FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053991

Facility Name: Aperion Care Toluca

Address: 101 E Via Ghiglieri (Number) Toluca (City) 61369 (Zip Code)

County: Marshall

Telephone Number: (815) 452-2367 **Fax #** (815) 452-2947

HFS ID Number:

Date of Initial License for Current Owners: 12/1/2015

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Aperion Care Toluca # 0053991 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,986	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,078	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,620	1,620	8
9	SNF/PED					9
10	ICF	19,266	836	3,194	23,296	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,266	836	4,814	24,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.46%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 04/01/15

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/15 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 65 and days of care provided 1,620

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Aperion Care Toluca # 0053991 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	218,360	16,825	14,560	249,745		249,745	(6,978)	242,767			1
2	Food Purchase		155,104		155,104		155,104	(687)	154,417			2
3	Housekeeping	119,442	17,308		136,750		136,750		136,750			3
4	Laundry	46,161	6,687		52,848		52,848		52,848			4
5	Heat and Other Utilities			87,917	87,917		87,917	(6,654)	81,263			5
6	Maintenance	57,869	25,564	79,475	162,908		162,908	14,615	177,523			6
7	Other (specify):*							1,687	1,687			7
8	TOTAL General Services	441,832	221,488	181,952	845,272		845,272	1,983	847,255			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,393,768	183,606	69,741	1,647,115		1,647,115	(36,338)	1,610,777			10
10a	Therapy	3,601			3,601		3,601		3,601			10a
11	Activities	81,770	4,722	130	86,622		86,622		86,622			11
12	Social Services	74,624		3,153	77,777		77,777		77,777			12
13	CNA Training											13
14	Program Transportation			115	115		115		115			14
15	Other (specify):*							3,154	3,154			15
16	TOTAL Health Care and Programs	1,553,763	188,328	85,139	1,827,230		1,827,230	(33,185)	1,794,045			16
	C. General Administration											
17	Administrative	76,488		184,161	260,649		260,649	(142,111)	118,538			17
18	Directors Fees											18
19	Professional Services			163,218	163,218		163,218	(90,953)	72,265			19
20	Dues, Fees, Subscriptions & Promotions			60,253	60,253		60,253	(44,783)	15,470			20
21	Clerical & General Office Expenses	78,041		134,776	212,817		212,817	3,342	216,159			21
22	Employee Benefits & Payroll Taxes			306,591	306,591		306,591		306,591			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,597	6,597		6,597	1,909	8,506			24
25	Other Admin. Staff Transportation			6,012	6,012		6,012	8,018	14,030			25
26	Insurance-Prop.Liab.Malpractice			75,429	75,429		75,429	1,627	77,056			26
27	Other (specify):*							10,498	10,498			27
28	TOTAL General Administration	154,529		937,037	1,091,566		1,091,566	(252,454)	839,112			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,150,124	409,816	1,204,128	3,764,068		3,764,068	(283,655)	3,480,413			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 Toluca #0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			12,188	12,188		12,188	(2,133)	10,055			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,315	26,315		26,315	4,657	30,972			32
33	Real Estate Taxes			18,181	18,181		18,181	1,935	20,116			33
34	Rent-Facility & Grounds			380,206	380,206		380,206	(29,785)	350,421			34
35	Rent-Equipment & Vehicles			13,632	13,632		13,632	1,192	14,824			35
36	Other (specify):*											36
37	**TOTAL Ownership**			450,522	450,522		450,522	(24,134)	426,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,365	306,035	434,400		434,400	(22,732)	411,668			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,032	199,032		199,032		199,032			42
43	Other (specify):*			14,458	14,458		14,458	(14,458)				43
44	**TOTAL Special Cost Centers**		128,365	519,525	647,890		647,890	(37,190)	610,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,150,124	538,181	2,174,175	4,862,480		4,862,480	(344,979)	4,517,501			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 Toluca # 0053991 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(399)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,205)	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	(6,823)	30		9
10	Interest and Other Investment Income	(250)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(718)	21		18
19	Entertainment	(1,556)	21		19
20	Contributions	(49,797)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,422)	21		24
25	Fund Raising, Advertising and Promotional	(12,708)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	7,499			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,431)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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)	(206,549)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (206,549)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (344,980)		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 Yes	2 No	3 Amount	4 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

Aperion Care Toluca

ID# 0053991

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Legal Fees	$ (98)	19	1
2	Marketing/Adverstising	(1,750)	43	2
3	Bank Charges	(5,916)	21	3
4	Theft/Damage Loss	(90)	21	4
5	Additional R&M	15,356	06	5
6	Credit Card Processing	(3)	21	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				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**	7,499		49

Aperion Care Toluca

ID# 0053991

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 Toluca # 0053991 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(6,978)								(6,978)	1
2	Food Purchase	(451)		164	(400)								(687)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,205)		30			180	341					(6,654)	5
6	Maintenance	15,356		664	(2,069)		323	341					14,615	6
7	Other (specify):*			30	1,513			144					1,687	7
8	**TOTAL General Services**	7,700		888	(7,934)		504	826					1,983	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			2,983	(39,321)								(36,338)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			179	2,975								3,154	15
16	**TOTAL Health Care and Programs**			3,162	(36,347)								(33,185)	16
	C. General Administration													
17	Administrative			(143,483)		1,371							(142,111)	17
18	Directors Fees													18
19	Professional Services	(98)		(48,772)	651	(40,164)	614	41		(3,225)			(90,953)	19
20	Fees, Subscriptions & Promotions	(49,797)		3,661	1,053	224		76					(44,783)	20
21	Clerical & General Office Expenses	(74,705)		21,044	348	55,694	422	539					3,342	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,140	737	32							1,909	24
25	Other Admin. Staff Transportation			4,112	3,051	854							8,018	25
26	Insurance-Prop.Liab.Malpractice			1,472				155					1,627	26
27	Other (specify):*			3,868		6,630							10,498	27
28	**TOTAL General Administration**	(124,600)		(156,957)	5,840	24,641	1,036	811		(3,225)			(252,454)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,900)		(152,907)	(38,440)	24,641	1,539	1,637		(3,225)			(283,655)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Toluca # 0053991 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,823)		975	149	58	781	2,727					(2,133)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(250)		3,455	12		589	851					4,657	32
33	Real Estate Taxes						911	1,024					1,935	33
34	Rent-Facility & Grounds			425			(7,210)	(23,000)					(29,785)	34
35	Rent-Equipment & Vehicles			66	289	259	275	303					1,192	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(7,073)		4,921	450	317	(4,654)	(18,095)					(24,134)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(22,732)				(22,732)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,458)											(14,458)	43
44	**TOTAL Special Cost Centers**	(14,458)							(22,732)				(37,190)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(138,431)		(147,986)	(37,991)	24,958	(3,115)	(16,458)	(22,732)	(3,225)			(344,979)	45

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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.**

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	APERION CARE, INC.	100.00%	$ 164	$ 164	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	30	30	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	664	664	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	30	30	18
19	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	2,983	2,983	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	179	179	20
21	V	17	ADMINISTRATIVE		APERION CARE, INC.	100.00%	40,678	40,678	21
22	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,634	1,634	22
23	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,661	3,661	23
24	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	21,044	21,044	24
25	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,140	1,140	25
26	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	4,112	4,112	26
27	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,472	1,472	27
28	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,868	3,868	28
29	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	975	975	29
30	V	32	INTEREST		APERION CARE, INC.	100.00%	3,455	3,455	30
31	V	34	RENT		APERION CARE, INC.	100.00%	425	425	31
32	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	66	66	32
33	V				APERION CARE, INC.	100.00%			33
34	V				APERION CARE, INC.	100.00%			34
35	V	17	MANAGEMENT FEE	184,161	APERION CARE, INC.	100.00%		(184,161)	35
36	V	19	HOME OFFICE	50,406	APERION CARE, INC.	100.00%		(50,406)	36
37	V				APERION CARE, INC.				37
38	V								38
39	Total			$ 234,567			$ 86,581	$ * (147,986)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	APERION CONSULTING, LLC	100.00%	$ 7,182	$ 7,182	15
16	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	4,181	4,181	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	1,513	1,513	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	22,279	22,279	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	2,975	2,975	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	651	651	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,053	1,053	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	348	348	22
23	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	737	737	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	3,051	3,051	24
25	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	149	149	25
26	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	12	12	26
27	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	289	289	27
28	V				APERION CONSULTING, LLC	100.00%			28
29	V				APERION CONSULTING, LLC	100.00%			29
30	V				APERION CONSULTING, LLC	100.00%			30
31	V				APERION CONSULTING, LLC	100.00%			31
32	V				APERION CONSULTING, LLC	100.00%			32
33	V				APERION CONSULTING, LLC	100.00%			33
34	V	10	CONSULTING	61,600	APERION CONSULTING, LLC	100.00%		(61,600)	34
35	V	01	DIETICIAN	14,160	APERION CONSULTING, LLC	100.00%		(14,160)	35
36	V	02	FOOD SERVICE	400	APERION CONSULTING, LLC	100.00%		(400)	36
37	V	06	PAINTER		APERION CONSULTING, LLC	100.00%			37
38	V	06	PROJECT MANAGER	6,250	APERION CONSULTING, LLC	100.00%		(6,250)	38
39	Total			$ 82,410			$ 44,419	$ * (37,991)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	APERION FINANCIAL, LLC	100.00%	$ 1,371	$ 1,371	15
16	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,077	1,077	16
17	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	224	224	17
18	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	55,694	55,694	18
19	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	32	32	19
20	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	854	854	20
21	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	6,630	6,630	21
22	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	58	58	22
23	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	259	259	23
24	V				APERION FINANCIAL, LLC	100.00%			24
25	V				APERION FINANCIAL, LLC	100.00%			25
26	V				APERION FINANCIAL, LLC	100.00%			26
27	V				APERION FINANCIAL, LLC	100.00%			27
28	V				APERION FINANCIAL, LLC	100.00%			28
29	V				APERION FINANCIAL, LLC	100.00%			29
30	V				APERION FINANCIAL, LLC	100.00%			30
31	V				APERION FINANCIAL, LLC	100.00%			31
32	V				APERION FINANCIAL, LLC	100.00%			32
33	V				APERION FINANCIAL, LLC	100.00%			33
34	V	19	HOME OFFICE EXPENSE	41,241	APERION FINANCIAL, LLC	100.00%		(41,241)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,241			$ 66,200	$ * 24,958	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	8131 N. MONTICELLO, LLC	100.00%	$ 180	$ 180	15
16	V	6	REPAIRS & MAINTENANCE		8131 N. MONTICELLO, LLC		323	323	16
17	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		614	614	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		422	422	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		781	781	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		589	589	20
21	V	34	RENT		8131 N. MONTICELLO, LLC		215	215	21
22	V	35	EQUIPMENT RENTAL		8131 N. MONTICELLO, LLC		275	275	22
23	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		911	911	23
24	V								24
25	V								25
26	V	34	RENT	7,000	8131 N. MONTICELLO, LLC			(7,000)	26
27	V	34	RENT	425	8131 N. MONTICELLO, LLC			(425)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,425			$ 4,310	$ * (3,115)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CHASE OFFICE,LLC	100.00%	$ 341	$ 341	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		341	341	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		144	144	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		41	41	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		76	76	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		539	539	20
21	V	26	INSURANCE		CHASE OFFICE,LLC		155	155	21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		2,727	2,727	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		851	851	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,024	1,024	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		303	303	25
26	V	34	RENT	23,000	CHASE OFFICE,LLC			(23,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,000			$ 6,542	$ * (16,458)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 304,307	Renewal Rehab	100.00%	$ 281,575	$ (22,732)	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			$ 304,307			$ 281,575	$ * (22,732)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 13,438	ProPay HR LLC	24.00%	$ 10,213	$ (3,225)	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			$ 13,438			$ 10,213	$ * (3,225)	39

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Trust	21.50%	Aperion Care Amboy	Amboy	HEALTHCARE CONSTRUCTION	CHICAGO	BLDG IMPROVEMENTS	1
2	David Berkowitz Delta Trust	21.50%	Aperion Care Bloomington	Bloomington	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	2
3	David Berkowitz Trust	21.50%	Aperion Care Bridgeport	Bridgeport	4655 W CHASE AVE	LINCOLNWOOD	HOME OFFICE, BUILDING C	3
4	Yosef Meystel Delta Trust	21.50%	Aperion Care Burbank	Burbank	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	Frederick S Frankel	3.00%	Aperion Care Chicago Heights	Chicago Heights	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Steve Turofsky	3.00%	Aperion Care Colfax	Colfax	APERION CARE, INC	SKOKIE	CORPORATE MANAGER	6
7	Jeremy Boshes	3.00%	Aperion Care Demotte	Demotte,IN	APERION CONSULTING, LLC	SKOKIE	CONSULTING CO.	7
8	Michelle Koder	3.00%	Aperion Care Dolton	Dolton	APERION FINANCIAL, LLC	SKOKIE	BOOKKEEPING	8
9	Naftali Wilhelm	2.00%	Aperion Care Elgin	Elgin	CONCERTO DIALYSIS	LINCOLNWOOD	DIALYSIS	9
10			Aperion Care Evanston	Evanston	CONCERTO HOME DIALYSIS	LINCOLNWOOD	DIALYSIS	10
11			Aperion Care Forest Park	Forest Park	CONCERTO RENAL	LINCOLNWOOD	DIALYSIS	11
12			Aperion Care Galesburg	Galesburg	ECO-BRITE	SKOKIE	LAUNDRY	12
13			Aperion Care Hidden Lake	St. Louis, MO	POINTE GROUP CARE, LLC	BOSTON, MA	BOOKKEEPING	13
14			Aperion Care Highwood	Highwood	POINTE PROPERTY, LLC	BOSTON, MA	PROPERTY MANAGEMENT	14
15			Aperion Care International	Chicago	APERION ESTATES PERU	PERU, IN	ALF	15
16			Aperion Care Jacksonville	Jacksonville	APERION CARE DEMOTTE	DEMOTTE, IN	ALF	16
17			Aperion Care Kokomo	Kokomo, IN	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ALF	17
18			Aperion Care Litchfield	Litchfield	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	ILF	18
19			Aperion Care Midlothian	Midlothian	APERION CARE HIDDEN LAKE	ST. LOUIS, MO	MEMORY CARE	19
20			Aperion Care Moline	East Moline	HEIGHTS CROSSING ASSISTED	BROCKTON, MA	ALF	20
21			Aperion Care Oak Lawn	Oak Lawn	PHARMORE	SKOKIE	PHARMACY	21
22			Aperion Care Peru	Peru, IN				22
23			Aperion Care Plum Grove	Palatine				23
24			Aperion Care Spring Valley	Spring Valley				24
25			Aperion Care Springfield	Springfield				25
26			Aperion Care St. Elmo	St. Elmo				26
27			Aperion Care Tolleston Park	Gary, IN				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 Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aperion Care Toluca # 0053991 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attached	0.9	2.25%	Alloc. Salary	$ 4,730	17-7	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.5	1.25%	Alloc. Salary	730	17-7	2
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.5	2.50%	Alloc. Salary	1,745	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.1	3.03%	Alloc. Salary	713	21-7	4
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.9	2.25%	Alloc. Salary	4,730	17-7	5
6	Frederick Frankel	Owner	Administrative	3.00%	See Attached	0.9	2.25%	Alloc. Salary	4,364	17-7	6
7	Steve Turofsky	Owner	Administrative	3.00%	See Attached	0.9	2.25%	Alloc. Salary	4,536	17-7	7
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.8	2.43%	Alloc. Salary	2,007	21-7	8
9	Michelle Koder	Owner	Nursing	3.00%	See Attached	0.9	2.25%	Alloc. Salary	3,140	10-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 26,695		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 Toluca # 0053991 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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Toluca # 0053991 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,053,513	34	$ 6,946	$	24,916	$ 164	1
2	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	1,265		24,916	30	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	28,061	21,169	24,916	664	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,053,513	34	1,271		24,916	30	4
5	10	SALARY- NURSE	ACTUAL CENSUS	1,053,513	34	126,141	126,141	24,916	2,983	5
6	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,053,513	34	7,576		24,916	179	6
7	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	1,719,984	1,519,984	24,916	40,678	7
8	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	69,096		24,916	1,634	8
9	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	154,783		24,916	3,661	9
10	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	889,796	1,222,825	24,916	21,044	10
11	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	48,189		24,916	1,140	11
12	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	173,887		24,916	4,112	12
13	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	62,237		24,916	1,472	13
14	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	163,535		24,916	3,868	14
15	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	41,232		24,916	975	15
16	32	INTEREST	ACTUAL CENSUS	1,053,513	34	146,102		24,916	3,455	16
17	34	RENT	ACTUAL CENSUS	1,053,513	34	17,963		24,916	425	17
18	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	2,801		24,916	66	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,660,864	$ 2,890,119		$ 86,581	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,053,513	34	$ 303,659	$ 303,659	24,916	$ 7,182	1
2	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,053,513	34	176,775	175,516	24,916	4,181	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,053,513	34	63,982		24,916	1,513	3
4	10	SALARY NURSE	PATIENT DAYS	1,053,513	34	941,995	941,995	24,916	22,279	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,053,513	34	125,781		24,916	2,975	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,053,513	34	27,541		24,916	651	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,053,513	34	44,521		24,916	1,053	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,053,513	34	14,707		24,916	348	8
9	24	SEMINARS	PATIENT DAYS	1,053,513	34	31,152		24,916	737	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,053,513	34	129,014		24,916	3,051	10
11	30	DEPRECIATION	PATIENT DAYS	1,053,513	34	6,318		24,916	149	11
12	32	INTEREST	PATIENT DAYS	1,053,513	34	508		24,916	12	12
13	35	AUTO LEASE	PATIENT DAYS	1,053,513	34	12,204		24,916	289	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		$ 44,419	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	ACTUAL CENSUS	1,053,513	34	$ 57,979	$ 57,979	24,916	$ 1,371	1
2	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	45,525		24,916	1,077	2
3	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	9,485		24,916	224	3
4	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,053,513	34	2,354,900	2,320,500	24,916	55,694	4
5	24	SEMINARS	ACTUAL CENSUS	1,053,513	34	1,360		24,916	32	5
6	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,053,513	34	36,125		24,916	854	6
7	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,053,513	34	280,317		24,916	6,630	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	2,458		24,916	58	8
9	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	10,954		24,916	259	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		$ 66,200	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	$ 7,614	$	24,916	$ 180	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	13,676		24,916	323	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	25,960		24,916	614	3
4	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	17,828		24,916	422	4
5	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	33,024		24,916	781	5
6	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	24,903		24,916	589	6
7	34	RENT	ACTUAL CENSUS	1,053,513	34	9,100		24,916	215	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	11,640		24,916	275	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	38,500		24,916	911	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 182,245	$		$ 4,310	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] NO [ ]

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

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: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,053,513	34	$ 14,427	$	24,916	$ 341	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,053,513	34	14,412		24,916	341	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,053,513	34	6,076		24,916	144	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,053,513	34	1,748		24,916	41	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,053,513	34	3,201		24,916	76	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,053,513	34	22,798		24,916	539	6
7	26	INSURANCE	ACTUAL CENSUS	1,053,513	34	6,544		24,916	155	7
8	30	DEPRECIATION	ACTUAL CENSUS	1,053,513	34	115,317		24,916	2,727	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,053,513	34	35,973		24,916	851	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,053,513	34	43,299		24,916	1,024	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,053,513	34	12,821		24,916	303	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 276,616	$		$ 6,542	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	104		$	$		281,575	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					$	$		$ 281,575	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X] NO [ ]

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W MAIN ST
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 10,213	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					$	$		$ 10,213	25

Facility Name & ID Number Aperion Care Toluca # 0053991 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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Toluca # 0053991 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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Toluca # 0053991 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							$	$			$	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Insurance Policies		X								1,905	6
7	The Private Bank		X	Line of Credit				800,000			24,410	7
8	Note Payable - Other		X		-			13,769				8
9	TOTAL Facility Related						$	$ 813,769			$ 26,315	9
	B. Non-Facility Related*											
10	Interest		X								(250)	10
11	Allocated from Aperion Care	X									3,455	11
12	Allocated from Aperion Consul	X									12	12
13	See Supplemental Schedule										1,440	13
14	TOTAL Non-Facility Related						$	$			$ 4,657	14
15	TOTALS (line 9+line14)						$	$ 813,769			$ 30,972	15

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

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

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated from Chase Office, LI	X		Interest Expense			$	$			$ 851	15
16	Allocate from 8131 N Monticell	X		Interest Expense							589	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										1,440	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.)

Facility Name & ID Number Aperion Care Toluca # 0053991 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	23,273	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.)	$	22,662	2
3. Under or (over) accrual (line 2 minus line 1).	$	(611)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	20,727	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.	$	20,116	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	20,333	10
2014	20,249	11
2015	20,727	12

$3024 Adj to Beginning accrual
2016 accrual = 2015 paid taxes
Allocated from 8131 N Monticello = $911
Allocated from Chase Office, LLC = $1024

FOR BHF USE ONLY

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

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Toluca COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0053991

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-206-001	Long Term Care Facility	$ 20,726.74	$ 20,726.74
2.	10-23-325-045-0000	Home Office Allocation	$ 65,893.19	$ 794.47
3.	10-27-307-027-0000	Home Office Allocation	$ 40,836.48	$ 403.74
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 127,456.41	$ 21,924.95

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 Toluca COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0053991

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Chase Office, LLC			$ 1,468	1
2					2
3	TOTALS			$ 1,468	3

Facility Name & ID Number Aperion Care Toluca # 0053991 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		81,191	2,452		2,082	(370)	6,855	68
69	Financial Statement Depreciation			12,188			(12,188)		69
70	TOTAL (lines 4 thru 69)		$ 81,191	$ 14,640		$ 2,082	$ (12,558)	$ 6,855	70

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 81,191	$ 14,640		$ 2,082	$ (12,558)	$ 6,855	1
2	16 Channel Nvr, 11 Cameras & Monitor	2015	6,785		20	339	339	368	2
3	Installation Of Cat5E For Data & Rack	2015	5,115		20	256	256	277	3
4	Trane Rooftop Hvac Unit	2016	7,500		20	250	250	250	4
5	Hvac	2016	3,362		20	98	98	98	5
6	Parking Lot	2016	36,108		20	602	602	602	6
7	Installed Water Heater	2016	5,519		20	368	368	368	7
8	Cut Out And Replaced Concrete	2016	3,058		20	204	204	204	8
9	Removed, Framed And Replaced Drop Ceiling	2016	2,800		20	187	187	187	9
10	Removed Existing Door And Frame, Replaced With Fire Door	2016	2,850		20	190	190	190	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)		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 154,289	$ 14,640		$ 4,575	$ (10,065)	$ 9,398	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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.

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010		281	39	245	(36)	2,534	3
4	Allocated from Chase Office, LLC	2016	13,216	141	39	141		141	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	705	113	10	35	(78)	247	9
10	Allocated from Aperion Care	2012	200	15	15	10	(5)	50	10
11	Allocated from Aperion Care	2013	85	10	10	4	(6)	17	11
12									12
13	Allocated from 8131 N Monticello	2010		496	20	214	(282)	2,242	13
14	Allocated from 8131 N Monticello	2013			20	37	37	228	14
15									15
16	Allocated Chase Office, LLC	2016	66,985	1,396	20	1,396		1,396	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)		$ 81,191	$ 2,452		$ 2,082	$ (370)	$ 6,855	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 81,191	$ 2,452		$ 2,082	$ (370)	$ 6,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 81,191	$ 2,452		$ 2,082	$ (370)	$ 6,855	34

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,644	$ 483	$ 312	$ (171)	10	$ 768	71
72	Current Year Purchases	71,960	1,489	4,901	3,412	10	4,901	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 74,604	$ 1,972	$ 5,213	$ 3,241		$ 5,669	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	$ 791	$ 161	$ 158	$ (3)	5	$ 355	76
77		Allocated from Aperion Consulti	2016	548	106	110	4	5	219	77
78										78
79										79
80	TOTALS			$ 1,339	$ 267	$ 268	$ 1		$ 574	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)	$ 231,700	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,879	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,056	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,823)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,641	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	Architect Fee deposits on	$ 216,212	92
93	interior remodel project		93
94			94
95		$ 216,212	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.

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Segula Properties
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. [X] 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:		104		$ 349,126			3
4	Additions							4
5	Storage				1,080			5
6	Allocated from 8131 N Monticello				215			6
7	TOTAL		104		$ 350,421 **			7

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: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$ 349,126
13.	/2018	$ 349,126
14.	/2019	$ 349,126

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: $ 14,535 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	Allocated from Aperion Consulting		$	$ 289	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 289	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.

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 137,786	$		$ 137,786	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			19,651			19,651	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			146,767			146,767	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				91,491		91,491	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,831	36,874		38,705	13
14	TOTAL			$		$ 306,035	$ 128,365		$ 434,400	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.

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Toluca **#** 0053991 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,028,730		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,133		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	162,100		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,259,963	$	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	62,640		15
16	Equipment, at Historical Cost	53,432		16
17	Accumulated Depreciation (book methods)	(12,287)		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): See Attached Schedule	217,337		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 321,122	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,581,085	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 771,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	813,769		29
30	Accrued Salaries Payable	131,100		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,030		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,727		32
33	Accrued Interest Payable	2,856		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,747,392	$	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	See Attached Schedule	1,426,259		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,426,259	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,173,651	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (592,566)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,581,085	$	48

***(See instructions.)**

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**2015 Income**	(48,200)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (48,200)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(544,366)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (544,366)	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)**	$ (592,566)	24 *

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

Facility Name & ID Number Aperion Care Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,983,375	1
2	Discounts and Allowances for all Levels	(789,206)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,194,169	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	99,756	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 99,756	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	399	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,072	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,902	19
20	Radiology and X-Ray	232	20
21	Other Medical Services	10,333	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,938	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	251	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 251	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,318,114	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	845,272	31
32	Health Care	1,827,230	32
33	General Administration	1,091,566	33
	B. Capital Expense		
34	Ownership	450,522	34
	C. Ancillary Expense		
35	Special Cost Centers	448,858	35
36	Provider Participation Fee	199,032	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,862,480	40
41	**Income before Income Taxes (line 30 minus line 40)****	(544,366)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (544,366)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,425,840	44
45	Private Pay - Net Inpatient Revenue	164,252	45
46	Medicare - Net Inpatient Revenue	744,105	46
47	Other-(specify) Insurance	859,972	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,194,169	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 Toluca # 0053991 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,692	1,832	$ 60,967	$ 33.28	1
2	Assistant Director of Nursing	1,048	1,120	28,543	25.48	2
3	Registered Nurses	9,564	10,671	271,842	25.47	3
4	Licensed Practical Nurses	12,298	12,874	308,987	24.00	4
5	CNAs & Orderlies	49,339	53,291	723,429	13.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	138	138	3,601	26.09	8
9	Activity Director	1,911	2,080	30,192	14.52	9
10	Activity Assistants	4,328	4,513	45,632	10.11	10
11	Social Service Workers	3,633	4,012	74,624	18.60	11
12	Dietician					12
13	Food Service Supervisor	1,902	2,173	40,938	18.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,256	15,156	177,422	11.71	15
16	Dishwashers					16
17	Maintenance Workers	3,463	3,880	57,869	14.91	17
18	Housekeepers	9,875	10,496	119,442	11.38	18
19	Laundry	4,908	5,299	46,161	8.71	19
20	Administrator	1,952	2,120	76,488	36.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,399	4,883	78,041	15.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	322	330	5,946	18.02	33
34	TOTAL (lines 1 - 33)	124,028	134,868	$ 2,150,124 *	$ 15.94	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,560	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	61,600	10-03	38
39	Pharmacist Consultant	Monthly	8,141	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	3	130	11-03	44
45	Social Service Consultant	Monthly	3,153	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3	$ 99,584		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Toluca # 0053991 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Diaz (1/1-6/6/16)	Administrator	0	$ 37,479
Julie Swanson (6/5-12/31/16)	Administrator	0	39,009
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,488

B. Administrative - Other

Description	Amount
Aperion Care - Management Fee	$ 184,161
TOTAL (agree to Schedule V, line 17, col. 3)	$ 184,161
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc	Unemployment Consult	$ 510
Aperion Consulting	Compliance Consulting	4,016
Aperion Care	Compliance Consulting	4,020
Creative Technology Solutions	Data Processing	7,865
National Datacare Corporation	Data Processing	2,499
Wescom Solutions	Data Processing	15,217
Aperion Care	Data Processing	9,607
E Health Data Solutions	Data Processing	2,062
Dmitry Kantarovich	Data Processing	1,100
Ability Network	Data Processing	3,211
See Supplemental Schedule		113,111
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 163,218

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,598
Unemployment Compensation Insurance	44,993
FICA Taxes	161,908
Employee Health Insurance	56,720
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	800
Employee Meals	182
Employee Benefits - Other	2,390
TOTAL (agree to Schedule V, line 22, col.8)	$ 306,591

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,156
Advertising: Employee Recruitment	690
Health Care Worker Background Check	1,871
(Indicate # of checks performed 187)	
Patient Background Checks 84	840
Dues & Subscriptions	5,282
Licenses & Permits	617
Allocated from Aperion Care	3,661
Allocated from Aperion Consulting	1,053
See Supplemental Schedule	300
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,470

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,597
Allocated from Aperion Care	1,140
Allocated from Aperion Consulting	737
See Supplemental Schedule	32
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,506

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Toluca # 0053991 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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,971** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **199,032**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **399**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(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