**	(373,369)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (373,369)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,096,060	44
45	Private Pay - Net Inpatient Revenue	353,050	45
46	Medicare - Net Inpatient Revenue	752,205	46
47	Other-(specify) <u>Insurance, MC, Contract. Adj.</u>	864,766	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,066,081	49

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

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

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

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

Facility Name & ID Number Aperion Care Bloomington

0053983

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	1,712	1,821	\$ 74,149	\$ 40.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,244	8,777	252,469	28.76	3
4	Licensed Practical Nurses	15,901	16,699	421,178	25.22	4
5	CNAs & Orderlies	54,608	58,145	683,776	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,208	2,389	36,854	15.43	8
9	Activity Director	1,956	2,036	26,536	13.03	9
10	Activity Assistants	4,975	5,520	50,882	9.22	10
11	Social Service Workers	4,988	5,340	101,703	19.05	11
12	Dietician					12
13	Food Service Supervisor	2,060	2,107	42,692	20.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,981	16,284	187,449	11.51	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,363	38,714	16.38	17
18	Housekeepers	7,657	8,170	75,565	9.25	18
19	Laundry	2,907	3,255	28,144	8.65	19
20	Administrator	2,011	2,040	90,617	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,294	4,433	57,135	12.89	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	1,986	2,115	31,659	14.97	31
32	Other Health Care(specify)					32
33	Other(specify)	1,248	1,392	16,992	12.21	33
34	TOTAL (lines 1 - 33)	133,738	142,886	\$ 2,216,514 *	\$ 15.51	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	548	\$ 32,080	01-03	35
36	Medical Director	Monthly	17,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	81,300	10-03	38
39	Pharmacist Consultant	Monthly	9,126	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	12	585	11-03	44
45	Social Service Consultant	33	1,788	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	593	\$ 142,779		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Leanne Thomas	Administrator	0	\$ 35,975	Workers' Compensation Insurance	\$ 65,051	IDPH License Fee	\$	
Corrie Magee	Administrator	0	4,531	Unemployment Compensation Insurance	46,027	Advertising: Employee Recruitment	19,154	
Stephanie Williams	Administrator	0	50,111	FICA Taxes	167,613	Health Care Worker Background Check (Indicate # of checks performed <u>125</u>)	1,258	
				Employee Health Insurance	57,697	Patient Background Checks	89	
				Employee Meals		Licenses and Permits	10,515	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,640	
				Other employee benefits	2,303	Allocated from Aperion Care	4,598	
				Employee Physicals	480	Allocated from Aperion Consulting	1,322	
				Employee Meals	444	Allocated fro Aperion Financial	377	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,617	TOTAL (agree to Schedule V, line 22, col.8)		\$ 45,757		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Aperion Care Inc.			\$ 229,434				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 229,434	TOTAL				
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
See Attached	Legal fees		694					
Personnel Planners	Unemployment Consulting		1,426					
Aperion Consulting	Compliance consulting		10,032					
Coal Fire	Security Assessment		769					
Healthcare Construction Solutions	Construction Consulting		2,396					
Alt & Witzig Engineering	Enginerring consulting		2,350					
Propay HR	Payroll Processing		14,752				Seminar Expense	
Marum LLP	Accounting fees		2,325				13,009	
Aperion Care	Home Office Exp		61,632				Allocated from Aperion Care	
Aperion Financial	Home Office Exp		50,426				1,431	
See Supplemental Schedule			69,372				Allocated from Aperion Consulting	
							925	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 216,174				Allocated from Aperion Financial	
							40	
							Entertainment Expense	
							()	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	
							\$ 15,405	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Bloomington# 0053983Report Period Beginning: 01/01/16Ending: 12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC 2,500
- (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? _____
- (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 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,596 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. \$ 245,363
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 benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees