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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053983

Facility Name: Aperion Care Bloomington

Address: 1509 North Calhoun Street (Number) Bloomington (City) 61701 (Zip Code)

County: Mclean

Telephone Number: (309) 827-6046 **Fax #** (309) 829-1992

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 01/01/17 to 12/31/17 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, 9 Parkway North, Suite 200 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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,705	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			1,196	1,196	8
9	SNF/PED					9
10	ICF	24,463	1,306	5,109	30,878	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,463	1,306	6,305	32,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.11%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 12/1/2015

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 1,196

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	211,566	15,764	16,130	243,460		243,460	(7,710)	235,750			1
2	Food Purchase		184,533		184,533		184,533	(9)	184,524			2
3	Housekeeping		6,000	167,042	173,042		173,042		173,042			3
4	Laundry		6,835	109,522	116,357		116,357	(7,031)	109,326			4
5	Heat and Other Utilities			118,147	118,147		118,147	(3,771)	114,376			5
6	Maintenance	41,794	23,253	146,099	211,146		211,146	(69,645)	141,501			6
7	Other (specify):*							2,860	2,860			7
8	**TOTAL General Services**	253,360	236,385	556,940	1,046,685		1,046,685	(85,306)	961,379			8
	B. Health Care and Programs											
9	Medical Director			16,900	16,900		16,900		16,900			9
10	Nursing and Medical Records	1,704,231	110,618	209,185	2,024,034		2,024,034	(90,884)	1,933,150			10
10a	Therapy	40,868	260		41,128		41,128		41,128			10a
11	Activities	98,247	4,890	297	103,434		103,434		103,434			11
12	Social Services	109,118		9,274	118,392		118,392		118,392			12
13	CNA Training											13
14	Program Transportation			503	503		503		503			14
15	Other (specify):*							4,282	4,282			15
16	**TOTAL Health Care and Programs**	1,952,464	115,768	236,159	2,304,391		2,304,391	(86,603)	2,217,788			16
	C. General Administration											
17	Administrative	61,097		244,958	306,055		306,055	(175,172)	130,883			17
18	Directors Fees											18
19	Professional Services			127,550	127,550	(145)	127,405	(2,905)	124,500			19
20	Dues, Fees, Subscriptions & Promotions			64,102	64,102		64,102	(28,779)	35,323			20
21	Clerical & General Office Expenses	153,272		126,823	280,095		280,095	43,794	323,889			21
22	Employee Benefits & Payroll Taxes			302,142	302,142		302,142		302,142			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,982	6,982		6,982	1,932	8,914			24
25	Other Admin. Staff Transportation			24,355	24,355		24,355	2,268	26,623			25
26	Insurance-Prop.Liab.Malpractice			111,133	111,133		111,133	1,716	112,849			26
27	Other (specify):*							14,406	14,406			27
28	**TOTAL General Administration**	214,369		1,008,045	1,222,414	(145)	1,222,269	(142,739)	1,079,530			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,420,193	352,153	1,801,144	4,573,490	(145)	4,573,345	(314,648)	4,258,697			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 Bloomington #0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			34,651	34,651		34,651	(4,334)	30,317			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,332	39,332		39,332	3,939	43,271			32
33	Real Estate Taxes			25,769	25,769	145	25,914	1,220	27,134			33
34	Rent-Facility & Grounds			668,261	668,261		668,261	(28,000)	640,261			34
35	Rent-Equipment & Vehicles			23,322	23,322		23,322	3,865	27,187			35
36	Other (specify):*			3,823	3,823		3,823	(3,823)				36
37	**TOTAL Ownership**			795,158	795,158	145	795,303	(27,133)	768,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,335	273,287	379,622		379,622	(10,833)	368,789			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,554	258,554		258,554		258,554			42
43	Other (specify):*			17,490	17,490		17,490	(17,490)				43
44	**TOTAL Special Cost Centers**		106,335	549,331	655,666		655,666	(28,323)	627,343			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,420,193	458,488	3,145,633	6,024,314		6,024,314	(370,104)	5,654,210			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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				4
5	Telephone, TV & Radio in Resident Rooms	(4,696)	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	(19,156)	30		9
10	Interest and Other Investment Income	(2,199)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,598)	21		18
19	Entertainment	(236)	21		19
20	Contributions	(33,555)	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	(68,297)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,849)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,661)		$	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)	(221,443)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (221,443)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (370,104)		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 Bloomington

ID# 0053983

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Advertising & Marketing	$ (14,810)	43	1
2	Promotional Products	(2,380)	43	2
3	Bank Charges	(3,181)	21	3
4	Non-Allowable Repairs	(645)	06	4
5	Amortization	(3,823)	36	5
6	Additional R&M	2,442	06	6
7	Collections Expense	(2,542)	21	7
8	PAC Dues	(2,340)	20	8
9	Non-Allowable Legal Expense	(7,340)	19	9
10	Non-Allowable Seminar	(38)	24	10
11	Capitalized R&M	(2,837)	06	11
12	Administrator wages	18,645	17	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**	(18,849)		49

Aperion Care Bloomington

ID# 0053983

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Bloomington # 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(7,710)								(7,710)	1
2	Food Purchase	(75)		63		3							(9)	2
3	Housekeeping													3
4	Laundry								(7,031)				(7,031)	4
5	Heat and Other Utilities	(4,696)		(11)			936						(3,771)	5
6	Maintenance	(1,040)		950	(71,436)		1,881						(69,645)	6
7	Other (specify):*			39	2,532		289						2,860	7
8	**TOTAL General Services**	(5,811)		1,041	(76,614)	3	3,106		(7,031)				(85,306)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			7,187	(98,071)								(90,884)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			363	3,919								4,282	15
16	**TOTAL Health Care and Programs**			7,550	(94,153)								(86,603)	16
	C. General Administration													
17	Administrative	18,645		(196,310)		2,493							(175,172)	17
18	Directors Fees													18
19	Professional Services	(7,340)		3,789	(3,026)	1,137	6,606			(4,071)			(2,905)	19
20	Fees, Subscriptions & Promotions	(35,895)		4,794	1,820	491	11						(28,779)	20
21	Clerical & General Office Expenses	(75,854)		34,161	6,510	77,334	1,643						43,794	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(38)		1,162	676	132							1,932	24
25	Other Admin. Staff Transportation			914	1,291	63							2,268	25
26	Insurance-Prop.Liab.Malpractice			1,716									1,716	26
27	Other (specify):*			3,951	865	9,590							14,406	27
28	**TOTAL General Administration**	(100,482)		(145,823)	8,136	91,240	8,261			(4,071)			(142,739)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(106,293)		(137,232)	(162,630)	91,243	11,367		(7,031)	(4,071)			(314,648)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bloomington # 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	(19,156)		1,243	223	274	13,082						(4,334)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,199)		3,174	15	(385)	3,334						3,939	32
33	Real Estate Taxes						1,220						1,220	33
34	Rent-Facility & Grounds						(28,000)						(28,000)	34
35	Rent-Equipment & Vehicles			2,417	354	330	764						3,865	35
36	Other (specify):*	(3,823)											(3,823)	36
37	TOTAL Ownership	(25,178)		6,834	592	219	(9,600)						(27,133)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(10,833)					(10,833)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(17,190)			(300)								(17,490)	43
44	TOTAL Special Cost Centers	(17,190)			(300)			(10,833)					(28,323)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(148,661)		(130,398)	(162,339)	91,462	1,767	(10,833)	(7,031)	(4,071)			(370,104)	45

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 63	$ 63	15
16	V	5	UTILITIES		APERION CARE, INC.	100.00%	(11)	(11)	16
17	V	6	MAINTENANCE SALARY		APERION CARE, INC.	100.00%	780	780	17
18	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	170	170	18
19	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	39	39	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	100.00%	7,187	7,187	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	363	363	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	100.00%	42,852	42,852	22
23	V	17	MANAGEMENT FEES		APERION CARE, INC.	100.00%	5,796	5,796	23
24	V	19	PROFESSIONAL FEES		APERION CARE, INC.	100.00%	3,789	3,789	24
25	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,794	4,794	25
26	V	21	CLERICAL SALARY		APERION CARE, INC.	100.00%	32,958	32,958	26
27	V	21	CLERICAL & GENERAL		APERION CARE, INC.	100.00%	1,203	1,203	27
28	V	24	SEMINARS		APERION CARE, INC.	100.00%	1,162	1,162	28
29	V	25	AUTO AND TRAVEL		APERION CARE, INC.	100.00%	914	914	29
30	V	26	INSURANCE		APERION CARE, INC.	100.00%	1,716	1,716	30
31	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,951	3,951	31
32	V	30	DEPRECIATION		APERION CARE, INC.	100.00%	1,243	1,243	32
33	V	32	INTEREST		APERION CARE, INC.	100.00%	3,174	3,174	33
34	V	35	AUTO LEASE		APERION CARE, INC.	100.00%	2,396	2,396	34
35	V	35	EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	20	20	35
36	V	17	MANAGEMENT FEE	244,958	APERION CARE, INC.	100.00%		(244,958)	36
37	V								37
38	V								38
39	Total			$ 244,958			$ 114,560	$ * (130,398)	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	DIETITIAN SALARY	$	APERION CONSULTING, LLC	100.00%	$ 8,420	$ 8,420	15
16	V	6	MAINTENANCY SALARY		APERION CONSULTING, LLC	100.00%	9,437	9,437	16
17	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	5	5	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	2,532	2,532	18
19	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	34,629	34,629	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	3,919	3,919	20
21	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	1,224	1,224	21
22	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	1,820	1,820	22
23	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	6,510	6,510	23
24	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	676	676	24
25	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	1,291	1,291	25
26	V	27	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	865	865	26
27	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	223	223	27
28	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	15	15	28
29	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	354	354	29
30	V								30
31	V								31
32	V								32
33	V	43	MARKETING	300	APERION CONSULTING, LLC	100.00%		(300)	33
34	V	10	CONSULTING	132,700	APERION CONSULTING, LLC	100.00%		(132,700)	34
35	V	01	DIETICIAN	16,130	APERION CONSULTING, LLC	100.00%		(16,130)	35
36	V	06	PROJECT MANAGER	76,878	APERION CONSULTING, LLC	100.00%		(76,878)	36
37	V	06	PAINTER	4,000	APERION CONSULTING, LLC	100.00%		(4,000)	37
38	V	19	MANAGED CARE CONSULT	4,250				(4,250)	38
39	Total			$ 234,258			$ 71,919	$ * (162,339)	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 FINANCIAL, LLC	100.00%	$ 3	$ 3	15
16	V	17	ADMINISTRATIVE		APERION FINANCIAL, LLC	100.00%	2,493	2,493	16
17	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC	100.00%	1,137	1,137	17
18	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC	100.00%	491	491	18
19	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC	100.00%	77,334	77,334	19
20	V	24	SEMINARS		APERION FINANCIAL, LLC	100.00%	132	132	20
21	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC	100.00%	63	63	21
22	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC	100.00%	9,590	9,590	22
23	V	30	DEPRECIATION		APERION FINANCIAL, LLC	100.00%	274	274	23
24	V	32	INTEREST		APERION FINANCIAL, LLC	100.00%	(385)	(385)	24
25	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC	100.00%	330	330	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			$			$ 91,462	$ * 91,462	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 936	$ 936	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,881	1,881	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		289	289	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		6,606	6,606	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		11	11	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		1,643	1,643	20
21	V	26	INSURANCE		CHASE OFFICE,LLC				21
22	V	30	DEPRECIATION		CHASE OFFICE,LLC		13,082	13,082	22
23	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		3,334	3,334	23
24	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,220	1,220	24
25	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		764	764	25
26	V	34	RENTAL INCOME	28,000	CHASE OFFICE,LLC			(28,000)	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			$ 28,000			$ 29,767	$ * 1,767	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 268,812	Renewal Rehab	100.00%	$ 257,979	$ (10,833)	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			$ 268,812			$ 257,979	$ * (10,833)	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	04	Laundry	$ 109,522	Ecobrite Linen	100.00%	$ 102,491	$ (7,031)	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			$ 109,522			$ 102,491	$ * (7,031)	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 16,963	ProPay HR LLC	24.00%	$ 12,892	$ (4,071)	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			$ 16,963			$ 12,892	$ * (4,071)	39

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Revocable Trust	21.50%	Aperion Care Bridgeport	Bridgeport	Interbuild Construction	Chicago	Bldg Improvements	1
2	David Berkowitz Delta Trust	21.50%	Aperion Care Burbank	Burbank	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	David Berkowitz Revocable Trust	21.50%	Aperion Care Chicago Heights	Chicago Heights	Propay	Evanston	Payroll Services	3
4	Yosef Meystel Delta Trust	21.50%	Aperion Care Demotte	Demotte,IN	Renewal Rehab	Skokie	Therapy Services	4
5	Fred Frankel	3.00%	Aperion Care Dolton	Dolton	Aperion Care, Inc.	Skokie	Corporate Manager	5
6	Steve Turofsky	3.00%	Aperion Care Elgin	Elgin	Aperion Consulting, Inc.	Skokie	Consulting Co.	6
7	Jeremy Boshes	3.00%	Aperion Care Evanston	Evanston	Aperion Financial, Inc.	Skokie	Bookkeeping	7
8	Michelle Koder	3.00%	Aperion Care Forest Park	Forest Park	Eco-Brite	Skokie	Laundry	8
9	Naftali Wilhelm	2.00%	Aperion Care Plum Grove	Palatine	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Galesburg	Galesburg	Pointe Property, LLC	Boston, MA	Property Management	10
11			Aperion Care Hidden Lake	St. Louis, MO	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Highwood	Highwood	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care International	Chicago	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Jacksonville	Jacksonville	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Kokomo	Kokomo, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Litchfield	Litchfield	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Midlothian	Midlothian	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Moline	East Moline				18
19			Aperion Care Oak Lawn	Oak Lawn				19
20			Aperion Care Peru	Peru, IN				20
21			Aperion Care Spring Valley	Spring Valley				21
22			Aperion Care Springfield	Springfield				22
23			Aperion Care St. Elmo	St. Elmo				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Toluca	Toluca				25
26			Aperion Care Valparaiso	Valparaiso, IN				26
27			Aperion Care Wilmington	Wilmington				27
28			Burgin Manor	Olney				28
29			The Arbors at Michigan City	Michigan City, IN				29
30			Aperion Care Cairo	Cairo				30

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Mascoutah	Mascoutah				1
2			Aperion Care Fairfield	Fairfield				2
3			Aperion Care Marseilles	Marseilles				3
4			Aperion Care West Chicago	Springfield				4
5			Aperion Care Princeton	Princeton				5
6			Aperion Care Capitol	Capitol				6
7			Aperion Care Peoria Heights	Springfield				7
8			Aperion Care Morton Villa	Morton				8
9			Aperion Care Morton Terrace	Morton				9
10			Tonganoxie Management, LLC	Tonganoxie, KS				10
11			Glennon Place Management, LLC	Bolivar, MO				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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	0.00%	See Attached	1.2	3.00%	Alloc Salary	$ 5,796	17-7	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc Salary	838	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.00%	Alloc Salary	199	17-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.088	2.63%	Alloc Salary	742	21-7	4
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc Salary	5,796	17-7	5
6	Fred Frankel	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Alloc Salary	5,315	17-7	6
7	Steve Turofsky	Owner	Administrative	3.00%	See Attached	1.2	3.00%	Alloc Salary	5,796	17-7	7
8	Nosson Factor	Relative	Clerical	0.00%	See Attached	1	3.04%	Alloc Salary	1,988	21-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 26,470		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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,106,839	47	$ 2,158	$	32,074	$ 63	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)		32,074	(11)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	26,901	32,074	780	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855		32,074	170	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359		32,074	39	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	248,007	32,074	7,187	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526		32,074	363	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	1,478,789	32,074	42,852	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000		32,074	5,796	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754		32,074	3,789	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435		32,074	4,794	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	1,137,341	32,074	32,958	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500		32,074	1,203	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097		32,074	1,162	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545		32,074	914	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232		32,074	1,716	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354		32,074	3,951	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899		32,074	1,243	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529		32,074	3,174	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699		32,074	2,396	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707		32,074	20	21
22										22
23										23
24										24
25	TOTALS					$ 3,953,315	$ 2,891,038		$ 114,560	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	DIETITIAN SALARY	PATIENT DAYS	1,106,839	47	$ 290,566	$ 290,566	32,074	$ 8,420	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	325,675	32,074	9,437	2
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162		32,074	5	3
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378		32,074	2,532	4
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	1,194,994	32,074	34,629	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233		32,074	3,919	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241		32,074	1,224	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820		32,074	1,820	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	200,283	32,074	6,510	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340		32,074	676	10
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550		32,074	1,291	11
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866		32,074	865	12
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685		32,074	223	13
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508		32,074	15	14
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204		32,074	354	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,481,871	$ 2,011,519		$ 71,919	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	FOOD	ACTUAL CENSUS	1,106,839	47	$ 92	$	32,074	$ 3	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	86,036	32,074	2,493	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233		32,074	1,137	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932		32,074	491	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	2,630,420	32,074	77,334	5
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567		32,074	132	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179		32,074	63	7
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931		32,074	9,590	8
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460		32,074	274	9
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)		32,074	(385)	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395		32,074	330	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					$ 3,156,251	$ 2,716,455		$ 91,462	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,106,839	47	$ 32,299	$	32,074	$ 936	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905		32,074	1,881	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989		32,074	289	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965		32,074	6,606	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387		32,074	11	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714		32,074	1,643	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47			32,074		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435		32,074	13,082	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060		32,074	3,334	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109		32,074	1,220	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374		32,074	764	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,027,237	$		$ 29,767	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		43	$	$		$ 257,979	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					$	$		$ 257,979	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Ecobrite Linen
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	4	Laundry	Direct			$	$		$ 102,491	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					$	$		$ 102,491	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 , ILLINOIS 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			$	$		$ 12,892	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					$	$		$ 12,892	25

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Retirement Home TV Corp		X	Capitalized Lease				8,875				6
7	The Private Bank		X	Line of Credit				504,894			36,946	7
8	See Supplemental Schedule										6,138	8
9	TOTAL Facility Related						$	$ 513,769			$ 43,084	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,199)	10
11	Insurance Policies		X								2,386	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 187	14
15	TOTALS (line 9+line14)						$	$ 513,769			$ 43,271	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 Bloomington **#** 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	24,562	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.)	$	26,385	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,823	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	25,165	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.)**	$	145	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.	$	27,133	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015	24,562	11
2016	25,165	12

2017 Accrual = 2016 RE Tax
Allocated From Chase Office: $1,220

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bloomington COUNTY Mclean

FACILITY IDPH LICENSE NUMBER 0053983

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-32-427-020	Long Term Care Property	$ 25,165.32	$ 25,165.32
2.	10-27-307-027-0000	Allocated From Chase Office	$ 41,108.68	$ 1,191.25
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,274.00	$ 26,356.57

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Bloomington COUNTY Mclean

FACILITY IDPH LICENSE NUMBER 0053983

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [ ] (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			$ 1,799	1
2					2
3	TOTALS			$ 1,799	3

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		103,229	6,840		4,766	(2,074)	7,033	68
69	Financial Statement Depreciation			34,651			(34,651)		69
70	TOTAL (lines 4 thru 69)		$ 103,229	$ 41,491		$ 4,766	$ (36,725)	$ 7,033	70

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 103,229	$ 41,491		$ 4,766	$ (36,725)	$ 7,033	1
2	Satellite	2015	16,989		20	849	849	1,770	2
3	Cameras, Cables, Monitors, Etc.	2016	10,318		20	516	516	1,032	3
4	Cable For Data	2016	6,506		20	325	325	651	4
5	Remove Old Flooring And Reset Framework	2016	2,540		20	127	127	191	5
6	New Doors	2016	5,030		20	252	252	356	6
7	Kitchen Door	2016	2,786		20	139	139	197	7
8	Parking Lot Done (56,000)	2016	44,486		20	2,224	2,224	2,780	8
9	Water Main Work, Replaced Main Gate Valve	2016	6,004		20	300	300	600	9
10	Heating / Cooling Thermostat Installation	2016	4,771		20	239	239	457	10
11	Roof Exhauster Installation	2016	3,330		20	167	167	236	11
12	Roof Replacement (Original Amount $307,000)	2017	292,540		20	11,513	11,513	11,513	12
13	Installed One Inch Gas Line From Utility Room To Kitchen	2017	2,837		20	142	142	142	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)		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	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
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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)		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	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
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19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 501,367	$ 41,491		$ 21,558	$ (19,933)	$ 26,957	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Chase Office	2016	16,194	415		415		588	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Aperion Care	2010	863	139	20	43	(96)	345	9
10	Allocated From Aperion Care	2012	245	19	20	12	(7)	73	10
11	Allocated From Aperion Care	2013	104	12	20	5	(7)	26	11
12									12
13	Allocated From Chase Office	2017	3,748	246	20	187	(59)	187	13
14	Allocated From Chase Office	2016	82,075	6,009	20	4,104	(1,905)	5,814	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)		$ 103,229	$ 6,840		$ 4,766	$ (2,074)	$ 7,033	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 103,229	$ 6,840		$ 4,766	$ (2,074)	$ 7,033	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 103,229	$ 6,840		$ 4,766	$ (2,074)	$ 7,033	34

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 50,227	$ 7,311	$ 5,092	$ (2,219)	10	$ 8,260	71
72	Current Year Purchases	21,277	413	3,338	2,925	10	3,338	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 71,503	$ 7,724	$ 8,431	$ 707		$ 11,599	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	2017	$ 969	$ 147	$ 194	$ 47	5	$ 629	76
77		Allocated From Aperion Consulti	2017	672	111	134	23	5	403	77
78										78
79										79
80	TOTALS			$ 1,641	$ 258	$ 328	$ 70		$ 1,032	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)	$ 576,310	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,473	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,317	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,156)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 39,588	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	Architech/Planning Fees	$ 241,177	92
93	Facility Renovation		93
94			94
95		$	95

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

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Segula Properties LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 640,261			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 640,261 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,320 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	Facility	General Motors	$ 1,039	$ 12,470	17
18	Allocated From Aperion Care			2,396	18
19					19
20					20
21	TOTAL		$ 1,039	$ 14,866	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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 115,977	$		$ 115,977	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,212			11,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			143,090			143,090	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				82,451		82,451	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					3,008	23,884		26,892	13
14	TOTAL			$		$ 273,287	$ 106,335		$ 379,622	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 Bloomington **#** 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 100	$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	668,477		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	179,843		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	261,600		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,111,020	$	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	407,855		15
16	Equipment, at Historical Cost	43,738		16
17	Accumulated Depreciation (book methods)	(45,099)		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	345,614		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 752,108	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,863,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 712,161	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	513,769		29
30	Accrued Salaries Payable	126,151		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,916		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,165		32
33	Accrued Interest Payable	1,870		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,101		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,387,133	$	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	1,414,629		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,414,629	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,801,762	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (938,634)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,863,128	$	48

***(See instructions.)**

Facility Name & ID Number Aperion Care Bloomington # 0053983 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (415,635)	1
2	Restatements (describe):		2
3	**Bad Debt**	(42,000)	3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (457,633)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(481,001)	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)**	$ (481,001)	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)**	$ (938,634)	24 *

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

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 6,830,683	1
2	Discounts and Allowances for all Levels	(1,454,928)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,375,755	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	161,422	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 161,422	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	392	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,134	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,937	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,199	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,199	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)**	$ 5,543,313	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,046,685	31
32	Health Care	2,304,391	32
33	General Administration	1,222,414	33
	B. Capital Expense		
34	Ownership	795,158	34
	C. Ancillary Expense		
35	Special Cost Centers	397,112	35
36	Provider Participation Fee	258,554	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,024,314	40
41	**Income before Income Taxes (line 30 minus line 40)****	(481,001)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (481,001)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,718,514	44
45	Private Pay - Net Inpatient Revenue	273,089	45
46	Medicare - Net Inpatient Revenue	585,449	46
47	Other-(specify) Insurance	395,829	47
48	Other-(specify) Managed Care	402,874	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,375,755	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 Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,376	1,463	$ 57,046	$ 38.99	1
2	Assistant Director of Nursing	340	340	14,794	43.51	2
3	Registered Nurses	9,335	9,951	308,748	31.03	3
4	Licensed Practical Nurses	18,486	19,714	547,949	27.79	4
5	CNAs & Orderlies	56,366	60,204	757,384	12.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,162	2,378	40,868	17.19	8
9	Activity Director	1,899	2,080	29,780	14.32	9
10	Activity Assistants	3,961	4,321	43,487	10.06	10
11	Social Service Workers	5,344	5,586	109,118	19.53	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,122	38,301	18.05	13
14	Head Cook	4,484	4,949	62,914	12.71	14
15	Cook Helpers/Assistants	10,009	10,525	110,351	10.48	15
16	Dishwashers					16
17	Maintenance Workers	2,104	2,157	41,794	19.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,464	1,629	61,097	37.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,904	1,936	65,167	33.66	23
24	Clerical	6,189	6,529	88,105	13.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,130	1,230	18,310	14.89	31
32	Other Health Care(specify)					32
33	Other(specify)	2,045	2,213	24,980	11.29	33
34	TOTAL (lines 1 - 33)	130,510	139,327	$ 2,420,193 *	$ 17.37	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	276	$ 16,130	01-03	35
36	Medical Director	Monthly	16,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	132,700	10-03	38
39	Pharmacist Consultant	Monthly	8,366	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	6	297	11-03	44
45	Social Service Consultant	171	9,274	12-03	45
46	Other(specify)				46
47	Psychiatric Medical Director	Monthly	10,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	453	$ 193,667		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,162	$ 58,119	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,162	$ 58,119		53

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LeAnn Thomas (1/1/17-9/11/17)	Administrator	0.00%	$ 61,097
Jodi Jude (9/11/17-12/31/17)	Acting Admin.	0.00%	
Transferred in from Wilmington			
on Page 5A $18,645			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,097

B. Administrative - Other

Description	Amount
Management Fees- Aperion Care Inc	$ 244,958
TOTAL (agree to Schedule V, line 17, col. 3)	$ 244,958
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Propay HR	Payroll Processing	$ 16,963
Marcum LLP	Accounting	21,192
See Attached	Legal Fees	8,454
Personnel Planners	Unemployment Consulting	1,074
Aperion Consulting	Managed Care Consulting	4,250
Point Click Care	Data Processing	31,303
Healthcare Construction Solutions	Energy Procurement	800
Interbuild	Energy Procurement	984
Coalfire	Healthcare Consulting	303
MTS Consulting	WOTC	720
Creative Technology Solutions	Data Processing	25,080
See Supplemental Schedule		16,427
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 127,550

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,275
Unemployment Compensation Insurance	29,416
FICA Taxes	183,406
Employee Health Insurance	51,493
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,040
Employee Meals	390
Other Employee Benefits	23,122
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,142

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	$ 1,990
Advertising: Employee Recruitment	12,099
Health Care Worker Background Check	
(Indicate # of checks performed 66)	664
Patient Background Checks 173	1,730
Dues and Subscriptions	5,913
Licenses & Permits	5,811
See Supplemental Schedule	7,116
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,944
See Supplemental Schedule	1,970
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,914

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Bloomington # 0053983 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $4,680**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,311** Line **10-2**

(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. $ **258,554**
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? **No** Indicate the amount. $ **N/A**

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees