



Facility Name & ID Number Aperion Care Spring Valley

# 0053611 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	98	Skilled (SNF)	98	35,868	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,701	509	4,216	6,426	8
9	SNF/PED					9
10	ICF	15,345	3,682		19,027	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,046	4,191	4,216	25,453	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.96%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES  NO

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

YES  NO

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

Date started 05/01/15

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

YES  Date 05/01/15 NO

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

YES  NO  If YES, enter number of beds certified 98 and days of care provided 3,140

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Aperion Care Spring Valley # 0053611 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	186,033	12,948	12,842	211,823		211,823	(4,724)	207,099		1
2	Food Purchase		151,806		151,806	(123)	151,683	(544)	151,139		2
3	Housekeeping	109,892	22,930		132,822		132,822		132,822		3
4	Laundry	42,692	10,731		53,423		53,423		53,423		4
5	Heat and Other Utilities			96,457	96,457		96,457	(5,442)	91,015		5
6	Maintenance	44,925	29,183	67,491	141,599		141,599	5,507	147,106		6
7	Other (specify):*							1,724	1,724		7
8	<b>TOTAL General Services</b>	383,542	227,598	176,790	787,930	(123)	787,807	(3,480)	784,327		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			28,900	28,900		28,900		28,900		9
10	Nursing and Medical Records	1,376,417	153,390	70,811	1,600,618		1,600,618	(37,993)	1,562,625		10
10a	Therapy	57,431	303	390	58,124		58,124		58,124		10a
11	Activities	84,861	1,593	1,170	87,624		87,624		87,624		11
12	Social Services	65,119		1,885	67,004		67,004		67,004		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,222	3,222		15
16	<b>TOTAL Health Care and Programs</b>	1,583,828	155,286	103,156	1,842,270		1,842,270	(34,771)	1,807,499		16
	<b>C. General Administration</b>										
17	Administrative	106,212		211,472	317,684		317,684	(168,516)	149,168		17
18	Directors Fees										18
19	Professional Services			163,915	163,915		163,915	(74,049)	89,866		19
20	Dues, Fees, Subscriptions & Promotions			77,639	77,639		77,639	(56,325)	21,314		20
21	Clerical & General Office Expenses	58,384		203,888	262,272		262,272	(79,568)	182,704		21
22	Employee Benefits & Payroll Taxes			253,607	253,607	123	253,730		253,730		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,947	6,947		6,947	1,950	8,897		24
25	Other Admin. Staff Transportation			11,231	11,231		11,231	8,191	19,422		25
26	Insurance-Prop.Liab.Malpractice			70,730	70,730		70,730	1,662	72,392		26
27	Other (specify):*							10,723	10,723		27
28	<b>TOTAL General Administration</b>	164,596		999,429	1,164,025	123	1,164,148	(355,932)	808,217		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,131,966	382,884	1,279,375	3,794,225		3,794,225	(394,183)	3,400,042		29

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

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

Facility Name & ID Number Aperion Care Spring Valley

#0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,219	9,219		9,219	5,929	15,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,062	23,062		23,062	4,937	27,999			32
33	Real Estate Taxes			54,093	54,093		54,093	1,976	56,069			33
34	Rent-Facility & Grounds			441,355	441,355		441,355	(29,780)	411,575			34
35	Rent-Equipment & Vehicles			5,288	5,288		5,288	1,218	6,506			35
36	Other (specify):*			8,667	8,667		8,667	(8,667)				36
37	<b>TOTAL Ownership</b>			541,684	541,684		541,684	(24,387)	517,297			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,660	481,318	559,978		559,978	(35,253)	524,725			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,736	179,736		179,736		179,736			42
43	Other (specify):*			17,978	17,978		17,978	(17,978)				43
44	<b>TOTAL Special Cost Centers</b>		78,660	679,032	757,692		757,692	(53,231)	704,461			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,131,966	461,544	2,500,091	5,093,601		5,093,601	(471,801)	4,621,800			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 Spring Valley**

# **0053611**

Report Period Beginning:

**01/01/16**

Ending:

**12/31/16**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(62)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,006)	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	1,137	30		9
10	Interest and Other Investment Income	(76)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(250)	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	(676)	21		18
19	Entertainment	(3,533)	21		19
20	Contributions	(59,797)	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	(145,541)	21		24
25	Fund Raising, Advertising and Promotional	(17,228)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,834)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (248,866)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(222,935)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (222,935)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (471,801)		37

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

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

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

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

Aperion Care Spring Valley

ID# 0053611

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (9,151)	21	1
2	Amortization	(8,667)	36	2
3	Non-Allowable Legal	(98)	19	3
4	Additional R&M	3,879	06	4
5	Credit Card Processing	(174)	21	5
6	Theft, Damage and Loss	(223)	21	6
7	PAC Dues	(1,650)	20	7
8	Marketing Fees	(750)	43	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				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(16,834)		49

Aperion Care Spring Valley

ID# 0053611

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Spring Valley# 0053611

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				(4,724)								(4,724)	1
2	Food Purchase	(312)		168	(400)								(544)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,006)		31			184	349					(5,442)	5
6	Maintenance	3,879		678	271		330	348					5,507	6
7	Other (specify):*			31	1,546			147					1,724	7
8	<b>TOTAL General Services</b>	<b>(2,439)</b>		<b>908</b>	<b>(3,307)</b>		<b>514</b>	<b>844</b>					<b>(3,480)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			3,048	(41,041)								(37,993)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			183	3,039								3,222	15
16	<b>TOTAL Health Care and Programs</b>			<b>3,231</b>	<b>(38,002)</b>								<b>(34,771)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(169,917)		1,401							(168,516)	17
18	Directors Fees													18
19	Professional Services	(98)		(5,127)	665	(66,641)	627	42		(3,517)			(74,049)	19
20	Fees, Subscriptions & Promotions	(61,447)		3,740	1,076	229		77					(56,325)	20
21	Clerical & General Office Expenses	(159,298)		21,498	355	56,895	431	551					(79,568)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,164	753	33							1,950	24
25	Other Admin. Staff Transportation			4,201	3,117	873							8,191	25
26	Insurance-Prop.Liab.Malpractice			1,504				158					1,662	26
27	Other (specify):*			3,951		6,772							10,723	27
28	<b>TOTAL General Administration</b>	<b>(220,843)</b>		<b>(138,985)</b>	<b>5,966</b>	<b>(439)</b>	<b>1,058</b>	<b>828</b>		<b>(3,517)</b>			<b>(355,932)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(223,282)</b>		<b>(134,846)</b>	<b>(35,343)</b>	<b>(439)</b>	<b>1,572</b>	<b>1,672</b>		<b>(3,517)</b>			<b>(394,183)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Spring Valley # 0053611 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,137		996	153	59	798	2,786					5,929	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(76)		3,530	12		602	869					4,937	32
33	Real Estate Taxes						930	1,046					1,976	33
34	Rent-Facility & Grounds			434			(7,214)	(23,000)					(29,780)	34
35	Rent-Equipment & Vehicles			68	295	265	281	310					1,218	35
36	Other (specify):*	(8,667)											(8,667)	36
37	<b>TOTAL Ownership</b>	<b>(7,606)</b>		<b>5,028</b>	<b>460</b>	<b>324</b>	<b>(4,603)</b>	<b>(17,989)</b>					<b>(24,387)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(35,253)				(35,253)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(17,978)											(17,978)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(17,978)</b>							<b>(35,253)</b>				<b>(53,231)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(248,866)</b>		<b>(129,819)</b>	<b>(34,884)</b>	<b>(115)</b>	<b>(3,031)</b>	<b>(16,317)</b>	<b>(35,253)</b>	<b>(3,517)</b>			<b>(471,801)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 FOOD	\$	APERION CARE, INC.	100.00%	\$ 168	\$ 168
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	31	31
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	678	678
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	31	31
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	3,048	3,048
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	183	183
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	41,555	41,555
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,669	1,669
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,740	3,740
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	21,498	21,498
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,164	1,164
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	4,201	4,201
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,504	1,504
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,951	3,951
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	996	996
30	V	32 INTEREST		APERION CARE, INC.	100.00%	3,530	3,530
31	V	34 RENT		APERION CARE, INC.	100.00%	434	434
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	68	68
33	V			APERION CARE, INC.	100.00%		
34	V			APERION CARE, INC.	100.00%		
35	V	17 MANAGEMENT FEE	211,472	APERION CARE, INC.	100.00%		(211,472)
36	V	19 HOME OFFICE	6,796	APERION CARE, INC.	100.00%		(6,796)
37	V			APERION CARE, INC.			
38	V						
39	Total		\$ 218,268			\$ 88,449	\$ * (129,819)

\* 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	<u>1</u> DIETARY	\$	APERION CONSULTING, LLC	100.00%	\$ 7,336	\$ 7,336
16	V	<u>6</u> REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	4,271	4,271
17	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,546	1,546
18	V	<u>10</u> SALARY NURSE		APERION CONSULTING, LLC	100.00%	22,759	22,759
19	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,039	3,039
20	V	<u>19</u> PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	665	665
21	V	<u>20</u> FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,076	1,076
22	V	<u>21</u> CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	355	355
23	V	<u>24</u> SEMINARS		APERION CONSULTING, LLC	100.00%	753	753
24	V	<u>25</u> AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,117	3,117
25	V	<u>30</u> DEPRECIATION		APERION CONSULTING, LLC	100.00%	153	153
26	V	<u>32</u> INTEREST		APERION CONSULTING, LLC	100.00%	12	12
27	V	<u>35</u> AUTO LEASE		APERION CONSULTING, LLC	100.00%	295	295
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	<u>10</u> CONSULTING	63,800	APERION CONSULTING, LLC	100.00%		(63,800)
35	V	<u>01</u> DIETICIAN	12,060	APERION CONSULTING, LLC	100.00%		(12,060)
36	V	<u>02</u> FOOD SERVICE	400	APERION CONSULTING, LLC	100.00%		(400)
37	V	<u>06</u> PAINTER		APERION CONSULTING, LLC	100.00%		
38	V	<u>06</u> PROJECT MANAGER	4,000	APERION CONSULTING, LLC	100.00%		(4,000)
39	Total		\$ 80,260			\$ 45,376	\$ * (34,884)

\* 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%	\$ 1,401	\$ 1,401
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,100	1,100
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	229	229
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	56,895	56,895
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	33	33
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	873	873
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,772	6,772
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	59	59
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	265	265
24	V			APERION FINANCIAL, LLC	100.00%		
25	V			APERION FINANCIAL, LLC	100.00%		
26	V			APERION FINANCIAL, LLC	100.00%		
27	V			APERION FINANCIAL, LLC	100.00%		
28	V			APERION FINANCIAL, LLC	100.00%		
29	V			APERION FINANCIAL, LLC	100.00%		
30	V			APERION FINANCIAL, LLC	100.00%		
31	V			APERION FINANCIAL, LLC	100.00%		
32	V			APERION FINANCIAL, LLC	100.00%		
33	V			APERION FINANCIAL, LLC	100.00%		
34	V	19 HOME OFFICE EXPENSE	67,741	APERION FINANCIAL, LLC	100.00%		(67,741)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 67,741			\$ 67,626	\$ * (115)

\* 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%	\$ 184	\$	184	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		330		330	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		627		627	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		431		431	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		798		798	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		602		602	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		220		220	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		281		281	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		930		930	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	434					(434)	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		\$ 7,434			\$ 4,403	\$ *	(3,031)	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%	\$ 349	\$ 349
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		348	348
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		147	147
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		42	42
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		77	77
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		551	551
21	V	26 INSURANCE		CHASE OFFICE,LLC		158	158
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		2,786	2,786
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		869	869
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,046	1,046
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		310	310
26	V	34 RENT	23,000	CHASE OFFICE,LLC			(23,000)
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		\$ 23,000			\$ 6,683	\$ * (16,317)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 471,919	Renewal Rehab	100.00%	\$ 436,666	\$ (35,253)
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		\$ 471,919			\$ 436,666	\$ * (35,253)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 14,653	ProPay HR LLC	24.00%	\$ 11,136	\$ (3,517)
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	<b>Total</b>		\$ 14,653			\$ 11,136	\$ * (3,517)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name &amp; ID Number

Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Delta Trust	24.00%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz Delta Trust	24.00%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Michael Rosen	24.00%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Jeremy Boshes	1.00%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Steven Turofsky	1.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Michelle Koder	1.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Frederick Frankel	1.25%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Morris Esformes	4.75%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Delecia Wirtenberg Revocable Trust	4.75%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	Sylvia Yolinsky Revocable Trust	4.75%	Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11	Jack Yolinsky	4.75%	Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12	David J. Wirtenberg	4.75%	Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

Facility Name & ID Number

Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number      Aperion Care Spring Valley      #      0053611      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	0.00%	See Attached	1	2.50%	Alloc Salary	\$ 4,832	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc Salary	746	17-7	2	
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.5	2.50%	Alloc Salary	1,783	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc Salary	729	21-7	4	
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1	2.50%	Alloc Salary	4,832	17-7	5	
6	Frederick Frankel	Owner	Administrative	1.25%	See Attached	1	2.50%	Alloc Salary	4,458	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1	2.50%	Alloc Salary	4,634	17-7	7	
8	Michael Rosen	Relative	Administrative	24.00%	See Attached	1	2.50%	Alloc. Fee	4,832	17-7	8	
9	Nosson Factor	Relative	Clerical	0%	See Attached	0.8	2.43%	Alloc Salary	2,050	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	\$ 28,896		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 Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$ 25,453	\$ 168	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	25,453	31	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	25,453	678
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	25,453	31	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	25,453	3,048
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	25,453	183	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	25,453	41,555
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	25,453	1,669	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	25,453	3,740	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	25,453	21,498
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	25,453	1,164	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	25,453	4,201	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	25,453	1,504	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	25,453	3,951	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	25,453	996	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	25,453	3,530	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	25,453	434	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	25,453	68	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 88,449	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 303,659	25,453	\$ 7,336	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	25,453	4,271	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		25,453	1,546	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	25,453	22,759	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		25,453	3,039	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		25,453	665	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		25,453	1,076	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		25,453	355	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		25,453	753	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		25,453	3,117	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		25,453	153	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		25,453	12	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		25,453	295	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		\$ 45,376	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 25,453	\$ 1,401	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	25,453	1,100	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	25,453	229	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	56,895	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	25,453	33	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	25,453	873	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	25,453	6,772	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	25,453	59	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	25,453	265	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	\$ 67,626	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

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	\$ 25,453	\$ 184	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	25,453	330	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	25,453	627	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	25,453	431	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	25,453	798	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	25,453	602	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	25,453	220	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	25,453	281	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	25,453	930	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	\$	\$ 4,403	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

( 847) 262-3800

Fax Number

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$ 25,453	\$ 349	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412	25,453	348	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076	25,453	147	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748	25,453	42	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201	25,453	77	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798	25,453	551	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544	25,453	158	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317	25,453	2,786	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973	25,453	869	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299	25,453	1,046	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821	25,453	310	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	\$	\$ 6,683	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Renewal Rehab  
 Street Address 4655 W Chase Ave  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 673-6767  
 Fax Number ( 847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	98	\$	\$		\$ 436,666	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				\$	\$		\$ 436,666	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization ProPay HR LLC  
 Street Address 2201 W Main St.  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847) 905-3268  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 11,136	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 11,136	25

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

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 Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

Aperion Care Spring Valley

# 0053611

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5				-																
<b>Working Capital</b>																				
6	The Private Bank		X	Line of Credit				750,000		21,586										
7	GM Financial		X	Line of Credit - Auto				57,963												
8				-																
9	<b>TOTAL Facility Related</b>							<b>807,963</b>		<b>21,586</b>										
<b>B. Non-Facility Related*</b>																				
10	Interest Insurance Policies		X							1,476										
11	Interest Income		X							(76)										
12	Allocated from Aperion Care	X								3,530										
13	See Supplemental Schedule				-					1,483										
14	<b>TOTAL Non-Facility Related</b>									<b>6,413</b>										
15	<b>TOTALS (line 9+line14)</b>							<b>807,963</b>		<b>27,999</b>										

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 Spring Valley

# 0053611

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
6																				
7	<b>TOTAL Long-Term</b>																			
<b>Working Capital</b>																				
8																				
9																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Working Capital</b>																			
<b>B. Non-Facility Related*</b>																				
15	Allocated from 8131 N Montice	X		Interest Expense						602										
16	Allocated from Chase Office	X		Interest Expense						869										
17	Allocated from Aperion Consul	X								12										
18																				
19																				
20	<b>TOTAL Non-Facility Related</b>									1,483										

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2015 report.		\$	<u>58,031</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>58,038</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>7</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>56,062</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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>56,069</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>49,009</u>	8
	2012	<u>48,947</u>	9
	2013	<u>47,790</u>	10
	2014	<u>54,229</u>	11
	2015	<u>56,062</u>	12

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

2016 Accrual = 2015 Tax

Beginning Accrual Adjusted

Allocated from Chase Office = \$1046

Allocated from 8131 N Monticello = \$930

**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.**

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

FACILITY NAME Aperion Care Spring Valley COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0053611

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-27-400-011</u>	<u>Long Term Care Property</u>	\$ <u>56,062.22</u>	\$ <u>56,062.22</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>65,893.19</u>	\$ <u>811.59</u>
3. <u>10-27-307-027-0000</u>	<u>Home Office Allocation</u>	\$ <u>40,836.48</u>	\$ <u>412.44</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>162,791.89</u></u>	\$ <u><u>57,286.25</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

**IMPORTANT NOTICE**

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

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

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

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

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

FACILITY NAME Aperion Care Spring Valley COUNTY Bureau  
 FACILITY IDPH LICENSE NUMBER 0053611  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,107 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from Chase Office, LLC</u>			<u>\$ 1,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 1,500</b>	<b>3</b>

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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			82,941	2,506	2,132	(374)	7,002	68
69				9,219		(9,219)		69
70			\$ 82,941	\$ 11,725	\$ 2,132	\$ (9,593)	\$ 7,002	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 82,941	\$ 11,725		\$ 2,132	\$ (9,593)	\$ 7,002	1
2	Data Cable Installation	2015	7,643		20	382	382	573	2
3	Data And Voice Cable Installation	2015	7,866		20	393	393	590	3
4	Install Outlets-Hall/Nurse Station/Dining/Laundry/Admin Office	2015	2,520		20	126	126	189	4
5	Compressor Replacement And Piping	2015	2,865		20	143	143	215	5
6	Signage For Road Sign / Glass Door / Awning	2015	5,837		20	292	292	438	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
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16								16
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	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)	\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 109,672	\$ 11,725		\$ 3,469	\$ (8,256)	\$ 9,007	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		287	39	250	(37)	2,588	3
4	Allocated from Chase Office, LLC	2016	13,501	144	39	144		144	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	720	116	10	36	(80)	252	9
10	Allocated from Aperion Care	2012	204	16	15	10	(6)	51	10
11	Allocated from Aperion Care	2013	87	10	4	10		17	11
12									12
13	Allocated from 8131 N Monticello	2010		507	20	218	(289)	2,291	13
14	Allocated from 8131 N Monticello	2013			20	38	38	233	14
15									15
16									16
17	Allocated Chase Office, LLC	2016	68,429	1,426	10	1,426		1,426	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)		\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

Report Period Beginning:

01/01/16

Ending:

12/31/16

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 82,941	\$ 2,506		\$ 2,132	\$ (374)	\$ 7,002	34

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

Facility Name & ID Number Aperion Care Spring Valley

# 0053611

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	\$ 2,701	\$ 493	\$ 319	\$ (174)	10	\$ 785	71
72	Current Year Purchases	40,086	1,521	2,497	976	10	2,497	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 42,787	\$ 2,014	\$ 2,816	\$ 802		\$ 3,282	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		Car 9/1/16 place in service	2016	\$ 57,278	\$	\$ 8,592	\$ 8,592	5	\$ 8,592	76
77		Allocated from Aperion Care	2016	808	164	162	(2)	5	363	77
78		Allocated from Aperion Consulti	2016	560	109	111	2	5	224	78
79										79
80	TOTALS			\$ 58,646	\$ 273	\$ 8,865	\$ 8,592		\$ 9,179	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)	\$ 212,605	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,012	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,149	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,137	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,468	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	Lobby, Offices, Dining Room	\$ 84,472	92
93	Bathrooms, Cove Bases, walls		93
94	floors, lighting		94
95		\$ 84,472	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: Spring Valley Real Estate

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:		98		\$ 411,355			3
4	Additions							4
5	<u>Allocated from 8131 N Monticello</u>				220			5
6								6
7	TOTAL		98		\$ 411,575			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: \$ 6,212 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>			\$ 295	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 295	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 185,308	\$		\$ 185,308	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,142			71,142	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			205,570			205,570	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				73,519		73,519	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>					19,298	5,141		24,439	13
14	TOTAL			\$		\$ 481,318	\$ 78,660		\$ 559,978	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 106,189	\$	1
2	Cash-Patient Deposits	380		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,418,565		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,991		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	144,477		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,736,602	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	19,629		15
16	Equipment, at Historical Cost	78,998		16
17	Accumulated Depreciation (book methods)	(11,092)		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>	438,014		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 525,549	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,262,151	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 296,636	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	807,963		29
30	Accrued Salaries Payable	96,969		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,772		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,062		32
33	Accrued Interest Payable	2,552		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	82,832		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,346,786	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	726,176		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 726,176	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,072,962	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 189,189	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,262,151	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>310,132</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding Equity</u>	<u>2</u>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>310,134</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(120,945)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>50,000</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(50,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(120,945)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>189,189</b>	<b>24</b> *

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

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,368,535	1
2	Discounts and Allowances for all Levels	(600,920)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,767,615	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,395	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 184,395	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	62	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	18,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,856	19
20	Radiology and X-Ray	12	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 20,570	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	76	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 76	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,972,656	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	787,930	31
32	Health Care	1,842,270	32
33	General Administration	1,164,025	33
<b>B. Capital Expense</b>			
34	Ownership	541,684	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	577,956	35
36	Provider Participation Fee	179,736	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,093,601	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(120,945)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (120,945)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,184,754	44
45	Private Pay - Net Inpatient Revenue	873,875	45
46	Medicare - Net Inpatient Revenue	1,440,433	46
47	Other-(specify) <u>Managed Care</u>	268,553	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,767,615	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 Spring Valley

# 0053611

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	2,040	2,195	\$ 80,049	\$ 36.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,095	7,508	200,756	26.74	3
4	Licensed Practical Nurses	19,197	20,268	504,004	24.87	4
5	CNAs & Orderlies	45,796	47,808	591,608	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,056	3,314	57,431	17.33	8
9	Activity Director	1,824	2,080	37,123	17.85	9
10	Activity Assistants	3,432	3,724	47,738	12.82	10
11	Social Service Workers	3,510	3,786	64,251	16.97	11
12	Dietician					12
13	Food Service Supervisor	2,149	2,261	43,820	19.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,142	14,182	142,213	10.03	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,273	44,925	19.76	17
18	Housekeepers	10,531	11,387	109,892	9.65	18
19	Laundry	4,387	4,732	42,692	9.02	19
20	Administrator	1,864	2,259	106,212	47.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,848	2,080	32,933	15.83	23
24	Clerical	1,813	1,989	25,451	12.80	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)	42	42	868	20.67	33
34	TOTAL (lines 1 - 33)	123,784	131,888	\$ 2,131,966 *	\$ 16.16	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	Monthly	\$ 12,842	01-03	35
36	Medical Director	Monthly	28,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	63,800	10-03	38
39	Pharmacist Consultant	Monthly	7,011	10-03	39
40	Physical Therapy Consultant	8	390	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,170	11-03	44
45	Social Service Consultant	38	1,885	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 115,998		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	
<u>John Koehler (01/01-6/2/16)</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 36,112</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 56,931</u>	<u>IDPH License Fee</u>	<u>\$ 3,642</u>	
<u>Jennifer Diaz (6/7-12/31/16)</u>	<u>Administrator</u>	<u>0</u>	<u>70,100</u>	<u>Unemployment Compensation Insurance</u>	<u>17,261</u>	<u>Advertising: Employee Recruitment</u>	<u>1,023</u>	
				<u>FICA Taxes</u>	<u>159,563</u>	<u>Health Care Worker Background Check</u>	<u>3,935</u>	
				<u>Employee Health Insurance</u>	<u>16,312</u>	<u>(Indicate # of checks performed <u>394</u>)</u>		
				<u>Employee Meals</u>	<u>123</u>	<u>Patient Background Checks</u>	<u>75</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>6,669</u>	
				<u>Employee Physicals</u>	<u>880</u>	<u>Licenses and Permits</u>	<u>178</u>	
				<u>Employee Meals</u>	<u>227</u>	<u>Allocated from Aperion Care</u>	<u>3,740</u>	
				<u>Employee Benefits - Other</u>	<u>2,433</u>	<u>Allocated from Aperion Consulting</u>	<u>1,076</u>	
						<u>See Supplemental Schedule</u>	<u>306</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 106,212</b>			<u>Less: Public Relations Expense</u>	<u>( )</u>	
<b>(List each licensed administrator separately.)</b>						<u>Non-allowable advertising</u>	<u>( )</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 253,730</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 21,314</b>	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Aperion Care - Management Fees</u>			<u>\$ 211,472</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 211,472</b>				<u>Seminar Expense</u>	<u>6,947</u>
<b>(Attach a copy of any management service agreement)</b>							<u>Allocated From Aperion Care</u>	<u>1,164</u>
							<u>Allocated from Aperion Consulting</u>	<u>753</u>
							<u>See Supplemental Schedule</u>	<u>33</u>
							<u>Entertainment Expense</u>	<u>( )</u>
							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ 8,897</b>
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount					
<u>Personnel Planners</u>	<u>Unemployment Consulting</u>		<u>\$ 486</u>					
<u>Aperion Consulting</u>	<u>Compliance Consulting</u>		<u>2,008</u>					
<u>Aperion Care</u>	<u>Compliance Consulting</u>		<u>3,477</u>					
<u>Legal Services</u>	<u>Legal Services</u>		<u>659</u>					
<u>Creative Technology Solutions</u>	<u>Data Processing</u>		<u>11,603</u>					
<u>National Datacare Corp.</u>	<u>Data Processing</u>		<u>2,968</u>					
<u>Wescom Solutions</u>	<u>Data Processing</u>		<u>13,179</u>					
<u>Aperion Care</u>	<u>Data Processing</u>		<u>7,066</u>					
<u>World Trade Office Solutions</u>	<u>Data Processing</u>		<u>2,000</u>					
<u>Aperion Care</u>	<u>Home Office</u>		<u>6,796</u>					
<u>Aperion Financial</u>	<u>Home Office</u>		<u>67,741</u>					
<u>See Supplemental Schedule</u>			<u>45,932</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 163,915</b>	<b>TOTAL</b>		<b>\$</b>		
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Aperion Care Spring Valley# 0053611

Report Period Beginning:

01/01/16

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$5000
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 9,112 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,736  
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. \$ 123 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 62
- (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? Yes  
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