

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,790	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,220	287	349	22,856	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,220	287	349	22,856	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.07%

D. How many bed-hold days during this year were paid by the Department?

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/2010

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

YES Date 09/01/2010 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Litchfield, Llc # 0051102 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	185,122	14,763	5,156	205,041		205,041	6,588	211,629		1
2	Food Purchase		120,423		120,423		120,423	136	120,559		2
3	Housekeeping	73,346	17,276		90,622		90,622		90,622		3
4	Laundry	31,616	6,855		38,471		38,471		38,471		4
5	Heat and Other Utilities			52,388	52,388		52,388	99	52,487		5
6	Maintenance	34,500	20,919	24,240	79,659		79,659	3,502	83,161		6
7	Other (specify):*							1,548	1,548		7
8	TOTAL General Services	324,584	180,236	81,784	586,604		586,604	11,873	598,477		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	639,876	39,965	31,886	711,727		711,727	1,824	713,551		10
10a	Therapy										10a
11	Activities	64,444	4,157	3,173	71,774		71,774		71,774		11
12	Social Services	89,789		284	90,073		90,073		90,073		12
13	CNA Training										13
14	Program Transportation			152	152		152		152		14
15	Other (specify):*							2,893	2,893		15
16	TOTAL Health Care and Programs	794,109	44,122	41,495	879,726		879,726	4,716	884,442		16
	C. General Administration										
17	Administrative	71,167		85,090	156,257		156,257	(46,517)	109,740		17
18	Directors Fees										18
19	Professional Services			164,684	164,684		164,684	(90,614)	74,070		19
20	Dues, Fees, Subscriptions & Promotions			101,314	101,314		101,314	(76,912)	24,402		20
21	Clerical & General Office Expenses	28,416		84,289	112,705		112,705	27,026	139,731		21
22	Employee Benefits & Payroll Taxes			165,617	165,617		165,617		165,617		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,818	3,818		3,818	1,751	5,569		24
25	Other Admin. Staff Transportation			6,080	6,080		6,080	7,355	13,435		25
26	Insurance-Prop.Liab.Malpractice			27,408	27,408		27,408	14,574	41,982		26
27	Other (specify):*							9,629	9,629		27
28	TOTAL General Administration	99,583		638,300	737,883		737,883	(153,707)	584,176		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,218,276	224,358	761,579	2,204,213		2,204,213	(137,118)	2,067,095		29

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

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

Facility Name & ID Number Aperion Care Litchfield, Llc

#0051102

Report Period Beginning:

01/01/16

Ending:

12/31/16

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			42,420	42,420		42,420	30,679	73,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,188	13,188		13,188	92,647	105,835			32
33	Real Estate Taxes			23,053	23,053		23,053	1,775	24,828			33
34	Rent-Facility & Grounds			190,000	190,000		190,000	(189,803)	197			34
35	Rent-Equipment & Vehicles			5,247	5,247		5,247	1,094	6,341			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			280,386	280,386		280,386	(70,086)	210,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,438		4,438		4,438		4,438			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,961	173,961		173,961		173,961			42
43	Other (specify):*			10,191	10,191		10,191	(10,191)				43
44	TOTAL Special Cost Centers		4,438	184,152	188,590		188,590	(10,191)	178,399			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,218,276	228,796	1,226,117	2,673,189		2,673,189	(217,395)	2,455,794			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 Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(406)	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	14,870	30		9
10	Interest and Other Investment Income	(130)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,337)	21		18
19	Entertainment	(4,306)	21		19
20	Contributions	(77,297)	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	(12,248)	21		24
25	Fund Raising, Advertising and Promotional	(559)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,287)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(234,887)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (317,602)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,207		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 100,207		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (217,395)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Aperion Care Litchfield, Llc

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising / Marketing	\$ (4,231)	43	1
2	Credit Card Processing	(19)	21	2
3	Bank Charges	(5,927)	21	3
4	Legal Settlement	(19,444)	21	4
5	Amortization	(6,478)	36	5
6	Bldg Co. Amortization	(89,833)	36	6
7	Bldg. Co. Bank Charges	(516)	21	7
8	Bldg. Co. Accounting Fees	(11,075)	19	8
9	Bldg. Co. Professional Fees	(1,042)	19	9
10	Additional R & M	2,590	06	10
11	PAC Dues	(3,655)	20	11
12	Bldg Co. - State Replacement Tax	(60)	21	12
13	Non Allowable Legal Fees	(1,749)	19	13
14	Marketing fees	(5,960)	43	14
15	Prepayment penalty	(84,847)	21	15
16	Capitalized R&M	(2,641)	06	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(234,887)		49

Aperion Care Litchfield, Llc

	ID#	<u>0051102</u>
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102

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				6,588								6,588	1
2	Food Purchase	(15)		151									136	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(406)		27			165	313					99	5
6	Maintenance	(51)		609	2,335		297	313					3,502	6
7	Other (specify):*			28	1,388			132					1,548	7
8	TOTAL General Services	(472)		815	10,311		462	757					11,873	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,737	(913)								1,824	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			164	2,729								2,893	15
16	TOTAL Health Care and Programs			2,901	1,815								4,716	16
	C. General Administration													
17	Administrative			(47,775)		1,258							(46,517)	17
18	Directors Fees													18
19	Professional Services	(13,866)	12,117	(47,936)	597	(40,020)	563	38	(2,108)				(90,614)	19
20	Fees, Subscriptions & Promotions	(81,511)		3,358	966	206		69					(76,912)	20
21	Clerical & General Office Expenses	(129,991)	85,423	19,304	319	51,090	387	495					27,026	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,045	676	30							1,751	24
25	Other Admin. Staff Transportation			3,772	2,799	784							7,355	25
26	Insurance-Prop.Liab.Malpractice		13,082	1,350				142					14,574	26
27	Other (specify):*			3,548		6,081							9,629	27
28	TOTAL General Administration	(225,368)	110,622	(63,333)	5,357	19,429	950	744	(2,108)				(153,707)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(225,840)	110,622	(59,617)	17,483	19,429	1,412	1,501	(2,108)				(137,118)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Litchfield, Llc # 0051102 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	14,870	11,506	895	137	53	716	2,502					30,679	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(130)	88,275	3,170	11		540	780					92,647	32
33	Real Estate Taxes						835	939					1,775	33
34	Rent-Facility & Grounds		(160,000)	390			(7,193)	(23,000)					(189,803)	34
35	Rent-Equipment & Vehicles			61	265	238	253	278					1,094	35
36	Other (specify):*	(96,311)	89,833										(6,478)	36
37	TOTAL Ownership	(81,571)	29,614	4,515	413	291	(4,848)	(18,500)					(70,086)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(10,191)											(10,191)	43
44	TOTAL Special Cost Centers	(10,191)											(10,191)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(317,602)	140,236	(55,102)	17,896	19,720	(3,436)	(16,999)	(2,108)				(217,395)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 160,000	1024 East Tyler, LLC	100.00%	\$	(160,000)	1
2	V	32 Interest	23	1024 East Tyler, LLC	100.00%	88,298	88,275	2
3	V	36 Amortization		1024 East Tyler, LLC	100.00%	89,833	89,833	3
4	V	21 Bank Charges		1024 East Tyler, LLC	100.00%	516	516	4
5	V	30 Depreciation		1024 East Tyler, LLC	100.00%	11,506	11,506	5
6	V	19 Accounting Fees		1024 East Tyler, LLC	100.00%	11,075	11,075	6
7	V	26 Insurance Expense		1024 East Tyler, LLC	100.00%	13,082	13,082	7
8	V	33 Real Estate Taxes	1,007	1024 East Tyler, LLC	100.00%	24,060	23,053	8
9	V	19 Professional Fees		1024 East Tyler, LLC	100.00%	1,042	1,042	9
10	V	21 State Replacement Tax		1024 East Tyler, LLC	100.00%	60	60	10
11	V	21 Prepayment Penalty		1024 East Tyler, LLC	100.00%	84,847	84,847	11
12	V	33 Rent Income -Real Estate	23,053				(23,053)	12
13	V							13
14	Total		\$ 184,083			\$ 324,319	\$ * 140,236	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 FOOD	\$	APERION CARE, INC.	100.00%	\$ 151	\$	151	15
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	27		27	16
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	609		609	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	28		28	18
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	2,737		2,737	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	164		164	20
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	37,315		37,315	21
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,499		1,499	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,358		3,358	23
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	19,304		19,304	24
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,045		1,045	25
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	3,772		3,772	26
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,350		1,350	27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,548		3,548	28
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	895		895	29
30	V	32 INTEREST		APERION CARE, INC.	100.00%	3,170		3,170	30
31	V	34 RENT		APERION CARE, INC.	100.00%	390		390	31
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	61		61	32
33	V			APERION CARE, INC.	100.00%				33
34	V			APERION CARE, INC.	100.00%				34
35	V	17 MANAGEMENT FEE	85,090	APERION CARE, INC.	100.00%			(85,090)	35
36	V	19 HOME OFFICE	49,435	APERION CARE, INC.	100.00%			(49,435)	36
37	V			APERION CARE, INC.					37
38	V								38
39	Total		\$ 134,525			\$ 79,423	\$ *	(55,102)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 6,588	\$ 6,588
16	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	3,835	3,835
17	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,388	1,388
18	V	10 SALARY NURSE		APERION CONSULTING, LLC	100.00%	20,437	20,437
19	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,729	2,729
20	V	19 PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	597	597
21	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	966	966
22	V	21 CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	319	319
23	V	24 SEMINARS		APERION CONSULTING, LLC	100.00%	676	676
24	V	25 AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	2,799	2,799
25	V	30 DEPRECIATION		APERION CONSULTING, LLC	100.00%	137	137
26	V	32 INTEREST		APERION CONSULTING, LLC	100.00%	11	11
27	V	35 AUTO LEASE		APERION CONSULTING, LLC	100.00%	265	265
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	21,350	APERION CONSULTING, LLC	100.00%		(21,350)
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	1,500	APERION CONSULTING, LLC	100.00%		(1,500)
39	Total		\$ 22,850			\$ 40,746	\$ * 17,896

* 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%	\$ 1,258	\$	1,258	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	988		988	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	206		206	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	51,090		51,090	18
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	30		30	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	784		784	20
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,081		6,081	21
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	53		53	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	238		238	23
24	V			APERION FINANCIAL, LLC	100.00%				24
25	V			APERION FINANCIAL, LLC	100.00%				25
26	V			APERION FINANCIAL, LLC	100.00%				26
27	V			APERION FINANCIAL, LLC	100.00%				27
28	V			APERION FINANCIAL, LLC	100.00%				28
29	V			APERION FINANCIAL, LLC	100.00%				29
30	V			APERION FINANCIAL, LLC	100.00%				30
31	V			APERION FINANCIAL, LLC	100.00%				31
32	V			APERION FINANCIAL, LLC	100.00%				32
33	V			APERION FINANCIAL, LLC	100.00%				33
34	V	19 HOME OFFICE EXPENSE	41,008	APERION FINANCIAL, LLC	100.00%			(41,008)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 41,008			\$ 60,727	\$ *	19,720	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%	\$ 165	\$	165	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		297		297	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		563		563	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		387		387	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		716		716	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		540		540	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		197		197	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		253		253	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		835		835	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	390					(390)	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		\$ 7,390			\$ 3,954	\$ *	(3,436)	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%	\$ 313	\$	313	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		313		313	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		132		132	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		38		38	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		69		69	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		495		495	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		142		142	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		2,502		2,502	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		780		780	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		939		939	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		278		278	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			\$ 6,001	\$ *	(16,999)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 8,784	ProPay HR LLC	24.00%	\$ 6,676	\$ (2,108)
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		\$ 8,784			\$ 6,676	\$ * (2,108)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

Table with 8 columns: Row Number, Owner Name, Ownership %, Related Nursing Home Name, City, Other Related Business Entity Name, City, Type of Business, and Row Number. It lists various owners and related entities for Aperion Care facilities across Illinois.

Facility Name & ID Number

Aperion Care Litchfield, Llc

0051102

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	Administrative	0.9	2.25%	Alloc. Salary	\$ 4,339	17-7	1	
2	Jay Meystel	Relative	Administrative	0	Administrative	0.4	1.00%	Alloc. Salary	670	17-7	2	
3	Joel Meystel	Relative	Clerical	0	Clerical	0.4	2.00%	Alloc. Salary	1,601	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0	Clerical	0.1	3.03%	Alloc. Salary	654	21-7	4	
5	Meir Meystel	Relative	Clerical	0	Clerical	0.1	1.45%	Alloc. Salary	571	21-7	5	
6	David Berkowitz	Owner	Administrative	47.00%	Administrative	0.9	2.25%	Alloc. Salary	4,339	17-7	6	
7	Fred Frankel	Owner	Administrative	1.00%	Administrative	0.9	2.25%	Alloc. Salary	4,003	17-7	7	
8	Steve Turofsky	Owner	Administrative	1.00%	Administrative	0.9	2.25%	Alloc. Salary	4,161	17-7	8	
9	Nosson Factor	Relative	Clerical	0	Clerical	0.7	2.13%	Alloc. Salary	1,841	21-7	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 22,179		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 Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 22,856	\$ 151	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	22,856	27	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	22,856	609
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	22,856	28	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	22,856	2,737
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	22,856	164	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	22,856	37,315
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	22,856	1,499	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	22,856	3,358	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	22,856	19,304
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	22,856	1,045	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	22,856	3,772	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	22,856	1,350	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	22,856	3,548	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	22,856	895	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	22,856	3,170	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	22,856	390	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	22,856	61	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 79,423	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 22,856	\$ 6,588	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	22,856	3,835	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982	22,856	1,388	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	22,856	20,437	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781	22,856	2,729	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541	22,856	597	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521	22,856	966	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707	22,856	319	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152	22,856	676	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014	22,856	2,799	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318	22,856	137	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508	22,856	11	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204	22,856	265	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,878,156	\$ 1,421,169	\$ 40,746	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

APERION FINANCIAL, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 22,856	\$ 1,258	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	22,856	988	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	22,856	206	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	51,090	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	22,856	30	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	22,856	784	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	22,856	6,081	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	22,856	53	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	22,856	238	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,799,102	\$ 2,378,479	\$ 60,727	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 7,614	\$ 22,856	\$ 165	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	22,856	297	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	22,856	563	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	22,856	387	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	22,856	716	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	22,856	540	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	22,856	197	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	22,856	253	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	22,856	835	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 182,245	\$	\$ 3,954	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

(

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	\$ 14,427	\$ 22,856	\$ 313	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412	22,856	313	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076	22,856	132	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748	22,856	38	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201	22,856	69	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798	22,856	495	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544	22,856	142	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317	22,856	2,502	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973	22,856	780	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299	22,856	939	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821	22,856	278	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 276,616	\$	\$ 6,001	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

ProPay HR LLC

Street Address

2201 W. MAIN ST

City / State / Zip Code

EVANSTON, ILLINOIS 60202

Phone Number

(847) 905 3268

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	19	Payroll Services	Direct Allocation		\$	\$		\$ 6,676	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 6,676	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Midwest Bank		X	Mortgage			\$	2,625,000		\$	88,298	1								
2												2								
3												3								
4												4								
5				-								5								
Working Capital																				
6	First Midwest Bank		X	Line of Credit				302,238	12.11.16	3.7340	13,034	6								
7	Assurance		X	Insurance Financing							154	7								
8				-								8								
9	TOTAL Facility Related						\$	2,927,238			\$	101,486	9							
B. Non-Facility Related*																				
10	Interest Income		X								(130)	10								
11	Interest Income - Bldg. Co		X								(23)	11								
12	Allocated from Aperion Care	X									3,170	12								
13	See Supplemental Schedule										1,331	13								
14	TOTAL Non-Facility Related						\$				\$	4,348	14							
15	TOTALS (line 9+line14)						\$	2,927,238			\$	105,834	15							

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

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

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

Facility Name & ID Number

Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15	Allocated - Aperion Consulting	X								11										
16	Allocated - 8131 N Monticello	X								540										
17	Allocated - Chase Office, LLC	X								780										
18										18										
19										19										
20	TOTAL Non-Facility Related									1,331										

* 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.)

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	<u>24,003</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>24,770</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>767</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>24,060</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>24,827</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>22,440</u>	8
	2012	<u>22,135</u>	9
	2013	<u>22,240</u>	10
	2014	<u>22,860</u>	11
	2015	<u>22,996</u>	12

2016 Accrual = \$22,996 x 1.05 = \$24,060 (ROUNDED)

Allocated from 8131 N. Monticello = \$835

Allocated from Chase Office, LLC = \$939

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

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 Litchfield, Llc COUNTY Montgomery
 FACILITY IDPH LICENSE NUMBER 0051102
 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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
TOTALS			\$ <hr/> <hr/>	\$ <hr/> <hr/>

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 Litchfield, Llc

0051102 Report Period Beginning:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2010</u>	<u>\$ 8,241</u>	<u>1</u>
2	<u>Allocated from Chase Office, LLC</u>			<u>1,347</u>	<u>2</u>
3	TOTALS			\$ 9,588	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65	2010	1971	\$ 666,776	\$ 11,506	35	\$ 19,051	\$ 7,545	\$ 120,656	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2011	197,162		20	10,312	10,312	65,146	9
10	Various		2012	77,849		20	6,395	6,395	29,879	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			74,478	2,250	1,909	(341)	6,288	68
69				42,420		(42,420)		69
70			\$ 1,016,265	\$ 56,176	\$ 37,667	\$ (18,509)	\$ 221,969	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,016,265	\$ 56,176		\$ 37,667	\$ (18,509)	\$ 221,969	1
2	Replaced 58 Sprinkler Heads	2013	3,250		20	325	325	1,300	2
3	New Sign Display Set In Concrete	2014	5,351		20	357	357	892	3
4	Install New Hot Water Heater	2014	5,936		20	297	297	841	4
5	Replace Heating Panel Wires In East Wing	2014	4,876		20	244	244	670	5
6	Electrical Upgrade Of Heating Panel	2014	5,147		20	257	257	751	6
7	Installed Phone System & Cabling	2015	4,650		20	930	930	1,860	7
8	Seal Work Completed Per Bid Proposal Dated 5/20/16	2016	2,641		20	132	132	132	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	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		\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	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		\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	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		\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,048,116	\$ 56,176		\$ 40,208	\$ (15,968)	\$ 228,414	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office, LLC	2016	12,124	130	35	130		130	3
4	Allocated from 8131 N Monticello	2010		258	35	224	(34)	2,324	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Chase Office, LLC	2016	61,447	1,280	35	1,280		1,280	9
10									10
11	Allocated from Aperion Care	2010	646	104	20	32	(72)	226	11
12	Allocated from Aperion Care	2012	183	14	20	9	(5)	46	12
13	Allocated from Aperion Care	2013	78	9	20	4	(5)	16	13
14									14
15	Allocated from 8131 N Monticello	2010		455	20	196	(259)	2,057	15
16	Allocated from 8131 N Monticello	2013			20	34	34	209	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 74,478	\$ 2,250		\$ 1,909	\$ (341)	\$ 6,288	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		\$ 74,478	\$ 2,250		\$ 1,909	\$ (341)	\$ 6,288	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 74,478	\$ 2,250		\$ 1,909	\$ (341)	\$ 6,288	34

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 224,390	\$ 443	\$ 25,797	\$ 25,354	10	\$ 123,041	71
72	Current Year Purchases	41,277	1,366	3,559	2,193	10	3,559	72
73	Fully Depreciated Assets	23,290				10	23,290	73
74								74
75	TOTALS	\$ 288,958	\$ 1,809	\$ 29,355	\$ 27,546		\$ 149,890	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		2007 Ford E350- Purchased New	2011	\$ 16,615	\$	\$ 2,035	\$ 2,035	5	\$ 13,562	76
77		2006 DODGE GRAND CARAVA	2014	7,031		1,255	1,255	5	4,103	77
78		Allocated from Aperion Care	2016	726	147	145	(2)	5	326	78
79		Allocated from Aperion Consulti	2016	503	98	101	3	5	201	79
80	TOTALS			\$ 24,875	\$ 245	\$ 3,536	\$ 3,291		\$ 18,192	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)	\$ 1,371,536	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,230	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,100	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,870	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 396,496	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								5
6	<u>Allocated from 8131 N Monticello</u>				<u>197</u>			6
7	TOTAL				\$ 197			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: \$ 6,077 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>Allocated from Aperion Consulting</u>		\$	\$ <u>265</u>	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 265	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	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
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39 - 02	# of prescripts				4,438		4,438	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>									13	
14	TOTAL			\$		\$	\$ 4,438		\$ 4,438	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 Litchfield, Llc# 0051102Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 111,867	\$ 254,713	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	372,314	372,314	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,067	49,067	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	308	20,654	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 533,556	\$ 696,748	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	281,839	311,254	15
16	Equipment, at Historical Cost	129,133	317,958	16
17	Accumulated Depreciation (book methods)	(226,355)	(487,130)	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>	1,066,470	1,921,250	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,251,087	\$ 2,576,766	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,784,643	\$ 3,273,514	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 100,042	\$ 100,044	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	302,238	302,238	29
30	Accrued Salaries Payable	72,260	72,260	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,469	2,469	31
32	Accrued Real Estate Taxes(Sch.IX-B)		24,060	32
33	Accrued Interest Payable		11,479	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	29,734	29,734	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 506,743	\$ 542,284	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,625,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	637,920	22,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 637,920	\$ 2,647,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,144,663	\$ 3,189,784	46
47	TOTAL EQUITY(page 18, line 24)	\$ 639,980	\$ 83,730	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,784,643	\$ 3,273,514	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 309,888	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>5</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 309,893	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	343,420	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,333)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 330,087	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 639,980	24 *

* This must agree with page 17, line 47.

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,134,347	1
2	Discounts and Allowances for all Levels	(1,119,602)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,014,745	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,734	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,734	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	130	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,016,609	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	586,604	31
32	Health Care	879,726	32
33	General Administration	737,883	33
B. Capital Expense			
34	Ownership	280,386	34
C. Ancillary Expense			
35	Special Cost Centers	14,629	35
36	Provider Participation Fee	173,961	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,673,189	40
41	Income before Income Taxes (line 30 minus line 40)**	343,420	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 343,420	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,912,952	44
45	Private Pay - Net Inpatient Revenue	56,790	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Insurance</u>	45,003	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,014,745	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 Litchfield, Llc

0051102

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	1,944	2,080	\$ 83,603	\$ 40.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,486	4,013	92,218	22.98	3
4	Licensed Practical Nurses	8,729	9,202	167,649	18.22	4
5	CNAs & Orderlies	24,603	26,352	296,406	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,815	2,134	34,810	16.31	9
10	Activity Assistants	68	68	892	13.12	10
11	Social Service Workers	3,625	4,017	89,789	22.35	11
12	Dietician					12
13	Food Service Supervisor	1,714	2,036	31,550	15.50	13
14	Head Cook	5,013	5,470	60,992	11.15	14
15	Cook Helpers/Assistants	6,419	7,414	92,580	12.49	15
16	Dishwashers					16
17	Maintenance Workers	1,824	2,112	34,500	16.34	17
18	Housekeepers	6,002	6,583	73,346	11.14	18
19	Laundry	2,284	2,546	31,616	12.42	19
20	Administrator	1,920	2,120	71,167	33.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,870	2,077	28,416	13.68	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,158	2,291	28,742	12.55	33
34	TOTAL (lines 1 - 33)	73,474	80,515	\$ 1,218,276 *	\$ 15.13	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	89	\$ 5,156	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	21,350	10-03	38
39	Pharmacist Consultant	Monthly	4,536	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	57	3,173	11-03	44
45	Social Service Consultant	6	284	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	152	\$ 46,499		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Andy Kindernay	Administrator	0	\$ 71,167	Workers' Compensation Insurance	\$ 2,172	IDPH License Fee	\$ 3,980		
				Unemployment Compensation Insurance	19,894	Advertising: Employee Recruitment	2,125		
				FICA Taxes	89,592	Health Care Worker Background Check			
				Employee Health Insurance	49,020	(Indicate # of checks performed <u>49</u>)	494		
				Employee Meals		Patient Background Checks <u>97</u>	970		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	11,232		
				Employee Physicals	320	License & Permits	1,002		
				Employee Meals	147	Allocated from Aperion Care	3,358		
				Employee Benefits Other	4,472	Allocated from Aperion Consulting	966		
						See Supplemental Schedule	275		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,167	TOTAL (agree to Schedule V, line 22, col.8)		\$ 165,617	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,402
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Aperion Care, Inc.			\$ 85,090				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 85,090				Seminar Expense	3,818	
							Allocated from Aperion Care	1,045	
C. Professional Services							Allocated from Aperion Consulting	676	
Vendor/Payee	Type		Amount				See Supplemental Schedule	30	
Aperion Care, Inc.	Data Processing		\$ 5,699				Entertainment Expense	()	
Creative Technology Solutions	Data Processing		8,360				(agree to Sch. V, line 24, col. 8)		
E-Health Data Solutions	MDS Software		900				TOTAL	\$ 5,569	
Galaxy Hosted Software	Clinical Software		3,000						
National Datacare Corp	Pharmacy Software		2,129						
Wescom Solutions	E.H.R. Software		13,189						
Ability Network Inc	Data Processing		3,036						
PointClickCare Technologies Inc	Data Processing		2,460						
Aperion Care, Inc.	Home Office Expense		49,435						
Aperion Financial	Home Office Expense		41,008						
See Supplemental Schedule			35,469						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 164,684	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102Report Period Beginning: 01/01/16Ending: 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 \$11,076.20
- (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. \$ 1,827 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 173,961
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% ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
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