



Facility Name & ID Number Aperion Care East Moline

# 0052324 Report Period Beginning: 01/01/16 Ending: 12/31/16

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,352	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	120		7,644	7,764	8
9	SNF/PED					9
10	ICF	18,864	3,070	3,583	25,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,984	3,070	11,227	33,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.78%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 05/01/13

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/13 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 72 and days of care provided 2,807

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

Facility Name & ID Number Aperion Care East Moline # 0052324 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
	<b>A. General Services</b>										
1	Dietary	161,571	18,279	8,511	188,361		188,361	9,593	197,954		1
2	Food Purchase		200,158		200,158		200,158	34	200,192		2
3	Housekeeping	122,426	27,131		149,557		149,557		149,557		3
4	Laundry	35,075	19,046		54,121		54,121		54,121		4
5	Heat and Other Utilities			118,725	118,725		118,725	(5,836)	112,889		5
6	Maintenance	72,834	13,716	62,059	148,609		148,609	4,747	153,356		6
7	Other (specify):*							2,253	2,253		7
8	<b>TOTAL General Services</b>	391,906	278,330	189,295	859,531		859,531	10,792	870,323		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,501,347	126,273	94,289	1,721,909		1,721,909	(38,357)	1,683,552		10
10a	Therapy	43,831	4,695		48,526		48,526		48,526		10a
11	Activities	65,247	1,271		66,518		66,518		66,518		11
12	Social Services	153,129		2,503	155,632		155,632		155,632		12
13	CNA Training										13
14	Program Transportation			427	427		427		427		14
15	Other (specify):*							4,212	4,212		15
16	<b>TOTAL Health Care and Programs</b>	1,763,554	132,239	115,219	2,011,012		2,011,012	(34,144)	1,976,868		16
	<b>C. General Administration</b>										
17	Administrative	84,445		268,955	353,400		353,400	(212,789)	140,611		17
18	Directors Fees										18
19	Professional Services			308,121	308,121	(7,320)	300,801	(186,441)	114,360		19
20	Dues, Fees, Subscriptions & Promotions			107,696	107,696		107,696	(70,576)	37,120		20
21	Clerical & General Office Expenses	94,754		386,937	481,691		481,691	(227,236)	254,455		21
22	Employee Benefits & Payroll Taxes			397,209	397,209		397,209		397,209		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,147	6,147		6,147	2,310	8,457		24
25	Other Admin. Staff Transportation			15,514	15,514		15,514	10,710	26,224		25
26	Insurance-Prop.Liab.Malpractice			119,967	119,967		119,967	2,173	122,140		26
27	Other (specify):*							14,021	14,021		27
28	<b>TOTAL General Administration</b>	179,199		1,610,546	1,789,745	(7,320)	1,782,425	(667,829)	1,114,596		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,334,659	410,569	1,915,060	4,660,288	(7,320)	4,652,968	(691,182)	3,961,786		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			114,315	114,315		114,315	65,077	179,392		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			40,825	40,825		40,825	167,581	208,406		32
33	Real Estate Taxes			38,608	38,608	7,320	45,928	2,584	48,512		33
34	Rent-Facility & Grounds			344,635	344,635		344,635	(344,347)	288		34
35	Rent-Equipment & Vehicles			16,847	16,847		16,847	1,593	18,440		35
36	Other (specify):*			6,478	6,478		6,478	(6,478)	0		36
37	<b>TOTAL Ownership</b>			561,708	561,708	7,320	569,028	(113,990)	455,038		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		106,776	448,570	555,346		555,346	(33,538)	521,808		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			253,788	253,788		253,788		253,788		42
43	Other (specify):*			23,470	23,470		23,470	(23,470)			43
44	<b>TOTAL Special Cost Centers</b>		106,776	725,828	832,604		832,604	(57,008)	775,596		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,334,659	517,345	3,202,596	6,054,600		6,054,600	(862,180)	5,192,420		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 East Moline**

# **0052324**

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,572)	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	(54,913)	30		9
10	Interest and Other Investment Income	(536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(185)	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	(828)	21		18
19	Entertainment	(2,911)	21		19
20	Contributions	(72,847)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(317,970)	21		24
25	Fund Raising, Advertising and Promotional	(23,470)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(107,025)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (587,257)		\$	30

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(274,923)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (274,923)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (862,180)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Aperion Care East Moline

ID# 0052324

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Bank Charges	\$ (9,651)	21	1
2	Theft & Damage Loss	(126)	21	2
3	Amortization	(6,478)	36	3
4	Building Company - Accounting Fees	(9,575)	19	4
5	Building Company - Amortization	(65,017)	36	5
6	Building Company - Bank Charges	(6,424)	21	6
7	Building Company - Professional Fees	(2,650)	19	7
8	Building Company - State Replacement Tax	(801)	21	8
9	Additional R&M	6,794	06	9
10	PAC Dues	(4,426)	20	10
11	Non-allowable Seminar Expense	(239)	24	11
12	Non-allowable Legal Expense	(1,358)	19	12
13	Collections	(420)	19	13
14	Capitalized R&M	(6,654)	06	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(107,025)		49

Aperion Care East Moline

ID# 0052324

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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care East Moline# 0052324

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				9,593								9,593	1
2	Food Purchase	(185)		219									34	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,572)		40			241	456					(5,836)	5
6	Maintenance	140		886	2,834		432	455					4,747	6
7	Other (specify):*			40	2,021			192					2,253	7
8	<b>TOTAL General Services</b>	<b>(6,617)</b>		<b>1,185</b>	<b>14,448</b>		<b>673</b>	<b>1,103</b>					<b>10,792</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			3,985	(42,342)								(38,357)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			239	3,973								4,212	15
16	<b>TOTAL Health Care and Programs</b>			<b>4,224</b>	<b>(38,368)</b>								<b>(34,144)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(214,620)		1,832							(212,789)	17
18	Directors Fees													18
19	Professional Services	(14,003)	12,225	(99,734)	870	(82,209)	820	55		(4,466)			(186,441)	19
20	Fees, Subscriptions & Promotions	(77,273)		4,890	1,406	300		101					(70,576)	20
21	Clerical & General Office Expenses	(338,711)	7,225	28,109	465	74,392	563	720					(227,236)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(239)		1,522	984	43							2,310	24
25	Other Admin. Staff Transportation			5,493	4,076	1,141							10,710	25
26	Insurance-Prop.Liab.Malpractice			1,966				207					2,173	26
27	Other (specify):*			5,166		8,855							14,021	27
28	<b>TOTAL General Administration</b>	<b>(430,226)</b>	<b>19,450</b>	<b>(267,208)</b>	<b>7,801</b>	<b>4,354</b>	<b>1,383</b>	<b>1,083</b>		<b>(4,466)</b>			<b>(667,829)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(436,843)</b>	<b>19,450</b>	<b>(261,799)</b>	<b>(16,120)</b>	<b>4,354</b>	<b>2,056</b>	<b>2,186</b>		<b>(4,466)</b>			<b>(691,182)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care East Moline # 0052324 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(54,913)	113,723	1,303	200	78	1,043	3,643					65,077	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(536)	161,563	4,615	16		787	1,136					167,581	32
33	Real Estate Taxes						1,216	1,368					2,584	33
34	Rent-Facility & Grounds		(314,635)	567			(7,280)	(23,000)					(344,347)	34
35	Rent-Equipment & Vehicles			88	386	346	368	405					1,593	35
36	Other (specify):*	(71,495)	65,017										(6,478)	36
37	<b>TOTAL Ownership</b>	<b>(126,944)</b>	<b>25,668</b>	<b>6,574</b>	<b>602</b>	<b>424</b>	<b>(3,866)</b>	<b>(16,448)</b>					<b>(113,990)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(33,538)				(33,538)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(23,470)											(23,470)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(23,470)</b>							<b>(33,538)</b>				<b>(57,008)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(587,257)</b>	<b>45,118</b>	<b>(255,225)</b>	<b>(15,518)</b>	<b>4,778</b>	<b>(1,810)</b>	<b>(14,262)</b>	<b>(33,538)</b>	<b>(4,466)</b>			<b>(862,180)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 314,635	430 South 30th Avenue	100.00%	\$	(314,635)	1
2	V	19 Accounting Fees		430 South 30th Avenue	100.00%	9,575	9,575	2
3	V	36 Amortization		430 South 30th Avenue	100.00%	65,017	65,017	3
4	V	21 Bank Charges		430 South 30th Avenue	100.00%	6,424	6,424	4
5	V	30 Depreciation Expense		430 South 30th Avenue	100.00%	113,723	113,723	5
6	V	32 Interest Expense	6	430 South 30th Avenue	100.00%	161,569	161,563	6
7	V	19 Professional Fees		430 South 30th Avenue	100.00%	2,650	2,650	7
8	V	21 State Replacement Tax		430 South 30th Avenue	100.00%	801	801	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 314,641			\$ 359,759	\$ * 45,118	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%	\$ 219	\$ 219
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	40	40
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	886	886
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	40	40
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	3,985	3,985
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	239	239
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	54,335	54,335
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,183	2,183
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,890	4,890
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	28,109	28,109
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,522	1,522
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	5,493	5,493
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,966	1,966
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	5,166	5,166
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	1,303	1,303
30	V	32 INTEREST		APERION CARE, INC.	100.00%	4,615	4,615
31	V	34 RENT		APERION CARE, INC.	100.00%	567	567
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	88	88
33	V			APERION CARE, INC.	100.00%		
34	V			APERION CARE, INC.	100.00%		
35	V	17 MANAGEMENT FEE	268,955	APERION CARE, INC.	100.00%		(268,955)
36	V	19 HOME OFFICE	101,917	APERION CARE, INC.	100.00%		(101,917)
37	V			APERION CARE, INC.			
38	V						
39	Total		\$ 370,872			\$ 115,647	\$ * (255,225)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 9,593	\$ 9,593
16	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5,584	5,584
17	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	2,021	2,021
18	V	10 SALARY NURSE		APERION CONSULTING, LLC	100.00%	29,758	29,758
19	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,973	3,973
20	V	19 PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	870	870
21	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,406	1,406
22	V	21 CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	465	465
23	V	24 SEMINARS		APERION CONSULTING, LLC	100.00%	984	984
24	V	25 AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	4,076	4,076
25	V	30 DEPRECIATION		APERION CONSULTING, LLC	100.00%	200	200
26	V	32 INTEREST		APERION CONSULTING, LLC	100.00%	16	16
27	V	35 AUTO LEASE		APERION CONSULTING, LLC	100.00%	386	386
28	V			APERION CONSULTING, LLC	100.00%		
29	V			APERION CONSULTING, LLC	100.00%		
30	V			APERION CONSULTING, LLC	100.00%		
31	V			APERION CONSULTING, LLC	100.00%		
32	V			APERION CONSULTING, LLC	100.00%		
33	V			APERION CONSULTING, LLC	100.00%		
34	V	10 CONSULTING	72,100	APERION CONSULTING, LLC	100.00%		(72,100)
35	V	01 DIETICIAN		APERION CONSULTING, LLC	100.00%		
36	V	02 FOOD SERVICE		APERION CONSULTING, LLC	100.00%		
37	V	06 PAINTER		APERION CONSULTING, LLC	100.00%		
38	V	06 PROJECT MANAGER	2,750	APERION CONSULTING, LLC	100.00%		(2,750)
39	Total		\$ 74,850			\$ 59,332	\$ * (15,518)

\* 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%	\$ 1,832	\$	1,832	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,438		1,438	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	300		300	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	74,392		74,392	18
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	43		43	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	1,141		1,141	20
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	8,855		8,855	21
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	78		78	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	346		346	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	83,647	APERION FINANCIAL, LLC	100.00%			(83,647)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 83,647			\$ 88,425	\$ *	4,778	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%	\$ 241	\$	241	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		432		432	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		820		820	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		563		563	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,043		1,043	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		787		787	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		287		287	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		368		368	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,216		1,216	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	567	8131 N. MONTICELLO, LLC				(567)	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		\$ 7,567			\$ 5,757	\$ *	(1,810)	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%	\$ 456	\$	456	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		455		455	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		192		192	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		55		55	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		101		101	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		720		720	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		207		207	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		3,643		3,643	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		1,136		1,136	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,368		1,368	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		405		405	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			\$ 8,738	\$ *	(14,262)	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	\$ 448,967	Renewal Rehab	100.00%	\$ 415,429	\$ (33,538)
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		\$ 448,967			\$ 415,429	\$ * (33,538)

\* 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	\$ 18,600	ProPay HR	24.00%	\$ 14,134	\$ (4,466)
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		\$ 18,600			\$ 14,134	\$ * (4,466)

\* 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	<b>Total</b>		\$			\$	\$ *	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: 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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending: 12/31/16

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DAVID A. BERKOWITZ REVOCABLE TRUST	33.33%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	DECLARATION OF TRUST OF YOSEF MEYSEL	33.34%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	MICHAEL ROSEN	33.33%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4			Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5			Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6			Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7			Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8			Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9			Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Oak Lawn	Oak Lawn	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Peru	Peru, IN	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Plum Grove	Palatine	430 SOUTH 30TH AVE	EAST MOLINE	BUILDING COMPANY	22
23			Aperion Care Spring Valley	Spring Valley				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

Facility Name & ID Number

Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Baypointe Rehab Center	Brockton, MA				1
2			Eastpointe Rehab Center	Chelsea, MA				2
3			Southpointe Rehab Center	Falls River, MA				3
4			The Arbors at Michigan City	Michigan City, IN				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending:

12/31/16

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0%	See Attached	1.3	3.25%	Alloc. Salary	\$ 6,318	17-07	1	
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.6	1.50%	Alloc. Salary	975	17-07	2	
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.6	3.00%	Alloc. Salary	2,331	21-07	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc. Salary	953	21-07	4	
5	Meir Meystel	Relative	Clerical	0%	See Attached	0.2	2.90%	Alloc. Salary	831	21-07	5	
6	Nosson Factor	Relative	Clerical	0%	See Attached	1	3.04%	Alloc. Salary	2,681	21-07	6	
7	David Berkowitz	Relative	Administrative	0%	See Attached	1.3	3.25%	Alloc. Salary	6,318	17-07	7	
8	Michael Rosen	Shareholder	Administrative	33.33%	See Attached	1.3	3.25%	Alloc. Salary	6,318	17-07	8	
9											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	\$ 26,725		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 East Moline

# 0052324

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization APERION CARE, INC.  
 Street Address 4655 W CHASE AVENUE  
 City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712  
 Phone Number ( 847) 262-8300  
 Fax Number (

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	\$ 33,281	\$ 219	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	33,281	40	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	33,281	886
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	33,281	40	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	33,281	3,985
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	33,281	239	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	33,281	54,335
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	33,281	2,183	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	33,281	4,890	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	33,281	28,109
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	33,281	1,522	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	33,281	5,493	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	33,281	1,966	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	33,281	5,166	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	33,281	1,303	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	33,281	4,615	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	33,281	567	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	33,281	88	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 115,647	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V 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	\$ 303,659	33,281	\$ 9,593	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	33,281	5,584	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		33,281	2,021	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	33,281	29,758	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		33,281	3,973	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		33,281	870	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		33,281	1,406	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		33,281	465	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		33,281	984	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		33,281	4,076	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		33,281	200	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		33,281	16	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		33,281	386	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		\$ 59,332	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	\$ 33,281	\$ 1,832	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	33,281	1,438	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	33,281	300	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	74,392	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	33,281	43	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	33,281	1,141	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	33,281	8,855	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	33,281	78	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	33,281	346	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	\$ 88,425	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

(

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	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 7,614	\$ 33,281	\$ 241	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	33,281	432	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	33,281	820	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	33,281	563	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	33,281	1,043	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	33,281	787	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	33,281	287	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	33,281	368	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	33,281	1,216	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	\$	\$ 5,757	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

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 CHASE OFFICE, LLC  
 Street Address 4655 W. CHASE AVE  
 City / State / Zip Code LINCOLNWOOD, IL 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	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$ 33,281	\$ 456	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412	33,281	455	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076	33,281	192	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748	33,281	55	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201	33,281	101	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798	33,281	720	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544	33,281	207	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317	33,281	3,643	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973	33,281	1,136	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299	33,281	1,368	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821	33,281	405	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	\$	\$ 8,738	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

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		\$	\$		\$ 415,429	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				\$	\$		\$ 415,429	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

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. Maint Street  
 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		\$	\$		\$ 14,134	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				\$	\$		\$ 14,134	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care East Moline

# 0052324

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Aperion Care East Moline

# 0052324

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First Midwest Bank		X	Mortgage			\$	\$ 7,058,804			\$	161,569						
2																		
3																		
4																		
5					-													
<b>Working Capital</b>																		
6	First Midwest Bank		X	Line of Credit				1,206,836				38,042						
7	GMC		X	Note Payable - Auto				7,972										
8					-													
9	<b>TOTAL Facility Related</b>						\$	\$ 8,273,612			\$	199,611						
<b>B. Non-Facility Related*</b>																		
10	Interest - Insurance Policies		X									2,783						
11	Interest Income		X									(536)						
12	Bldg. Co. - Interest Income		X									(6)						
13	See Supplemental Schedule				-							6,554						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	8,795						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 8,273,612			\$	208,406						

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 East Moline

# 0052324

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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8						\$	\$			\$	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15	Allocated - Aperion Care, Inc	X				\$	\$			\$	4,615	15						
16	Allocated - Aperion Consulting	X									16	16						
17	Allocated - 8131 N Monticello	X									787	17						
18	Allocated - Chase Office, LLC	X									1,136	18						
19												19						
20	<b>TOTAL Non-Facility Related</b>										6,554	20						

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Aperion Care East Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0052324

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

**A. Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-02-20-40-22</u>	<u>Nursing Home</u>	\$ <u>62,426.40</u>	\$ <u>62,426.40</u>
2. <u>10-23-325-045-0000</u>	<u>Allocated - 8131 N Monticello</u>	\$ <u>65,893.19</u>	\$ <u>1,061.19</u>
3. <u>10-27-307-027-0000</u>	<u>Allocated - Chase Office, LLC</u>	\$ <u>40,836.48</u>	\$ <u>539.28</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>169,156.07</u></u>	\$ <u><u>64,026.87</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

**IMPORTANT NOTICE**

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

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

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

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

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Aperion Care East Moline COUNTY Rock Island  
 FACILITY IDPH LICENSE NUMBER 0052324  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

**A. Summary of Real Estate Tax Cost**

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Aperion Care East Moline

# 0052324

Report Period Beginning:

01/01/16

Ending:

12/31/16

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 27,040 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2015</u>	<u>\$ 373,200</u>	<u>1</u>
2	<u>Allocated - Chase Office, LLC</u>			<u>1,962</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 375,162</b>	<b>3</b>

**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	120		2015	1971	\$ 3,358,800	\$ 86,123	35	\$ 95,966	\$ 9,843	\$ 232,014	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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				
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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								68				
69								69				
70								70				
67	Related Building Company (Pages 12F & 12G)							67				
68	Related Party Allocations (Pages 12H & 12I)		108,450	3,276		2,781	(495)	9,156				
69	Financial Statement Depreciation			114,315			(114,315)					
70	TOTAL (lines 4 thru 69)	\$	3,467,250	\$	203,714	\$	98,747	\$	(104,967)	\$	241,170	

\*\*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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,467,250	\$ 203,714		\$ 98,747	\$ (104,967)	\$ 241,170	1
2	Roof	2013	52,500		20	2,625	2,625	9,625	2
3	Gutters	2013	7,990		20	400	400	1,465	3
4	Plumbing - New Roof Drains & Sheeting	2013	3,051		20	204	204	712	4
5	Water Heater	2013	3,560		20	178	178	608	5
6	Landscaping	2013	10,980		20	732	732	2,623	6
7	Sidewalk	2013	8,900		20	593	593	1,928	7
8	New Roof	2013	7,942		20	397	397	1,291	8
9	C-Wing Corridor Flooring & 2 New Closets	2013	5,284		20	264	264	815	9
10	Admissions Office Carpet, Admissions & Guest Bathrooms Toilets	2013	284,923		20	14,246	14,246	43,926	10
11	C-Wing Corridor Remove Sprinklers; Lobby Circuits; Corridor C	2014	21,541		20	1,077	1,077	3,231	11
12	Lobby Drywall, Doors, Light Fixtures; Lounge Light Fixtures; Admi	2014	103,270		20	5,164	5,164	15,491	12
13	Storage Room Drywall	2014	2,860		20	143	143	417	13
14	Therapy Room Bathtub, Plumbing, Wallcovering, Flooring, Light	2014	35,703		20	1,785	1,785	4,314	14
15	Dining Rm Handrail & Bumper Guard, Paint Corridors B-E, Ad	2014	13,278		20	664	664	1,604	15
16	Cables & Wiring For Voice Data	2014	6,625		20	331	331	718	16
17	Awning & Sign	2014	4,720		20	236	236	551	17
18	Therapy Room / Corridor - Cove Base, Vct, Activity Sign	2015	7,494		20	375	375	749	18
19	Installed Full Privacy Fence With Walk Gate	2016	6,654		20	6,654	6,654	333	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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24								24
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,054,525	\$ 203,714		\$ 134,814	\$ (68,900)	\$ 331,570	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 <b>Building Company</b>		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 <b>Leasehold Improvements:</b>							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
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26							
27							
28							
29							
30							
31							
32							
33							
34 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$

\*\*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
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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	<b>Related Party</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated - 8131 N. Monticello	2010		376	39	327	(49)	3,384	3
4	Allocated - Chase Office, LLC	2016	17,654	189	39	189		189	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated - Aperion Care, Inc	2010	941	151	20	47	(104)	329	9
10	Allocated - Aperion Care, Inc	2012	267	21	20	13	(8)	67	10
11	Allocated - Aperion Care, Inc	2013	114	13	20	6	(7)	23	11
12									12
13	Allocated - 8131 N. Monticello	2010		662	20	285	(377)	2,995	13
14	Allocated - 8131 N. Monticello	2013			20	50	50	305	14
15									15
16	Allocated - Chase Office, LLC	2016	89,474	1,864	20	1,864		1,864	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	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		\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 108,450	\$ 3,276		\$ 2,781	\$ (495)	\$ 9,156	34

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

Facility Name & ID Number Aperion Care East Moline

# 0052324

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	\$ 286,003	\$ 28,244	\$ 35,736	\$ 7,492	10	\$ 89,679	71
72	Current Year Purchases	40,221	1,989	1,787	(202)	10	1,787	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 326,224	\$ 30,233	\$ 37,523	\$ 7,290		\$ 91,466	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		2013 GMC SAVANNA	2013	\$ 54,662	\$	\$ 6,696	\$ 6,696	5	\$ 31,228	76
77		Allocated - Aperion Care, Inc	2016	1,057	214	211	(3)	5	474	77
78		Allocated - Aperion Consulting, I	2016	732	142	146	4	5	293	78
79										79
80	TOTALS			\$ 56,451	\$ 356	\$ 7,053	\$ 6,697		\$ 31,995	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)	\$ 4,812,362	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 234,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,390	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (54,913)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 455,031	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		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from 8131 N. Monticello</u>				<u>287</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>287</b>			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: \$ 8,594

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>BMW</u>	\$ <u>830</u>	\$ <u>9,460</u>	17
18	<u>Allocated - Aperion Consulting, LLC</u>			<u>386</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>830</b>	\$ <b>9,846</b>	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 159,805	\$		\$ 159,805	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,024			85,024	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			202,650			202,650	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				91,964		91,964	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>					1,091	14,812		15,903	13
14	TOTAL			\$		\$ 448,570	\$ 106,776		\$ 555,346	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.

Facility Name & ID Number Aperion Care East Moline# 0052324Report Period Beginning: 01/01/16Ending: 12/31/16

## 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 124,753	\$ 390,253	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,218,108	2,218,108	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,242	79,242	6
7	Other Prepaid Expenses	935	935	7
8	Accounts Receivable (owners or related parties)	500,000	500,000	8
9	Other(specify):		147,115	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,923,038	\$ 3,335,653	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		373,200	13
14	Buildings, at Historical Cost		3,358,800	14
15	Leasehold Improvements, at Historical Cost	691,023	691,023	15
16	Equipment, at Historical Cost	114,463	252,463	16
17	Accumulated Depreciation (book methods)	(351,542)	(537,492)	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): <u>See Attached Schedule</u>	2,603,219	2,665,003	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,057,163	\$ 6,802,997	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,980,201	\$ 10,138,650	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 300,493	\$ 300,492	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,214,808	1,214,808	29
30	Accrued Salaries Payable	149,148	149,148	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,877	5,877	31
32	Accrued Real Estate Taxes(Sch.IX-B)		64,915	32
33	Accrued Interest Payable	4,247	18,842	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	49,652	49,652	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,724,225	\$ 1,803,734	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,058,804	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	4,378,979	1,454,174	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,378,979	\$ 8,512,978	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,103,204	\$ 10,316,712	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (123,003)	\$ (178,062)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,980,201	\$ 10,138,650	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>38,019</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	(1)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>38,018</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	137,312	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(298,333)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (161,021)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (123,003)	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,516,458	1
2	Discounts and Allowances for all Levels	444,108	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,960,566	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,886	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 148,886	8
<b>C. Other Operating Revenue</b>			
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	71,356	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,283	19
20	Radiology and X-Ray	1,878	20
21	Other Medical Services	3,407	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 81,924	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	536	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 536	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,191,912	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	859,531	31
32	Health Care	2,011,012	32
33	General Administration	1,789,745	33
<b>B. Capital Expense</b>			
34	Ownership	561,708	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	578,816	35
36	Provider Participation Fee	253,788	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,054,600	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	137,312	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 137,312	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,719,095	44
45	Private Pay - Net Inpatient Revenue	520,310	45
46	Medicare - Net Inpatient Revenue	1,455,609	46
47	Other-(specify) <u>Insurance</u>	1,265,552	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,960,566	49

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

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

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

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

Facility Name & ID Number Aperion Care East Moline

# 0052324

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	1,744	2,091	\$ 67,939	\$ 32.49	1
2	Assistant Director of Nursing	1,977	2,324	65,220	28.06	2
3	Registered Nurses	7,611	7,978	229,177	28.73	3
4	Licensed Practical Nurses	18,384	19,392	448,260	23.12	4
5	CNAs & Orderlies	59,062	61,340	661,523	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,176	2,411	43,831	18.18	8
9	Activity Director	1,683	1,725	24,156	14.00	9
10	Activity Assistants	4,118	4,331	38,142	8.81	10
11	Social Service Workers	7,086	7,833	153,129	19.55	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,174	39,854	18.33	13
14	Head Cook	6,084	6,620	58,863	8.89	14
15	Cook Helpers/Assistants	6,909	7,280	62,854	8.63	15
16	Dishwashers					16
17	Maintenance Workers	4,645	5,004	72,834	14.56	17
18	Housekeepers	13,102	13,897	122,426	8.81	18
19	Laundry	3,400	3,796	35,075	9.24	19
20	Administrator	2,051	2,160	84,445	39.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,864	1,978	37,321	18.87	23
24	Clerical	5,502	5,939	57,433	9.67	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	2,076	2,136	29,228	13.68	31
32	Other Health Care(specify)					32
33	Other(specify)	257	265	2,949	11.13	33
34	TOTAL (lines 1 - 33)	151,715	160,674	\$ 2,334,659 *	\$ 14.53	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	155	\$ 8,511	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	72,200	10-03	38
39	Pharmacist Consultant	Monthly	10,089	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				44
45	Social Service Consultant	39	2,503	12-03	45
46	Other(specify) <u>Psychiatric MD</u>	Monthly	12,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	\$ 123,303		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number **Aperion Care East Moline**

# **0052324**

Report Period Beginning: **01/01/16**

Ending: **12/31/16**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions					
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount					
Tamara Stoneberger (1/1/16 - 3/31/16)	Administrator	0	\$ 22,800	Workers' Compensation Insurance	\$ 142,211	IDPH License Fee	\$ 1,990					
Laurie Paxton (Started 4/5/16)	Administrator	0	61,645	Unemployment Compensation Insurance	69,325	Advertising: Employee Recruitment	1,649					
				FICA Taxes	174,898	Health Care Worker Background Check	9,361					
				Employee Health Insurance	5,845	(Indicate # of checks performed <u>936</u> )						
				Employee Meals		Patient Background Checks						
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,754					
				Employee Physicals	1,520	Licenses and Permits	669					
				Employee Meals	327							
				Employee Benefits - Other	3,083	Allocated - Aperion Care, Inc	4,890					
						See Supplemental Schedule	1,807					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,445	TOTAL (agree to Schedule V, line 22, col.8)			\$ 397,209	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 37,120		
(List each licensed administrator separately.)								Less: Public Relations Expense ( )				
								Non-allowable advertising ( )				
								Yellow page advertising ( )				
<b>B. Administrative - Other</b>												
Description			Amount	Description			Amount					
Aperion Care Inc.			\$ 268,955									
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 268,955	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)				Description			Line #	Amount	Description			Amount
<b>C. Professional Services</b>				Vendor/Payee			Type	Amount	Out-of-State Travel			\$
Aperion Care				Home Office Expense				\$ 101,917	In-State Travel			
Aperion Financial				Home Office Expense				83,647	Seminar Expense			5,908
ProPay HR				Payroll Processing				18,600	Allocated - Aperion Care, Inc			1,522
Galaxy Hosted Software				Clinical Solutions				3,750	Allocated - Aperion Consulting, LLC			984
Creative Technology Solutions				Data Processing				14,549	See Supplemental Schedule			43
Wescom Solutions				E.H.R. Software				16,088	Entertainment Expense ( )			
National Datacare Corp				Financial Software				2,507	(agree to Sch. V, line 24, col. 8)			
Aperion Care				Data Processing				7,911	TOTAL			\$ 8,457
e-Health Data Solutions				MDS Software				4,111				
Marcum				Accounting				20,992				
Legal				See Attached				11,025				
See Supplemental Schedule								23,025				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 308,122	TOTAL			\$					
(For legal fee disclosure, see page 39 of instructions)												

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Aperion Care East Moline# 0052324

Report Period Beginning:

01/01/16

Ending:

12/31/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$13,413
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,197 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 253,788  
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. \$ No 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% In 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees