

Facility Name & ID Number Aperion Care Springfield, Llc

0051086 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	11,626	30	11,284	22,940	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,626	30	11,284	22,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.43%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 09/01/2010

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

YES Date 09/01/2010 NO

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Springfield, Llc # 0051086 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	142,809	12,556	9,600	164,965		164,965	(2,988)	161,977		1
2	Food Purchase		120,626		120,626		120,626	149	120,775		2
3	Housekeeping	71,347	10,274		81,621		81,621		81,621		3
4	Laundry	20,108	8,063		28,171		28,171		28,171		4
5	Heat and Other Utilities			73,016	73,016		73,016	(6,011)	67,005		5
6	Maintenance	41,179	25,067	33,838	100,084		100,084	9,324	109,408		6
7	Other (specify):*							1,553	1,553		7
8	TOTAL General Services	275,443	176,586	116,454	568,483		568,483	2,027	570,510		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	618,019	38,170	21,153	677,342		677,342	7,859	685,201		10
10a	Therapy										10a
11	Activities	59,490	4,626	2,852	66,968		66,968		66,968		11
12	Social Services	83,284		244	83,528		83,528		83,528		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,904	2,904		15
16	TOTAL Health Care and Programs	760,793	42,796	41,049	844,638		844,638	10,763	855,401		16
	C. General Administration										
17	Administrative	94,384		87,649	182,033		182,033	(48,934)	133,099		17
18	Directors Fees										18
19	Professional Services			190,473	190,473		190,473	(113,747)	76,726		19
20	Dues, Fees, Subscriptions & Promotions			99,168	99,168		99,168	(74,585)	24,583		20
21	Clerical & General Office Expenses	27,521		61,883	89,404		89,404	41,601	131,005		21
22	Employee Benefits & Payroll Taxes			172,376	172,376		172,376		172,376		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,260	4,260		4,260	1,757	6,017		24
25	Other Admin. Staff Transportation			10,839	10,839		10,839	7,382	18,221		25
26	Insurance-Prop.Liab.Malpractice			35,354	35,354		35,354	1,497	36,851		26
27	Other (specify):*							9,665	9,665		27
28	TOTAL General Administration	121,905		662,002	783,907		783,907	(175,364)	608,543		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,158,141	219,382	819,505	2,197,028		2,197,028	(162,574)	2,034,454		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 Springfield, Llc

#0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,333	44,333		44,333	31,474	75,807			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,087	14,087		14,087	105,124	119,211			32
33	Real Estate Taxes			19,323	19,323		19,323	1,781	21,104			33
34	Rent-Facility & Grounds			240,267	240,267		240,267	(240,069)	198			34
35	Rent-Equipment & Vehicles			1,407	1,407		1,407	1,098	2,505			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			325,895	325,895		325,895	(107,070)	218,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		989		989		989		989			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,061	173,061		173,061		173,061			42
43	Other (specify):*			11,218	11,218		11,218	(11,218)				43
44	TOTAL Special Cost Centers		989	184,279	185,268		185,268	(11,218)	174,050			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,158,141	220,371	1,329,679	2,708,191		2,708,191	(280,862)	2,427,329			45

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

Aperion Care Springfield, Llc

ID# 0051086

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing / Advertising	\$ (11,218)	43	1
2	Bank Charges	(5,713)	21	2
3	Theft & Damage Loss	(1,325)	21	3
4	Amortization	(6,478)	36	4
5	Additional R&M	5,052	06	5
6	PAC Dues	(3,154)	20	6
7	Building Company - Home Office Expense	(11,350)	19	7
8	Building Company - Amortization	(37,539)	36	8
9	Building Company - Bank Charges	(2,713)	21	9
10	Building Company - Replacement Tax	(355)	21	10
11	Non-allowable Legal Fees	(3,001)	19	11
12	Non-allowable Professional Fees	(19,444)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(97,238)		49

Aperion Care Springfield, Llc

ID# 0051086
 Report Period Beginning: 01/01/16
 Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086 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				(2,988)								(2,988)	1
2	Food Purchase	(2)		151									149	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,519)		28			166	314					(6,011)	5
6	Maintenance	5,052		611	3,049		298	314					9,324	6
7	Other (specify):*			28	1,393			132					1,553	7
8	TOTAL General Services	(1,469)		818	1,454		464	760					2,027	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,747	5,112								7,859	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			165	2,739								2,904	15
16	TOTAL Health Care and Programs			2,912	7,851								10,763	16
	C. General Administration													
17	Administrative			(50,196)		1,262							(48,934)	17
18	Directors Fees													18
19	Professional Services	(33,795)	11,350	(49,533)	600	(40,841)	565	38	(2,131)				(113,747)	19
20	Fees, Subscriptions & Promotions	(79,201)		3,370	969	207		70					(74,585)	20
21	Clerical & General Office Expenses	(33,324)	3,068	19,375	320	51,277	388	496					41,601	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,049	678	30							1,757	24
25	Other Admin. Staff Transportation			3,786	2,809	787							7,382	25
26	Insurance-Prop.Liab.Malpractice			1,355				142					1,497	26
27	Other (specify):*			3,561		6,104							9,665	27
28	TOTAL General Administration	(146,320)	14,418	(67,233)	5,376	18,826	953	747	(2,131)				(175,364)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(147,789)	14,418	(63,503)	14,681	18,826	1,417	1,507	(2,131)				(162,574)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	16,002	11,152	898	138	54	719	2,511					31,474	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,227)	103,833	3,181	11		542	783					105,124	32
33	Real Estate Taxes						838	943					1,781	33
34	Rent-Facility & Grounds		(210,267)	391			(7,193)	(23,000)					(240,069)	34
35	Rent-Equipment & Vehicles			61	266	239	253	279					1,098	35
36	Other (specify):*	(44,017)	37,539										(6,478)	36
37	TOTAL Ownership	(31,242)	(57,743)	4,531	415	293	(4,840)	(18,484)					(107,070)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(11,218)											(11,218)	43
44	TOTAL Special Cost Centers	(11,218)											(11,218)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,249)	(43,325)	(58,972)	15,096	19,119	(3,423)	(16,977)	(2,131)				(280,862)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 210,267	525 South MLK Drive, LLC	100.00%	\$	(210,267)	1
2	V	19 Home Office Expense		525 South MLK Drive, LLC	100.00%	11,350	11,350	2
3	V	36 Amortization		525 South MLK Drive, LLC	100.00%	37,539	37,539	3
4	V	21 Bank Charges		525 South MLK Drive, LLC	100.00%	2,713	2,713	4
5	V	30 Depreciation		525 South MLK Drive, LLC	100.00%	11,152	11,152	5
6	V	32 Interest Expense	4	525 South MLK Drive, LLC	100.00%	103,837	103,833	6
7	V	33 Real Estate Taxes	19,323	525 South MLK Drive, LLC	100.00%	19,323		7
8	V	21 Replacement Tax		525 South MLK Drive, LLC	100.00%	355	355	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 229,594			\$ 186,269	\$ * (43,325)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 FOOD	\$	APERION CARE, INC.	100.00%	\$ 151	\$	151	15
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	28		28	16
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	611		611	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	28		28	18
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	2,747		2,747	19
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	165		165	20
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	37,452		37,452	21
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,505		1,505	22
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,370		3,370	23
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	19,375		19,375	24
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,049		1,049	25
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	3,786		3,786	26
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,355		1,355	27
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,561		3,561	28
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	898		898	29
30	V	32 INTEREST		APERION CARE, INC.	100.00%	3,181		3,181	30
31	V	34 RENT		APERION CARE, INC.	100.00%	391		391	31
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	61		61	32
33	V			APERION CARE, INC.	100.00%				33
34	V			APERION CARE, INC.	100.00%				34
35	V	17 MANAGEMENT FEE	87,649	APERION CARE, INC.	100.00%			(87,649)	35
36	V	19 HOME OFFICE	51,038	APERION CARE, INC.	100.00%			(51,038)	36
37	V			APERION CARE, INC.					37
38	V								38
39	Total		\$ 138,687			\$ 79,715	\$ *	(58,972)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	APERION CONSULTING, LLC	100.00%	\$ 6,612	\$ 6,612	15
16	V	6	REPAIRS & MAINTENANCE	APERION CONSULTING, LLC	100.00%	3,849	3,849	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY	APERION CONSULTING, LLC	100.00%	1,393	1,393	17
18	V	10	SALARY NURSE	APERION CONSULTING, LLC	100.00%	20,512	20,512	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE	APERION CONSULTING, LLC	100.00%	2,739	2,739	19
20	V	19	PROFESSIONAL FEES	APERION CONSULTING, LLC	100.00%	600	600	20
21	V	20	FEES, SUBSCRIPTIONS	APERION CONSULTING, LLC	100.00%	969	969	21
22	V	21	CLERICAL & GENERAL	APERION CONSULTING, LLC	100.00%	320	320	22
23	V	24	SEMINARS	APERION CONSULTING, LLC	100.00%	678	678	23
24	V	25	AUTO AND TRAVEL	APERION CONSULTING, LLC	100.00%	2,809	2,809	24
25	V	30	DEPRECIATION	APERION CONSULTING, LLC	100.00%	138	138	25
26	V	32	INTEREST	APERION CONSULTING, LLC	100.00%	11	11	26
27	V	35	AUTO LEASE	APERION CONSULTING, LLC	100.00%	266	266	27
28	V			APERION CONSULTING, LLC	100.00%			28
29	V			APERION CONSULTING, LLC	100.00%			29
30	V			APERION CONSULTING, LLC	100.00%			30
31	V			APERION CONSULTING, LLC	100.00%			31
32	V			APERION CONSULTING, LLC	100.00%			32
33	V			APERION CONSULTING, LLC	100.00%			33
34	V	10	CONSULTING	APERION CONSULTING, LLC	100.00%		(15,400)	34
35	V	01	DIETICIAN	APERION CONSULTING, LLC	100.00%		(9,600)	35
36	V	02	FOOD SERVICE	APERION CONSULTING, LLC	100.00%			36
37	V	06	PAINTER	APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	APERION CONSULTING, LLC	100.00%		(800)	38
39	Total		\$ 25,800			\$ 40,896	\$ * 15,096	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE	\$	APERION FINANCIAL, LLC	100.00%	\$ 1,262	\$	1,262	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	991		991	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	207		207	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	51,277		51,277	18
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	30		30	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	787		787	20
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,104		6,104	21
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	54		54	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	239		239	23
24	V			APERION FINANCIAL, LLC	100.00%				24
25	V			APERION FINANCIAL, LLC	100.00%				25
26	V			APERION FINANCIAL, LLC	100.00%				26
27	V			APERION FINANCIAL, LLC	100.00%				27
28	V			APERION FINANCIAL, LLC	100.00%				28
29	V			APERION FINANCIAL, LLC	100.00%				29
30	V			APERION FINANCIAL, LLC	100.00%				30
31	V			APERION FINANCIAL, LLC	100.00%				31
32	V			APERION FINANCIAL, LLC	100.00%				32
33	V			APERION FINANCIAL, LLC	100.00%				33
34	V	19 HOME OFFICE EXPENSE	41,832	APERION FINANCIAL, LLC	100.00%			(41,832)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 41,832			\$ 60,951	\$ *	19,119	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 166	\$	166	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		298		298	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		565		565	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		388		388	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		719		719	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		542		542	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		198		198	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		253		253	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		838		838	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	391	8131 N. MONTICELLO, LLC				(391)	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		\$ 7,391			\$ 3,968	\$ *	(3,423)	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%	\$ 314	\$	314	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		314		314	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		132		132	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		38		38	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		70		70	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		496		496	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		142		142	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		2,511		2,511	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		783		783	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		943		943	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		279		279	25
26	V	34 RENT	23,000	CHASE OFFICE,LLC				(23,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 23,000			\$ 6,023	\$ *	(16,977)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 8,881	ProPay HR LLC	24.00%	\$ 6,750	\$ (2,131)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 8,881			\$ 6,750	\$ * (2,131)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

Table with 8 columns: Row Number, Owner Name, Ownership %, Related Nursing Home Name, City, Other Business Name, City, Type of Business, and Row Number. It lists various owners like Yosef Meyetel Trust and David Berkowitz, and related nursing homes like Aperion Care Amboy and Bloomington, along with other business entities like HEALTHCARE CONSTRUCTION and 8131 N. MONTICELLO.

Facility Name & ID Number

Aperion Care Springfield, Llc

#

0051086

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0%	See Attached	1	2.50%	Alloc Salary	\$ 4,832	17-7	1	
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.4	1.00%	Alloc Salary	672	17-7	2	
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.4	2.00%	Alloc Salary	1,607	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc Salary	657	21-7	4	
5	David Berkowitz	Owner	Administrative	47.00%	See Attached	0.9	2.25%	Alloc Salary	4,355	17-7	5	
6	Fred Frankel	Owner	Administrative	1.00%	See Attached	0.9	2.25%	Alloc Salary	4,018	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.9	2.25%	Alloc Salary	4,176	17-7	7	
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.7	2.13%	Alloc Salary	1,848	21-7	8	
9	Meir Meystel	Relative	Clerical	0%	See Attached	0.1	1.45%	Alloc Salary	573	21-7	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 22,738		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 Springfield, Llc

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01/01/16

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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 Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	\$ 6,946	\$ 22,940	\$ 151	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	22,940	28	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	22,940	611
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	22,940	28	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	22,940	2,747
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	22,940	165	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	22,940	37,452
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	22,940	1,505	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	22,940	3,370	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	22,940	19,375
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	22,940	1,049	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	22,940	3,786	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	22,940	1,355	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	22,940	3,561	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	22,940	898	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	22,940	3,181	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	22,940	391	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	22,940	61	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 79,715	25

Facility Name & ID Number Aperion Care Springfield, Llc

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Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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 (

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,053,513	34	\$ 303,659	\$ 22,940	\$ 6,612	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	22,940	3,849	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982	22,940	1,393	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	22,940	20,512	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781	22,940	2,739	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541	22,940	600	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521	22,940	969	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707	22,940	320	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152	22,940	678	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014	22,940	2,809	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318	22,940	138	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508	22,940	11	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204	22,940	266	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,878,156	\$ 1,421,169	\$ 40,896	25

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

Report Period Beginning:

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Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

APERION FINANCIAL, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 22,940	\$ 1,262	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	22,940	991	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	22,940	207	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	51,277	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	22,940	30	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	22,940	787	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	22,940	6,104	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	22,940	54	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	22,940	239	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,799,102	\$ 2,378,479	\$ 60,951	25

Facility Name & ID Number Aperion Care Springfield, Llc

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Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

8131 N. MONTICELLO, LLC

Street Address

8131 N. MONTICELLO

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 7,614	\$ 22,940	\$ 166	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	22,940	298	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	22,940	565	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	22,940	388	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	22,940	719	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	22,940	542	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	22,940	198	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	22,940	253	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	22,940	838	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 182,245	\$	\$ 3,968	25

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	\$ 14,427	\$ 22,940	\$ 314	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412	22,940	314	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076	22,940	132	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748	22,940	38	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201	22,940	70	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798	22,940	496	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544	22,940	142	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317	22,940	2,511	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973	22,940	783	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299	22,940	943	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821	22,940	279	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	\$	\$ 6,023	25

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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		\$	\$		6,750	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		6,750	25

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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 Springfield, Llc

0051086 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 Springfield, Llc

0051086

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 Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Midwest Bank		X	Mortgage			\$	\$ 2,700,000			\$	103,837						
2																		
3																		
4																		
5					-													
Working Capital																		
6	Assurance		X	Insurance Financing								177						
7	First Midwest Bank		X	Line of Credit				340,542	12/11/2017	3.7340		13,910						
8					-													
9	TOTAL Facility Related						\$	\$ 3,040,542			\$	117,924						
B. Non-Facility Related*																		
10	Interest Income		X									(3,227)						
11	Building Co. Interest Income		X									(4)						
12	Allocated Aperion Care	X										3,181						
13	See Supplemental Schedule				-							1,336						
14	TOTAL Non-Facility Related						\$	\$			\$	1,286						
15	TOTALS (line 9+line14)						\$	\$ 3,040,542			\$	119,210						

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 Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
6																				
7	TOTAL Long-Term																			
Working Capital																				
8																				
9																				
10																				
11																				
12																				
13																				
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15	Allocated Aperion Consulting	X								11										
16	Allocated Chase Office	X								783										
17	Allocated 8131 Monticello	X								542										
18																				
19																				
20	TOTAL Non-Facility Related									1,336										

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2015 report.		\$	<u>17,838</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>19,890</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,052</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>19,052</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>21,104</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>16,491</u>	8
	2012	<u>16,907</u>	9
	2013	<u>17,236</u>	10
	2014	<u>17,630</u>	11
	2015	<u>18,109</u>	12

2016 Accrual = 18109 x 1.05 = 19052 (rounded)

Allocated from 8131 Monticello = \$838

Allocated from Chase Office, LLC = \$943

FOR BHF USE ONLY

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

NOTES:

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

Facility Name & ID Number Aperion Care Springfield, LLC

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>525 South MLK Drive, LLC</u>		<u>2011</u>	<u>\$ 183,518</u>	<u>1</u>
2	<u>Allocated from Chase Office, LLC</u>			<u>1,352</u>	<u>2</u>
3	TOTALS			\$ 184,870	3

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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	65	2011	1972	\$ 639,905	\$ 11,170	35	\$ 18,283	\$ 7,113	\$ 115,792	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2011	19,082		20	1,908	1,908	13,340	9
10	Various		2012	161,607		20	20,189	20,189	89,697	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			74,752	2,258	1,916	(342)	6,311	68
69				44,315		(44,315)		69
70		\$	895,346	\$	42,296	\$	225,141	70

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

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

Report Period Beginning:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 895,346	\$ 57,743		\$ 42,296	\$ (15,447)	\$ 225,141	1
2	Fire Door	2013	2,828		20	141	141	566	2
3	Installation Of New Cat 5 Cables In All Work Stations	2013	4,800		20	240	240	760	3
4	American Backflow Prevention New Backflow Preventer With Shut	2014	7,200		20	360	360	900	4
5	Installed New Power Vent Hot Water Heater	2015	2,870		20	144	144	275	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)		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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)	\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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)	\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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		\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	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)	\$ 913,044	\$ 57,743		\$ 43,181	\$ (14,562)	\$ 227,641	34

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

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		259	35	225	(34)	2,333	3
4	Allocated from Chase Office, LLC	2016	12,168	130	39	130		130	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	649	104	20	32	(72)	227	9
10	Allocated from Aperion Care	2012	184	14	20	9	(5)	46	10
11	Allocated from Aperion Care	2013	78	9	20	4	(5)	16	11
12									12
13	Allocated from 8131 N Monticello	2010		457	20	197	(260)	2,064	13
14	Allocated from 8131 N Monticello	2013			20	34	34	210	14
15	Allocated from 8131 N Monticello								15
16									16
17	Allocated Chase Office, LLC	2016	61,673	1,285	20	1,285		1,285	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 74,752	\$ 2,258		\$ 1,916	\$ (342)	\$ 6,311	34

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

Facility Name & ID Number Aperion Care Springfield, Llc

0051086

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	\$ 211,966	\$ 445	\$ 23,963	\$ 23,518	10	\$ 120,593	71
72	Current Year Purchases	30,587	1,371	1,565	194	10	1,565	72
73	Fully Depreciated Assets	28,623				10	28,623	73
74								74
75	TOTALS	\$ 271,176	\$ 1,816	\$ 25,528	\$ 23,712		\$ 150,781	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		2010 FORD E350 - Transfer from	2012	\$ 47,641	\$	\$ 5,836	\$ 5,836	5	\$ 33,052	76
77		2005 DODGE CARAVAN USED	2014	5,626		1,004	1,004	5	3,283	77
78		Allocated from Aperion Care	2016	728	148	146	(2)	5	327	78
79		Allocated from Aperion Consulti	2016	505	98	112	14	5	202	79
80	TOTALS			\$ 54,500	\$ 246	\$ 7,098	\$ 6,852		\$ 36,864	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,423,590	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,805	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,807	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,002	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 415,286	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from 8131 N Monticello</u>		<u>65</u>		<u>198</u>			5
6								6
7	TOTAL		65		\$ 198			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: \$ 7,303

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>Prior Period</u>	\$	<u>(5,064)</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>266</u>	18
19					19
20					20
21	TOTAL		\$ -	\$ (4,798)	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				989		989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Supplemental</u>									13
14	TOTAL			\$		\$	989	\$	989	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 63,977	\$ 239,656	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	287,914	287,914	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,682	49,682	6
7	Other Prepaid Expenses		5,688	7
8	Accounts Receivable (owners or related parties)	200,000	1,319,256	8
9	Other(specify): <u>See Attached Schedule</u>	6,895	15,205	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 608,468	\$ 1,917,401	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,440	13
14	Buildings, at Historical Cost		342,849	14
15	Leasehold Improvements, at Historical Cost	92,053	115,665	15
16	Equipment, at Historical Cost	235,049	417,344	16
17	Accumulated Depreciation (book methods)	(236,717)	(489,276)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,122,433	1,552,538	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,212,818	\$ 2,124,560	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,821,286	\$ 4,041,961	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 124,257	\$ 124,257	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	340,542	340,542	29
30	Accrued Salaries Payable	86,043	86,043	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,364	2,364	31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,052	32
33	Accrued Interest Payable	1,014	12,821	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,122	1,122	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 555,342	\$ 586,201	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,700,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	930,251	1,013,959	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 930,251	\$ 3,713,959	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,485,593	\$ 4,300,160	46
47	TOTAL EQUITY(page 18, line 24)	\$ 335,693	\$ (258,199)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,821,286	\$ 4,041,961	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (41,938)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (41,938)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,964	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,333)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 377,631	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 335,693	24 *

* This must agree with page 17, line 47.

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,166,449	1
2	Discounts and Allowances for all Levels	(1,070,780)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,095,669	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 259	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,227	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,227	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,099,155	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	568,483	31
32	Health Care	844,638	32
33	General Administration	783,907	33
B. Capital Expense			
34	Ownership	325,895	34
C. Ancillary Expense			
35	Special Cost Centers	12,207	35
36	Provider Participation Fee	173,061	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,708,191	40
41	Income before Income Taxes (line 30 minus line 40)**	390,964	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 390,964	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,570,539	44
45	Private Pay - Net Inpatient Revenue	5,400	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Insurance</u>	1,519,730	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,095,669	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 Springfield, Llc**

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	2,016	2,120	\$ 80,156	\$ 37.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,419	4,815	108,832	22.60	3
4	Licensed Practical Nurses	7,922	8,648	167,550	19.37	4
5	CNAs & Orderlies	22,164	24,358	261,481	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,914	2,021	25,740	12.74	9
10	Activity Assistants	836	852	7,724	9.07	10
11	Social Service Workers	3,944	4,160	83,284	20.02	11
12	Dietician					12
13	Food Service Supervisor	1,776	1,848	33,934	18.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,315	11,275	108,875	9.66	15
16	Dishwashers					16
17	Maintenance Workers	3,031	3,159	41,179	13.04	17
18	Housekeepers	5,643	6,063	71,347	11.77	18
19	Laundry	2,158	2,369	20,108	8.49	19
20	Administrator	2,024	2,120	94,384	44.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,140	27,521	12.86	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,067	2,158	26,026	12.06	33
34	TOTAL (lines 1 - 33)	72,189	78,106	\$ 1,158,141 *	\$ 14.83	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	\$ 9,600	01-03	35
36	Medical Director	Monthly	16,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	15,400	10-03	38
39	Pharmacist Consultant	105	5,253	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,852	11-03	44
45	Social Service Consultant	5	244	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	164	\$ 50,649		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		
Jackie Liddell	Administrator	0	\$ 94,384	Workers' Compensation Insurance	\$ 10,032	IDPH License Fee	\$ 3,980		
				Unemployment Compensation Insurance	13,847	Advertising: Employee Recruitment	1,088		
				FICA Taxes	85,590	Health Care Worker Background Check			
				Employee Health Insurance	57,323	(Indicate # of checks performed <u>71</u>)	714		
				Employee Meals		Patient Background Checks	13		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	12,125		
				Other Employee Benefits	4,161	Licenses and Permits	1,932		
				Employee Physicals	320	Allocated from Aperion Care	3,370		
				401K	405	Allocated from Aperion Consulting	969		
				Employee Meals	698	See Supplemental Schedule	277		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,384	TOTAL (agree to Schedule V, line 22, col.8)		\$ 172,376	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,583
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Aperion Care, Inc			\$ 87,649				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 87,649				Seminar Expense	4,260	
							Allocated from Aperion Care	1,049	
C. Professional Services							Allocated from Aperion Consulting	678	
Vendor/Payee	Type		Amount				See Supplemental Schedule	30	
Creative Technology Solutions	Data Processing		\$ 6,669				Entertainment Expense	()	
National Datacare Corporation	Data Processing		2,050				(agree to Sch. V, line 24, col. 8)		
Wescom Solutions	Data Processing		10,782						
Galaxy Hosted Software	Data Processing		3,000						
Aperion Care Inc	Data Processing		6,993						
E-Health Data Solutions	Data Processing		1,800						
Relass from Equip to Data Proc	Data Processing		1,557						
Ability Network	Data Processing		3,211						
Point Click Care	Data Processing		2,460						
Aperion Care Inc	Home Office Expense		51,038						
Aperion Financial	Home Office Expense		41,832						
See Supplemental Schedule			59,082						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 190,474	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086

Report Period Beginning:

01/01/16

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$9557
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 645 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. \$ 173,061
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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