

Facility Name & ID Number Aperion Care Forest Park

0049247 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	232	Skilled (SNF)	232	84,912	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	232	TOTALS	232	84,912	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	5,326	112	16,590	22,028	8
9	SNF/PED					9
10	ICF	23,468	1,228	15,004	39,700	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,794	1,340	31,594	61,728	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.70%

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 7/1/2007

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

YES Date 7/1/2007 NO

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

YES NO If YES, enter number of beds certified 232 and days of care provided 12,475

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Forest Park # 0049247 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	322,721	41,803	57,582	422,106		422,106	(22,478)	399,628		1
2	Food Purchase		319,659		319,659		319,659	(15,712)	303,947		2
3	Housekeeping	23,446	9,287	425,841	458,574		458,574		458,574		3
4	Laundry		6,012	176,207	182,219		182,219		182,219		4
5	Heat and Other Utilities			295,270	295,270		295,270	(15,825)	279,445		5
6	Maintenance	85,781	66,988	197,205	349,974		349,974	(14,445)	335,529		6
7	Other (specify):*							4,179	4,179		7
8	TOTAL General Services	431,948	443,749	1,152,105	2,027,802		2,027,802	(64,281)	1,963,521		8
	B. Health Care and Programs										
9	Medical Director			43,500	43,500		43,500		43,500		9
10	Nursing and Medical Records	4,088,925	328,535	91,403	4,508,863		4,508,863	(7,535)	4,501,328		10
10a	Therapy	153,386	23,195		176,581		176,581		176,581		10a
11	Activities	201,756	12,549	1,444	215,749		215,749		215,749		11
12	Social Services	298,778		4,185	302,963		302,963		302,963		12
13	CNA Training										13
14	Program Transportation			90,418	90,418		90,418		90,418		14
15	Other (specify):*							7,814	7,814		15
16	TOTAL Health Care and Programs	4,742,845	364,279	230,950	5,338,074		5,338,074	279	5,338,353		16
	C. General Administration										
17	Administrative	126,137		707,031	833,168		833,168	(602,856)	230,312		17
18	Directors Fees										18
19	Professional Services			698,455	698,455		698,455	(537,877)	160,578		19
20	Dues, Fees, Subscriptions & Promotions			146,008	146,008		146,008	(74,746)	71,262		20
21	Clerical & General Office Expenses	214,405		635,612	850,017		850,017	(363,479)	486,538		21
22	Employee Benefits & Payroll Taxes			953,163	953,163		953,163		953,163		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,331	13,331		13,331	4,729	18,060		24
25	Other Admin. Staff Transportation			8,505	8,505		8,505	19,864	28,369		25
26	Insurance-Prop.Liab.Malpractice			527,968	527,968		527,968	4,030	531,998		26
27	Other (specify):*							26,006	26,006		27
28	TOTAL General Administration	340,542		3,690,073	4,030,615		4,030,615	(1,524,327)	2,506,288		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,515,335	808,028	5,073,128	11,396,491		11,396,491	(1,588,329)	9,808,162		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 Forest Park

#0049247

Report Period Beginning:

01/01/16

Ending:

12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			329,069	329,069		329,069	(139,866)	189,203			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,721	103,721		103,721	9,315	113,036			32
33	Real Estate Taxes			493,331	493,331		493,331	4,793	498,124			33
34	Rent-Facility & Grounds			1,805,770	1,805,770		1,805,770	(30,466)	1,775,304			34
35	Rent-Equipment & Vehicles			19,405	19,405		19,405	2,954	22,359			35
36	Other (specify):*			6,478	6,478		6,478	(6,478)				36
37	TOTAL Ownership			2,757,774	2,757,774		2,757,774	(159,749)	2,598,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		760,641	1,884,521	2,645,162		2,645,162	(130,723)	2,514,439			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			422,266	422,266		422,266		422,266			42
43	Other (specify):*			74,551	74,551		74,551	(74,551)				43
44	TOTAL Special Cost Centers		760,641	2,381,338	3,141,979		3,141,979	(205,274)	2,936,705			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,515,335	1,568,669	10,212,240	17,296,244		17,296,244	(1,953,352)	15,342,892			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 Forest Park**

0049247

Report Period Beginning:

01/01/16

Ending:

12/31/16

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,190)	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	(151,488)	30		9
10	Interest and Other Investment Income	(2,842)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(9,303)	21		18
19	Entertainment	(9,257)	21		19
20	Contributions	(80,150)	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	(515,674)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(144,822)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (930,795)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,022,557)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,022,557)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,953,352)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Aperion Care Forest Park

ID# 0049247

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (38,754)	43	1
2	Marketing Fees	(22,125)	43	2
3	Promotional Products	(13,672)	43	3
4	Bank Charges	(14,294)	21	4
5	Theft & Damage Loss	(4,485)	21	5
6	Amortization	(6,478)	36	6
7	Vending Commissions	(1,250)	02	7
8	Jury Duty Income	(220)	10	8
9	Credit Cared Processing	(3,823)	21	9
10	PAC Dues	(7,018)	20	10
11	Out of Period Legal	(11,160)	19	11
12	Additional R&M	12,582	06	12
13	Capitalized R&M	(34,125)	06	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	(144,822)		49

Aperion Care Forest Park

ID# 0049247
 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 Forest Park# 0049247

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				(22,478)								(22,478)	1
2	Food Purchase	(1,319)		407	(14,800)								(15,712)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(17,190)		74			446	845					(15,825)	5
6	Maintenance	(21,543)		1,644	3,808		801	844					(14,445)	6
7	Other (specify):*			74	3,749			356					4,179	7
8	TOTAL General Services	(40,052)		2,199	(29,721)		1,247	2,046					(64,281)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(220)		7,391	(14,706)								(7,535)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			444	7,370								7,814	15
16	TOTAL Health Care and Programs	(220)		7,835	(7,336)								279	16
	C. General Administration													
17	Administrative			(606,253)		3,397							(602,856)	17
18	Directors Fees													18
19	Professional Services	(11,160)		(295,021)	1,614	(227,908)	1,521	102		(7,025)			(537,877)	19
20	Fees, Subscriptions & Promotions	(87,168)		9,069	2,609	556		188					(74,746)	20
21	Clerical & General Office Expenses	(556,836)		52,135	862	137,980	1,045	1,336					(363,479)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			2,824	1,825	80							4,729	24
25	Other Admin. Staff Transportation			10,188	7,559	2,117							19,864	25
26	Insurance-Prop.Liab.Malpractice			3,647				383					4,030	26
27	Other (specify):*			9,582		16,424							26,006	27
28	TOTAL General Administration	(655,164)		(813,828)	14,469	(67,354)	2,566	2,009		(7,025)			(1,524,327)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(695,436)		(803,794)	(22,588)	(67,354)	3,813	4,055		(7,025)			(1,588,329)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Forest Park # 0049247 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	(151,488)		2,416	370	144	1,935	6,757					(139,866)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,842)		8,560	30		1,459	2,108					9,315	32
33	Real Estate Taxes						2,256	2,537					4,793	33
34	Rent-Facility & Grounds			1,052			(7,519)	(24,000)					(30,466)	34
35	Rent-Equipment & Vehicles			164	715	642	682	751					2,954	35
36	Other (specify):*	(6,478)											(6,478)	36
37	TOTAL Ownership	(160,808)		12,193	1,115	786	(1,187)	(11,847)					(159,749)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(130,723)				(130,723)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(74,551)											(74,551)	43
44	TOTAL Special Cost Centers	(74,551)							(130,723)				(205,274)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(930,795)		(791,602)	(21,473)	(66,568)	2,626	(7,792)	(130,723)	(7,025)			(1,953,352)	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 6-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: 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%	\$ 407	\$ 407
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	74	74
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	1,644	1,644
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	74	74
19	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	7,391	7,391
20	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	444	444
21	V	17 ADMINISTRATIVE		APERION CARE, INC.	100.00%	100,778	100,778
22	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	4,049	4,049
23	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	9,069	9,069
24	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	52,135	52,135
25	V	24 SEMINARS		APERION CARE, INC.	100.00%	2,824	2,824
26	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	10,188	10,188
27	V	26 INSURANCE		APERION CARE, INC.	100.00%	3,647	3,647
28	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	9,582	9,582
29	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	2,416	2,416
30	V	32 INTEREST		APERION CARE, INC.	100.00%	8,560	8,560
31	V	34 RENT		APERION CARE, INC.	100.00%	1,052	1,052
32	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	164	164
33	V						
34	V						
35	V	17 MANAGEMENT FEE	707,031	APERION CARE, INC.	100.00%		(707,031)
36	V	19 HOME OFFICE	281,683	APERION CARE, INC.	100.00%		(281,683)
37	V	19 DATA PROCESSING	17,387	APERION CARE, INC.	100.00%		(17,387)
38	V						
39	Total		\$ 1,006,101			\$ 214,499	\$ * (791,602)

* 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%	\$ 17,792	\$ 17,792 15
16	V	6 REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	10,358	10,358 16
17	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	3,749	3,749 17
18	V	10 SALARY NURSE		APERION CONSULTING, LLC	100.00%	55,194	55,194 18
19	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	7,370	7,370 19
20	V	19 PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	1,614	1,614 20
21	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	2,609	2,609 21
22	V	21 CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	862	862 22
23	V	24 SEMINARS		APERION CONSULTING, LLC	100.00%	1,825	1,825 23
24	V	25 AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	7,559	7,559 24
25	V	30 DEPRECIATION		APERION CONSULTING, LLC	100.00%	370	370 25
26	V	32 INTEREST		APERION CONSULTING, LLC	100.00%	30	30 26
27	V	35 AUTO LEASE		APERION CONSULTING, LLC	100.00%	715	715 27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V	10 CONSULTING	69,900	APERION CONSULTING, LLC	100.00%		(69,900) 34
35	V	01 DIETICIAN	40,270	APERION CONSULTING, LLC	100.00%		(40,270) 35
36	V	02 FOOD SERVICE	14,800	APERION CONSULTING, LLC	100.00%		(14,800) 36
37	V			APERION CONSULTING, LLC	100.00%		37
38	V	06 PROJECT MANAGER	6,550	APERION CONSULTING, LLC	100.00%		(6,550) 38
39	Total		\$ 131,520			\$ 110,047	\$ * (21,473) 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%	\$ 3,397	\$	3,397	15
16	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	2,667		2,667	16
17	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	556		556	17
18	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	137,980		137,980	18
19	V	24 SEMINARS		APERION FINANCIAL, LLC	100.00%	80		80	19
20	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	2,117		2,117	20
21	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	16,424		16,424	21
22	V	30 DEPRECIATION		APERION FINANCIAL, LLC	100.00%	144		144	22
23	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	642		642	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	19 HOME OFFICE EXPENSE	230,575	APERION FINANCIAL, LLC	100.00%			(230,575)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 230,575			\$ 164,007	\$ *	(66,568)	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%	\$ 446	\$	446	15
16	V	6 REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		801		801	16
17	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		1,521		1,521	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		1,045		1,045	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,935		1,935	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,459		1,459	20
21	V	34 RENT		8131 N. MONTICELLO, LLC		533		533	21
22	V	35 EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		682		682	22
23	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,256		2,256	23
24	V								24
25	V								25
26	V	34 RENT	7,000	8131 N. MONTICELLO, LLC				(7,000)	26
27	V	34 RENT	1,052	8131 N. MONTICELLO, LLC				(1,052)	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		\$ 8,052			\$ 10,678	\$ *	2,626	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%	\$ 845	\$	845	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		844		844	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		356		356	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		102		102	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		188		188	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,336		1,336	20
21	V	26 INSURANCE		CHASE OFFICE,LLC		383		383	21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		6,757		6,757	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,108		2,108	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		2,537		2,537	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		751		751	25
26	V	34 RENT	24,000	CHASE OFFICE,LLC				(24,000)	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		\$ 24,000			\$ 16,208	\$ *	(7,792)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 THERAPY SERVICES	\$ 1,749,979	RENEWAL REHAB	100.00%	\$ 1,619,256	\$ (130,723)
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		\$ 1,749,979			\$ 1,619,256	\$ * (130,723)

* 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	\$ 29,259	ProPay HR LLC	24.00%	\$ 22,234	\$ (7,025)
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		\$ 29,259			\$ 22,234	\$ * (7,025)

* 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	04 laundry Services	\$ 176,207	EcoBrite Linen	100.00%	\$ 176,207	\$	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		\$ 176,207			\$ 176,207	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkovitz as Trustee of the Berkovitz		Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	Revocable Trust	47.75%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Yosef Meystel as the Trustee of the Declaration		Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	of Trust of Yosef Meystel	47.75%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	David Kleiner	1.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Mordechai Groner	1.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Isaac Scheiner Ugma Rachel Scheiner	1.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Jacob Scheiner Ugma Ari Scheiner	0.50%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10	Jacob Scheiner Ugma Dov Scheiner	0.50%	Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11	Jacob Scheiner Ugma Nosson Scheiner	0.50%	Aperion Care Galesburg	Galesburg	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Hidden Lake	St. Louis, MO	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Highwood	Highwood	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care International	Chicago	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care Jacksonville	Jacksonville	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Kokomo	Kokomo, IN	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Moline	East Moline	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Oak Lawn	Oak Lawn	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Peru	Peru, IN	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Plum Grove	Palatine	8300 ROOSEVELT, LLC	FOREST PARK	PARKING LOT	22
23			Aperion Care Spring Valley	Spring Valley				23
24			Aperion Care Springfield	Springfield				24
25			Aperion Care St. Elmo	St. Elmo				25
26			Aperion Care Tolleston Park	Gary, IN				26
27			Aperion Care Toluca	Toluca				27
28			Aperion Care Valparaiso	Valparaiso, IN				28
29			Aperion Care Wilmington	Wilmington				29
30			Burgin Manor	Olney				30

Facility Name & ID Number

Aperion Care Forest Park

0049247

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	2.3	5.75%	Alloc. Salary	\$ 11,719	17-07	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	1,809	17-07	2	
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	1.2	6.00%	Alloc. Salary	4,323	21-7	3	
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	2.3	5.75%	Alloc. Salary	11,719	17-07	4	
5	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.2	6.06%	Alloc. Salary	1,767	21-07	5	
6	Meir Meystel	Relative	Clerical	0.00%	See Attached	0.4	5.80%	Alloc. Salary	1,541	21-7	6	
7	Nosson Factor	Relative	Clerical	0.00%	See Attached	1.9	5.78%	Alloc. Salary	4,973	21-7	7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 37,851		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 Forest Park

0049247

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 Forest Park

0049247

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	\$ 61,728	\$ 407	1	
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265	61,728	74	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	61,728	1,644	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271	61,728	74	4	
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	61,728	7,391	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576	61,728	444	6	
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	61,728	100,778	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096	61,728	4,049	8	
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783	61,728	9,069	9	
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	61,728	52,135	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189	61,728	2,824	11	
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887	61,728	10,188	12	
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237	61,728	3,647	13	
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535	61,728	9,582	14	
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232	61,728	2,416	15	
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102	61,728	8,560	16	
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963	61,728	1,052	17	
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801	61,728	164	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,660,864	\$ 2,890,119	\$ 214,499	25	

Facility Name & ID Number Aperion Care Forest Park

0049247

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	\$ 61,728	\$ 17,792	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	61,728	10,358	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982	61,728	3,749	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	61,728	55,194	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781	61,728	7,370	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541	61,728	1,614	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521	61,728	2,609	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707	61,728	862	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152	61,728	1,825	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014	61,728	7,559	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318	61,728	370	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508	61,728	30	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204	61,728	715	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	\$ 110,047	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	\$ 57,979	\$ 61,728	\$ 3,397	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525	61,728	2,667	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485	61,728	556	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	137,980	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360	61,728	80	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125	61,728	2,117	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317	61,728	16,424	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458	61,728	144	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954	61,728	642	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	\$ 164,007	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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	\$ 61,728	\$ 446	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676	61,728	801	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960	61,728	1,521	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828	61,728	1,045	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024	61,728	1,935	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903	61,728	1,459	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100	61,728	533	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640	61,728	682	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500	61,728	2,256	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	\$	\$ 10,678	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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	34	\$ 14,427	\$	61,728	\$ 845	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	34	14,412		61,728	844	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	34	6,076		61,728	356	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	34	1,748		61,728	102	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	34	3,201		61,728	188	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	34	22,798		61,728	1,336	6
7	26	INSURANCE	ACTUAL CENSUS	34	6,544		61,728	383	7
8	30	DEPRECIATION	ACTUAL CENSUS	34	115,317		61,728	6,757	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	34	35,973		61,728	2,108	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	34	43,299		61,728	2,537	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	34	12,821		61,728	751	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	\$		\$ 16,208	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

RENEWAL REHAB

Street Address

8131 N. MONTICELLO

City / State / Zip Code

SKOKIE, IL 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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	39	THERAPY SERVICES	DIRECT		\$	\$		\$ 1,619,256	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				\$	\$		\$ 1,619,256	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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, ILLINOIS 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		\$	\$		\$ 22,234	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				\$	\$		\$ 22,234	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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 EcoBrite Linen
 Street Address 3712 Jarvis Avenue
 City / State / Zip Code Skokie, IL 60076
 Phone Number (847) 582-4000
 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	4	Laundry Services	Direct		\$	\$		\$ 176,207	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				\$	\$		\$ 176,207	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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 Forest Park

0049247

Report Period Beginning:

01/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5				-																
Working Capital																				
6	First Midwest Bank		X	Line of Credit				3,097,051		103,721										
7																				
8				-																
9	TOTAL Facility Related							3,097,051		103,721										
B. Non-Facility Related*																				
10	Interest Income		X							(2,842)										
11	Allocated from Aperion Care		X							8,560										
12	Allocated from Aperion Consulting		X							30										
13	See Supplemental Schedule				-					3,567										
14	TOTAL Non-Facility Related									9,315										
15	TOTALS (line 9+line14)							3,097,051		113,036										

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.)

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital									14										
B. Non-Facility Related*																				
15	Allocated from 8131 N Monticello	X								1,459	15									
16	Allocated from Chase Office	X								2,108	16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related									3,567	20									

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

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

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>468,034</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>485,476</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>17,442</u>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>480,683</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>498,125</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<u>352,742</u>	8
	2012	<u>424,323</u>	9
	2013	<u>435,134</u>	10
	2014	<u>468,034</u>	11
	2015	<u>480,683</u>	12

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

2016 Tax Accrual based on 2015 Tax Bills
Allocated from 8131 N. Monticello = \$2,256
Allocated from Chase Office LLC \$2,537

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 Forest Park COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049247
 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.	<u>15-24-100-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>480,682.73</u>	\$ <u>480,682.73</u>
2.	<u>10-23-325-045-0000</u>	<u>Management Company</u>	\$ <u>65,893.16</u>	\$ <u>1,968.24</u>
3.	<u>10-27-307-027-0000</u>	<u>Home Office</u>	\$ <u>40,836.48</u>	\$ <u>1,000.23</u>
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>587,412.37</u>	\$ <u>483,651.20</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 Forest Park COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049247
 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.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
		TOTALS	\$ <hr/> <hr/>	\$ <hr/> <hr/>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Aperion Care Forest Park

0049247 Report Period Beginning:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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>2016</u>	<u>\$ 3,638</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 3,638	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		2007	15,031		20	833	833	7,790
10	Various		2008	91,691		20	6,786	6,786	63,694
11	Various		2009	60,525		20	5,473	5,473	39,821
12	Various		2010	247,742		20	15,284	15,284	117,933
13	Various		2011	240,578		20	13,722	13,722	76,824
14	Various		2012	323,677		20	17,826	17,826	76,297
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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								68
69								69
70								70
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)		201,147	6,076		5,157	(919)	16,982
69	Financial Statement Depreciation			329,066			(329,066)	
70	TOTAL (lines 4 thru 69)		\$ 1,180,390	\$ 335,142		\$ 65,081	\$ (270,061)	\$ 399,340

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

Facility Name & ID Number Aperion Care Forest Park# 0049247

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,180,390	\$ 335,142		\$ 65,081	\$ (270,061)	\$ 399,340	1
2	Door Replacement	2013	5,450		20	273	273	931	2
3	Plumbing Work	2013	2,800		20	140	140	490	3
4	Electrical Work	2013	3,784		20	189	189	694	4
5	Concrete Electrical Work	2013	14,950		20	1,495	1,495	4,610	5
6	Expansion Power Supply	2013	5,025		20	251	251	879	6
7	Fire Dampers	2013	3,978		20	199	199	796	7
8	Guest Bathrooms: Plumbing, Wall Tile & Flooring, Repair Drywa	2013	9,287		20	929	929	3,018	8
9	2Nd Floor Corridor: Sconces & Their Installation	2013	7,046		20	352	352	1,145	9
10	Rooms 204-211: Floor Work, Electrical Outlets, Lighting, Bumper	2013	25,894		20	1,295	1,295	4,208	10
11	Various Areas: Painting	2013	7,292		20	365	365	1,185	11
12	Physicians Lounge: Replace Flooring, Installation Of Kitchen Cab	2013	11,381		20	569	569	1,849	12
13	2Nd Floor Nurses Station: Install Reatec On Nurses Station	2013	25,074		20	1,254	1,254	4,075	13
14	2Nd Floor Mds Office: Floor Prep, New Flooring	2013	2,858		20	143	143	464	14
15	2Nd Floor Theater: Remove Old Carpet And Install New	2013	10,614		20	531	531	1,725	15
16	3 Floor Dining Room: Lighting	2013	4,001		20	200	200	650	16
17	3Rd Floor Nurses Station: Bumper Rail	2013	3,007		20	150	150	489	17
18	Pump Repair	2013	5,265		20	263	263	943	18
19	Upholstered Cornice	2013	6,932		20	347	347	1,098	19
20	Pavement Resurfacing	2014	29,851		20	1,990	1,990	5,141	20
21	New D/F Illuminated Display Aluminum Sign	2014	9,146		20	1,829	1,829	4,725	21
22	Remove Cove Base & Vct; Pvt & Cove Base Installation	2014	9,541		20	477	477	1,431	22
23	Nac Panel Repair	2014	2,794		20	559	559	1,676	23
24	Install Circuits On Emergrncy Panel	2014	3,385		20	169	169	480	24
25	Elevator Hydraulic Repairs - New Oil Coolers	2014	23,800		20	1,190	1,190	3,570	25
26	Elevator Repairs - 3 Units - Replace Leaky Gaskets, Valves	2014	14,500		20	725	725	2,054	26
27	2Nd Floor Nourishment Room - Replacement Of Solid Surface To	2014	11,657		20	583	583	1,748	27
28	New Hot Water Heater & Tank	2014	24,900		20	1,245	1,245	2,801	28
29	New Air Handler Pump	2014	3,477		20	174	174	449	29
30	2 Elevator Keypads	2014	3,150		20	158	158	368	30
31	Replaced Elevator Door Motor	2014	2,728		20	136	136	398	31
32	4Th Floor Signage, Wallcovering, Handrails, Paint Nurses Lounge	2014	43,505		20	2,175	2,175	4,532	32
33	4Th Floor Corridor-Remove Soffit, Install New Suspended Grid &	2014	14,599		20	730	730	1,521	33
34	TOTAL (lines 1 thru 33)		\$ 1,532,059	\$ 335,142		\$ 86,165	\$ (248,977)	\$ 459,482	34

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

Facility Name & ID Number Aperion Care Forest Park# 0049247

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,532,059	\$ 335,142		\$ 86,165	\$ (248,977)	\$ 459,482	1
2	4Th Floor Corridor & Nurses Station - New Light Fixtures	2014	12,455		20	623	623	1,297	2
3	4Th Floor Corridor - Remove Wood Base & Vct, Pvt Installation	2014	19,417		20	971	971	2,023	3
4	4Th Flr Corridor & Nrs Station-Ceiling Tile, Floor Prep, Semi-Cu	2014	41,018		20	2,051	2,051	4,273	4
5	4Th Floor Wallcovering Materials	2014	14,604		20	730	730	1,521	5
6	Installation Of New Bumper Guards & Corner Guards	2014	12,061		20	603	603	1,256	6
7	4Th Floor Lockers, Demo & Install New Tile, Plumbing, Paint Wa	2014	3,198		20	160	160	333	7
8	4Th Flr Dining Rm-New Light Fixtures, Ceiling Tile, Wall Sheetin	2014	27,306		20	1,365	1,365	2,844	8
9	4Th Floor Nourishment Room - Custom Cabinets	2014	6,172		20	309	309	643	9
10	3 Exhaust Fans For Each Oxygen Rm With Fresh Air Ducting	2015	8,900		20	445	445	890	10
11	Voip Cable Wiring	2015	5,120		20	256	256	469	11
12	Landscaping: Retaining Wall, Debris Removal, Drainage, Planting	2015	56,533		20	2,827	2,827	4,947	12
13	Lobby: Wallcovering, Ceramic Tile, Atrium: Ceramic Tile, 4Th Fl	2015	84,676		20	4,234	4,234	6,704	13
14	4Th Fl Corridor Nurses Station Countertop & Lobby Light Fixtur	2015	25,789		20	1,289	1,289	2,042	14
15	Pump Motor And Relay Board	2015	4,906		20	245	245	388	15
16	Connect All Resident Rms & Nurses Stations To Phone Lines	2015	2,600		20	130	130	184	16
17	Chiller	2015	14,679		20	734	734	979	17
18	4Th Floor Dining Room Window Treatments	2015	4,393		20	220	220	311	18
19	Door Wander Control	2015	9,579		20	479	479	679	19
20	Reception Counter, 2Nd Floor 2-Tier Lockers	2015	6,781		20	339	339	396	20
21	2 Elevator Floors, Handrails, Walls & 2Nd Fl Guest Bath Plumbin	2015	49,796		20	2,490	2,490	2,697	21
22	Replace Laundry Exhaust Fan	2015	3,219		20	161	161	188	22
23	Atrium: Framing,Electrical,Lighting,Wallcovering,Tile,Fireplace	2015	103,434		20	5,172	5,172	9,481	23
24	3Rd Flr Shwr Rm: New Drywall,Floor & Wall Tile,Shower Fixtur	2015	50,134		20	2,507	2,507	4,596	24
25	4Th Flr Lockers & Mds Office: New Tile, Custom Workstations	2015	10,430		20	522	522	956	25
26	Roof Patch Up	2015	4,550		20	228	228	265	26
27	Replace Elevator Motor & Door Board	2015	3,141		20	157	157	236	27
28	Repair Multiple Exhaust Fans	2015	4,661		20	233	233	291	28
29	Door And Latch For Chiller	2016	11,736		20	587	587	587	29
30	Excavation/Gravel/Concrete-West & East Side Of Building	2016	5,400		20	203	203	203	30
31	Dialysis Center (98,000)-Demolition,Drywall,Painting,Flooring...	2016	77,851		20	729	729	729	31
32	Cable For Camera	2016	5,611		20	140	140	140	32
33	Condenser Fan Motos & Blades On Chiller	2016	16,803		20	210	210	210	33
34	TOTAL (lines 1 thru 33)		\$ 2,239,013	\$ 335,142		\$ 117,511	\$ (217,631)	\$ 512,240	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	Totals from Page 12C, Carried Forward		\$ 2,239,013	\$ 335,142		\$ 117,511	\$ (217,631)	\$ 512,240	1
2	Replaced Bad Power Supply	2016	6,740		20	337	337	337	2
3	Installed New Valves For Chiller A/C And Boiler	2016	5,395		20	270	270	270	3
4	Replace Pump And Motor Assembly And Wire	2016	10,815		20	541	541	541	4
5	Kitchen Air Handler - Frozen Busted Coil	2016	2,982		20	149	149	149	5
6	Elevator Wander Guard Kit	2016	3,510		20	176	176	176	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)		\$ 2,268,456	\$ 335,142		\$ 118,983	\$ (216,159)	\$ 513,712	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		\$ 2,268,456	\$ 335,142		\$ 118,983	\$ (216,159)	\$ 513,712	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		\$ 2,268,456	\$ 335,142		\$ 118,983	\$ (216,159)	\$ 513,712	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010		697	35	606	(91)	6,277	3
4	Allocated from Chase Office	2016	32,743	350	35	350		350	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	1,746	281	20	87	(194)	611	9
10	Allocated from Aperion Care	2012	495	38	20	25	(13)	124	10
11	Allocated from Aperion Care	2013	211	24	20	11	(13)	42	11
12									12
13	Allocated from 8131 N. Monticello	2010		1,229	20	529	(700)	5,555	13
14	Allocated from 8131 N. Monticello	2013			20	92	92	566	14
15									15
16	Allocated from Chase Office	2016	165,952	3,457	20	3,457		3,457	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)		\$ 201,147	\$ 6,076		\$ 5,157	\$ (919)	\$ 16,982	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		\$ 201,147	\$ 6,076		\$ 5,157	\$ (919)	\$ 16,982	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)	\$ 201,147	\$ 6,076		\$ 5,157	\$ (919)	\$ 16,982	34

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

Facility Name & ID Number Aperion Care Forest Park

0049247

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	\$ 464,920	\$ 1,196	\$ 65,300	\$ 64,104	10	\$ 257,746	71
72	Current Year Purchases	86,366	3,691	4,255	564	10	4,255	72
73	Fully Depreciated Assets	112,436				10	112,436	73
74								74
75	TOTALS	\$ 663,722	\$ 4,887	\$ 69,555	\$ 64,668		\$ 374,437	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2016	\$ 1,960	\$ 398	\$ 392	\$ (6)	5	\$ 880	76
77		Allocated from Aperion Consulti	2016	1,358	264	272	8	5	543	77
78										78
79										79
80	TOTALS			\$ 3,318	\$ 662	\$ 664	\$ 2		\$ 1,423	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)	\$ 2,939,134	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 340,691	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 189,203	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (151,488)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 889,572	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	Renovations	\$ 606,958	92
93			93
94			94
95		\$ 606,958	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: Forest Park Property

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>232</u>		\$ <u>1,774,770</u>			3
4	Additions							4
5	<u>Allocated from 8131 N. Monticello</u>				<u>533</u>			5
6								6
7	TOTAL		232		\$ 1,775,303			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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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: \$ 21,644 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Aperion Consulting</u>		\$ _____	\$ <u>715</u>	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 715	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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 682,846							\$ 682,846		1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				253,676							253,676		2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs				813,459							813,459		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							686,333				686,333		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>						134,540			74,308				208,848		13
14	TOTAL				\$		\$ 1,884,521			\$ 760,641				\$ 2,645,162		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	\$ 389,025	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,028,299		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	393,563		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	186,500		8
9	Other(specify): <u>See Attached Schedule</u>	287,094		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,284,481	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,218,710		15
16	Equipment, at Historical Cost	546,780		16
17	Accumulated Depreciation (book methods)	(1,354,741)		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>	4,812,240		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,222,989	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,507,470	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,653,923	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,097,051		29
30	Accrued Salaries Payable	525,047		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,291		31
32	Accrued Real Estate Taxes(Sch.IX-B)	480,683		32
33	Accrued Interest Payable	10,560		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	3,790,664		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,583,219	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,583,219	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,924,251	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,507,470	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,154,736	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,154,734	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(210,083)	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	(20,400)	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)	\$ (230,483)	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)	\$ 1,924,251	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	\$ 17,138,406	1
2	Discounts and Allowances for all Levels	(236,441)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,901,965	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,263	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,263	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	26,900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,788	19
20	Radiology and X-Ray	824	20
21	Other Medical Services	3,109	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,621	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,842	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,842	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,470	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,470	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,086,161	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,027,802	31
32	Health Care	5,338,074	32
33	General Administration	4,030,615	33
B. Capital Expense			
34	Ownership	2,757,774	34
C. Ancillary Expense			
35	Special Cost Centers	2,719,713	35
36	Provider Participation Fee	422,266	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,296,244	40
41	Income before Income Taxes (line 30 minus line 40)**	(210,083)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (210,083)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,225,570	44
45	Private Pay - Net Inpatient Revenue	381,255	45
46	Medicare - Net Inpatient Revenue	7,165,795	46
47	Other-(specify) <u>Insurance</u>	4,129,345	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,901,965	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 Forest Park

0049247

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,120	2,200	\$ 88,664	\$ 40.30	1
2	Assistant Director of Nursing	1,696	1,760	76,753	43.61	2
3	Registered Nurses	30,255	32,451	1,049,738	32.35	3
4	Licensed Practical Nurses	43,982	47,457	1,389,594	29.28	4
5	CNAs & Orderlies	109,125	116,539	1,448,972	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,650	8,753	153,386	17.52	8
9	Activity Director	1,520	1,613	33,243	20.61	9
10	Activity Assistants	14,650	15,808	168,513	10.66	10
11	Social Service Workers	11,575	12,411	298,778	24.07	11
12	Dietician					12
13	Food Service Supervisor	3,506	4,051	74,679	18.43	13
14	Head Cook	5,300	5,986	70,359	11.75	14
15	Cook Helpers/Assistants	14,910	16,210	177,683	10.96	15
16	Dishwashers					16
17	Maintenance Workers	3,832	4,126	85,781	20.79	17
18	Housekeepers	2,024	2,079	23,446	11.28	18
19	Laundry					19
20	Administrator	2,608	2,656	91,494	34.45	20
21	Assistant Administrator	1,728	1,760	34,643	19.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,627	12,052	214,405	17.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,984	2,046	35,204	17.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	269,092	289,958	\$ 5,515,335 *	\$ 19.02	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	1,001	\$ 57,582	01-03	35
36	Medical Director	Monthly	43,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	932	74,100	10-03	38
39	Pharmacist Consultant	Monthly	17,303	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	28	1,444	11-03	44
45	Social Service Consultant	70	4,185	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,031	\$ 198,114		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Aperion Care Forest Park**

0049247

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

Ending: **12/31/16**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Valerie Buniao	Administrator	0	\$ 72,338	Workers' Compensation Insurance	\$ 202,348	IDPH License Fee	\$		
Yael Weinschneider	Admin in Training	0	19,155	Unemployment Compensation Insurance	55,035	Advertising: Employee Recruitment	7,993		
Doivid Seiter	Assistant Admin	0	34,643	FICA Taxes	417,786	Health Care Worker Background Check	3,474		
				Employee Health Insurance	218,136	(Indicate # of checks performed <u>347</u>)			
				Employee Meals		Patient Background Checks	<u>307</u> 3,077		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	35,606		
				Union Pension Fund	35,387	Licenses & Fees	8,690		
				401K Expense	2,728	Allocated from Aperion Care	9,069		
				Employee Physicals	2,560	Allocated from Aperion Consulting	2,609		
				Other Employee Benefits	19,183	See Supplemental Schedule	744		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,136	TOTAL (agree to Schedule V, line 22, col.8)		\$ 953,163	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 71,262
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	
Aperion Care - Management Fees			\$ 707,031			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 707,031				Seminar Expense	13,331	
							Allocated from Aperion Care	2,824	
							Allocated from Aperion Consulting	1,825	
							See Supplemental Schedule	80	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 698,455	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 18,060

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Forest Park# 0049247

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 \$21,265
- (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. \$ 48,199 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 422,266
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees