



Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,570	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	476		1,475	1,951	8
9	SNF/PED					9
10	ICF	7,024	3,511		10,535	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,500	3,511	1,475	12,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.01%

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)

Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/14

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/14 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 42 and days of care provided 1,244

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Aperion Care St. Elmo, Llc # 0052696 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	99,414	7,387	3,437	110,238		110,238	3,278	113,516		1
2	Food Purchase		81,285		81,285		81,285	(336)	80,949		2
3	Housekeeping	59,895	14,248		74,143		74,143		74,143		3
4	Laundry	34,926	5,691		40,617		40,617		40,617		4
5	Heat and Other Utilities			59,188	59,188		59,188	(8,908)	50,280		5
6	Maintenance	37,624	13,366	49,217	100,207		100,207	(7,983)	92,224		6
7	Other (specify):*							1,114	1,114		7
8	<b>TOTAL General Services</b>	231,859	121,977	111,842	465,678		465,678	(12,835)	452,843		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	792,667	45,625	27,553	865,845		865,845	(9,135)	856,710		10
10a	Therapy		587		587		587		587		10a
11	Activities	49,786	2,596	5,191	57,573		57,573		57,573		11
12	Social Services	32,780			32,780		32,780		32,780		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							1,667	1,667		15
16	<b>TOTAL Health Care and Programs</b>	875,233	48,808	43,744	967,785		967,785	(7,468)	960,317		16
	<b>C. General Administration</b>										
17	Administrative	66,635		111,595	178,230		178,230	(91,686)	86,544		17
18	Directors Fees										18
19	Professional Services			164,904	164,904	(56)	164,848	(76,968)	87,880		19
20	Dues, Fees, Subscriptions & Promotions			77,268	77,268		77,268	(63,357)	13,911		20
21	Clerical & General Office Expenses	34,852		93,021	127,873		127,873	(12,533)	115,340		21
22	Employee Benefits & Payroll Taxes			139,506	139,506		139,506		139,506		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,553	4,553		4,553	767	5,320		24
25	Other Admin. Staff Transportation			5,055	5,055		5,055	883	5,938		25
26	Insurance-Prop.Liab.Malpractice			45,788	45,788		45,788	558	46,346		26
27	Other (specify):*							5,608	5,608		27
28	<b>TOTAL General Administration</b>	101,487		641,690	743,177	(56)	743,121	(236,728)	506,393		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,208,579	170,785	797,276	2,176,640	(56)	2,176,584	(257,031)	1,919,553		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 &amp; ID Number

Aperion Care St. Elmo, Llc

#0052696

Report Period Beginning:

01/01/17

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			44,199	44,199		44,199	25,415	69,614			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,712	15,712		15,712	119,960	135,672			32
33	Real Estate Taxes			24,809	24,809	56	24,865	475	25,340			33
34	Rent-Facility & Grounds			244,000	244,000		244,000	(244,000)				34
35	Rent-Equipment & Vehicles			6,032	6,032		6,032	1,505	7,537			35
36	Other (specify):*			10,398	10,398		10,398	(10,398)	0			36
37	<b>TOTAL Ownership</b>			345,150	345,150	56	345,206	(107,044)	238,162			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,366	195,131	264,497		264,497	(7,388)	257,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,612	99,612		99,612		99,612			42
43	Other (specify):*			25,984	25,984		25,984	(25,984)				43
44	<b>TOTAL Special Cost Centers</b>		69,366	320,727	390,093		390,093	(33,372)	356,721			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,208,579	240,151	1,463,153	2,911,883		2,911,883	(397,446)	2,514,437			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 St. Elmo, Llc

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**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,268)	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	(37,167)	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	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	(820)	21		18
19	Entertainment	(15)	21		19
20	Contributions	(62,123)	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	(54,021)	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	(66,485)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (230,130)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(167,316)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (167,316)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (397,446)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Aperion Care St. Elmo, Llc

ID# 0052696

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Amortization	\$ (10,398)	36	1
2	Advertising/Marketing	(23,211)	43	2
3	Promotional Products	(1,498)	43	3
4	Bank Charges	(4,023)	21	4
5	Meals on Wheels	(132)	02	5
6	Corporate events	(206)	21	6
7	Theft & Damage Loss	(4)	21	7
8	Bldg Co - Amortization	(18,429)	36	8
9	Bldg Co - Professional Fees	(55)	19	9
10	Bldg Co - Accounting Fees/Bookkeeping Fees Yam	(8,025)	19	10
11	Bldg Co - Licenses and Permits	(282)	20	11
12	Bldg Co - State Replacement Tax	(14)	21	12
13	Additional R&M	5,865	06	13
14	Non Allowable Legal Fees	(727)	19	14
15	PAC Dues	(4,004)	20	15
16	Other Unclassified Income	(21)	21	16
17	Non-Allowable Professional Fees	(1,321)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(66,485)		49

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				3,278								3,278	1
2	Food Purchase	(361)		24		1							(336)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,268)		(4)			364						(8,908)	5
6	Maintenance	5,865		369	(14,949)		732						(7,983)	6
7	Other (specify):*			15	986		113						1,114	7
8	<b>TOTAL General Services</b>	<b>(3,764)</b>		<b>404</b>	<b>(10,685)</b>	<b>1</b>	<b>1,209</b>						<b>(12,835)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			2,798	(11,933)								(9,135)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			141	1,526								1,667	15
16	<b>TOTAL Health Care and Programs</b>			<b>2,939</b>	<b>(10,407)</b>								<b>(7,468)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(92,657)		971							(91,686)	17
18	Directors Fees													18
19	Professional Services	(10,128)	13,080	(25,777)	(3,923)	(50,169)	2,572		(2,622)				(76,968)	19
20	Fees, Subscriptions & Promotions	(66,409)	282	1,866	709	191	4						(63,357)	20
21	Clerical & General Office Expenses	(59,124)	14	13,298	2,534	30,105	640						(12,533)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			452	263	52							767	24
25	Other Admin. Staff Transportation			356	503	25							883	25
26	Insurance-Prop.Liab.Malpractice		(110)	668									558	26
27	Other (specify):*			1,538	337	3,733							5,608	27
28	<b>TOTAL General Administration</b>	<b>(135,661)</b>	<b>13,266</b>	<b>(100,256)</b>	<b>422</b>	<b>(15,093)</b>	<b>3,216</b>		<b>(2,622)</b>				<b>(236,728)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(139,425)</b>	<b>13,266</b>	<b>(96,913)</b>	<b>(20,670)</b>	<b>(15,092)</b>	<b>4,425</b>		<b>(2,622)</b>				<b>(257,031)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696

Report Period Beginning:

01/01/17

Ending:

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## 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(37,167)	56,811	484	87	107	5,093						25,415	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2)	117,572	1,236	6	(150)	1,298						119,960	32
33	Real Estate Taxes						475						475	33
34	Rent-Facility & Grounds		(216,000)				(28,000)						(244,000)	34
35	Rent-Equipment & Vehicles			941	138	129	298						1,505	35
36	Other (specify):*	(28,827)	18,429										(10,398)	36
37	<b>TOTAL Ownership</b>	<b>(65,996)</b>	<b>(23,188)</b>	<b>2,661</b>	<b>231</b>	<b>86</b>	<b>(20,837)</b>						<b>(107,044)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(7,388)					(7,388)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(24,709)			(1,275)								(25,984)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(24,709)</b>			<b>(1,275)</b>			<b>(7,388)</b>					<b>(33,372)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(230,130)</b>	<b>(9,922)</b>	<b>(94,252)</b>	<b>(21,714)</b>	<b>(15,006)</b>	<b>(16,412)</b>	<b>(7,388)</b>	<b>(2,622)</b>				<b>(397,446)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 216,000	221 East Cumberland, LLC	100.00%	\$	(216,000)	1
2	V	19 Accounting Fees		221 East Cumberland, LLC	100.00%	8,025	8,025	2
3	V	36 Amortization		221 East Cumberland, LLC	100.00%	18,429	18,429	3
4	V	33 Real Estate Tax	24,809	221 East Cumberland, LLC	100.00%	24,809		4
5	V	30 Depreciation		221 East Cumberland, LLC	100.00%	56,811	56,811	5
6	V	32 Interest	5	221 East Cumberland, LLC	100.00%	117,577	117,572	6
7	V	19 Professional Fees/Legal Fees		221 East Cumberland, LLC	100.00%	55	55	7
8	V	20 Licenses and Permits		221 East Cumberland, LLC	100.00%	282	282	8
9	V	21 State Replacement Tax		221 East Cumberland, LLC	100.00%	14	14	9
10	V	26 Insurance Expense	110	221 East Cumberland, LLC	100.00%		(110)	10
11	V	19 Bookkeeping YAM		221 East Cumberland, LLC	100.00%	5,000	5,000	11
12	V							12
13	V							13
14	Total		\$ 240,924			\$ 231,002	\$ * (9,922)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 FOOD	\$	APERION CARE, INC.	100.00%	\$ 24	\$ 24
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	(4)	(4)
17	V	6 MAINTENANCE SALARY		APERION CARE, INC.	100.00%	303	303
18	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	66	66
19	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	15	15
20	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	2,798	2,798
21	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	141	141
22	V	17 ADMINISTRATIVE SALARIES		APERION CARE, INC.	100.00%	16,682	16,682
23	V	17 MANAGEMENT FEES		APERION CARE, INC.	100.00%	2,256	2,256
24	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	1,475	1,475
25	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	1,866	1,866
26	V	21 CLERICAL SALARY		APERION CARE, INC.	100.00%	12,830	12,830
27	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	468	468
28	V	24 SEMINARS		APERION CARE, INC.	100.00%	452	452
29	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	356	356
30	V	26 INSURANCE		APERION CARE, INC.	100.00%	668	668
31	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	1,538	1,538
32	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	484	484
33	V	32 INTEREST		APERION CARE, INC.	100.00%	1,236	1,236
34	V	35 AUTO LEASE		APERION CARE, INC.	100.00%	933	933
35	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	8	8
36	V	17 MANAGEMENT FEE	111,595	APERION CARE, INC.	100.00%		(111,595)
37	V	19 HOME OFFICE	27,252	APERION CARE, INC.	100.00%		(27,252)
38	V						
39	Total		\$ 138,847			\$ 44,595	\$ * (94,252)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETITIAN SALARY	\$	APERION CONSULTING, LLC	100.00%	\$ 3,278	\$ 3,278	15
16	V	6	MAINTENANCY SALARY		APERION CONSULTING, LLC	100.00%	3,674	3,674	16
17	V	6	REPAIRS & MAINTENANCE		APERION CONSULTING, LLC	100.00%	2	2	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC	100.00%	986	986	18
19	V	10	SALARY NURSE		APERION CONSULTING, LLC	100.00%	13,480	13,480	19
20	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	1,526	1,526	20
21	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC	100.00%	477	477	21
22	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC	100.00%	709	709	22
23	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC	100.00%	2,534	2,534	23
24	V	24	SEMINARS		APERION CONSULTING, LLC	100.00%	263	263	24
25	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC	100.00%	503	503	25
26	V	27	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC	100.00%	337	337	26
27	V	30	DEPRECIATION		APERION CONSULTING, LLC	100.00%	87	87	27
28	V	32	INTEREST		APERION CONSULTING, LLC	100.00%	6	6	28
29	V	35	AUTO LEASE		APERION CONSULTING, LLC	100.00%	138	138	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	10	CONSULTING	25,413	APERION CONSULTING, LLC	100.00%		(25,413)	34
35	V	06	PROJECT MANAGER	18,625	APERION CONSULTING, LLC	100.00%		(18,625)	35
36	V	19	MANAGED CARE	4,400	APERION CONSULTING, LLC	100.00%		(4,400)	36
37	V	43	MARKETING	1,275	APERION CONSULTING, LLC	100.00%		(1,275)	37
38	V								38
39	Total		\$ 49,713				\$ 27,999	\$ * (21,714)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	APERION FINANCIAL, LLC	100.00%	\$ 1	\$ 1	15
16	V	17	ADMINISTRATIVE	APERION FINANCIAL, LLC	100.00%	971	971	16
17	V	19	PROFESSIONAL FEES	APERION FINANCIAL, LLC	100.00%	443	443	17
18	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC	100.00%	191	191	18
19	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC	100.00%	30,105	30,105	19
20	V	24	SEMINARS	APERION FINANCIAL, LLC	100.00%	52	52	20
21	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC	100.00%	25	25	21
22	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC	100.00%	3,733	3,733	22
23	V	30	DEPRECIATION	APERION FINANCIAL, LLC	100.00%	107	107	23
24	V	32	INTEREST	APERION FINANCIAL, LLC	100.00%	(150)	(150)	24
25	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC	100.00%	129	129	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V	19	HOME OFFICE EXPENSE	APERION FINANCIAL, LLC	100.00%		(50,612)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 50,612			\$ 35,606	\$ * (15,006)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 364	\$	364	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		732		732	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		113		113	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		2,572		2,572	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		4		4	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		640		640	20
21	V	26 INSURANCE		CHASE OFFICE,LLC					21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		5,093		5,093	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		1,298		1,298	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		475		475	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		298		298	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			\$ 11,588	\$ *	(16,412)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 183,336	Renewal Rehab	100.00%	\$ 175,948	\$ (7,388)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 183,336			\$ 175,948	\$ * (7,388)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 10,923	ProPay HR LLC	24.00%	\$ 8,301	\$ (2,622)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 10,923			\$ 8,301	\$ * (2,622)

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



**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

VII. RELATED PARTIES

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	David Berkowitz Trust	48.50%	Aperion Care Bloomington	Bloomington	221 East Cumberland, LLC	St. Elmo	Building Co.	1
2	Yosef Meystel Trust	48.50%	Aperion Care Bridgeport	Bridgeport	Interbuild Construction	Chicago	Bldg Improvements	2
3	Fred Frankel	1.50%	Aperion Care Burbank	Burbank	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	3
4	Steve Turofsky	1.50%	Aperion Care Chicago Heights	Chicago Heights	Propay	Evanston	Payroll Services	4
5			Aperion Care Demotte	Demotte,IN	Renewal Rehab	Skokie	Therapy Services	5
6			Aperion Care Dolton	Dolton	Aperion Care, Inc.	Skokie	Corporate Manager	6
7			Aperion Care Elgin	Elgin	Aperion Consulting, Inc.	Skokie	Consulting Co.	7
8			Aperion Care Evanston	Evanston	Aperion Financial, Inc.	Skokie	Bookkeeping	8
9			Aperion Care Forest Park	Forest Park	Eco-Brite	Skokie	Laundry	9
10			Aperion Care Plum Grove	Palatine	Pointe Group Care, LLC	Boston, MA	Bookkeeping	10
11			Aperion Care Galesburg	Galesburg	Pointe Property, LLC	Boston, MA	Property Management	11
12			Aperion Care Hidden Lake	St. Louis, MO	Aperion Estates Peru	Peru, IN	ALF	12
13			Aperion Care Highwood	Highwood	Aperion Care Demotte	Demotte, IN	ALF	13
14			Aperion Care International	Chicago	Aperion Care Hidden Lake	St. Louis, MO	ALF	14
15			Aperion Care Jacksonville	Jacksonville	Aperion Care Hidden Lake	St. Louis, MO	ILF	15
16			Aperion Care Kokomo	Kokomo, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	16
17			Aperion Care Litchfield	Litchfield	San Antonio Property, LLC	San Antonio, TX	Building Co.	17
18			Aperion Care Midlothian	Midlothian	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	18
19			Aperion Care Moline	East Moline				19
20			Aperion Care Oak Lawn	Oak Lawn				20
21			Aperion Care Peru	Peru, IN				21
22			Aperion Care Spring Valley	Spring Valley				22
23			Aperion Care Springfield	Springfield				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 &amp; ID Number

Aperion Care St. Elmo, Llc

#

0052696

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0%	See Attached	0.5	1.25%	Alloc. Salary	\$ 2,256	17-7	1	
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.2	0.50%	Alloc. Salary	326	17-7	2	
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.2	1.00%	Alloc. Salary	72	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.032	0.96%	Alloc. Salary	268	21-7	4	
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.5	1.25%	Alloc. Salary	2,256	17-7	5	
6	Fred Frankel	Owner	Administrative	1.50%	See Attached	0.5	1.25%	Alloc. Salary	2,069	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.5	1.25%	Alloc. Salary	2,256	17-7	7	
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.4	1.22%	Alloc. Salary	774	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	\$ 10,277		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 St. Elmo, Llc

# 0052696

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
Line Reference									
1	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 2,158	\$ 12,486	\$ 24	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)	12,486	(4)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	12,486	303	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855	12,486	66	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359	12,486	15	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	12,486	2,798	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526	12,486	141	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	12,486	16,682	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000	12,486	2,256	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754	12,486	1,475	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435	12,486	1,866	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	12,486	12,830	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500	12,486	468	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097	12,486	452	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545	12,486	356	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232	12,486	668	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354	12,486	1,538	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899	12,486	484	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529	12,486	1,236	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699	12,486	933	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707	12,486	8	21
22									22
23									23
24									24
25	TOTALS					\$ 3,953,315	\$ 2,891,038	\$ 44,595	25



Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETITIAN SALARY	PATIENT DAYS	1,106,839	47	\$ 290,566	\$ 12,486	\$ 3,278	1	
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	12,486	3,674	2	
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162	12,486	2	3	
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378	12,486	986	4	
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	1,194,994	12,486	13,480	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233	12,486	1,526	6	
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241	12,486	477	7	
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820	12,486	709	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	200,283	12,486	2,534	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340	12,486	263	10	
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550	12,486	503	11	
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866	12,486	337	12	
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685	12,486	87	13	
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508	12,486	6	14	
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204	12,486	138	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	\$ 27,999	25	

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 92	\$ 12,486	\$ 1	1	
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	86,036	12,486	971	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233		12,486	443	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932		12,486	191	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	2,630,420	12,486	30,105	5
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567		12,486	52	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179		12,486	25	7
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931		12,486	3,733	8
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460		12,486	107	9
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)		12,486	(150)	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395		12,486	129	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	\$	35,606	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

( 847) 262-3800

Fax Number

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	\$ 32,299	\$ 12,486	\$ 364	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905	12,486	732	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989	12,486	113	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965	12,486	2,572	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387	12,486	4	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714	12,486	640	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47		12,486		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435	12,486	5,093	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060	12,486	1,298	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109	12,486	475	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374	12,486	298	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	\$	\$ 11,588	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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

Renewal Rehab

Street Address

4655 W Chase Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

( 847) 673-6767

Fax Number

( 847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	43	\$	\$		\$ 175,948	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				\$	\$		\$ 175,948	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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 ProPay HR LLC

Street Address 2201 W Main St

City / State / Zip Code Evanston, IL 60202

Phone Number ( 847) 905-3268

Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 8,301	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				\$	\$		\$ 8,301	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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



Facility Name & ID Number

Aperion Care St. Elmo, Llc

# 0052696

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First Midwest Bank		X	Mortgage			\$	\$ 2,160,000			\$	117,577						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6	Bank Leumi		X	Line of Credit				381,153				15,648						
7	Insurance Policies		X									64						
8																		
9	<b>TOTAL Facility Related</b>						\$	\$ 2,541,153			\$	133,289						
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X									(2)						
11	Interest Income - Bldg Co		X									(5)						
12																		
13	See Supplemental Schedule											2,390						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	2,383						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,541,153			\$	135,672						

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2016 report.		\$	<u>23,751</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>24,495</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>744</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>24,540</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>56</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>25,340</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012		8
	2013	<u>22,873</u>	9
	2014	<u>23,188</u>	10
	2015	<u>23,505</u>	11
	2016	<u>24,020</u>	12

**2017 Accrual = \$24,020 x 1.02 (rounded) = \$24,540**

**Allocated from Chase Office \$475**

<b>FOR BHF USE ONLY</b>			
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.**



**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 St. Elmo, Llc COUNTY Fayette  
 FACILITY IDPH LICENSE NUMBER 0052696  
 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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
2.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
3.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
4.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
5.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
6.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
7.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
8.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
9.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
10.	<hr/>	<hr/>	\$ <hr/>	\$ <hr/>
<b>TOTALS</b>			\$ <hr/> <hr/>	\$ <hr/> <hr/>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696 Report Period Beginning:

01/01/17 Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,076 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 1

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

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

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

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

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

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

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>51,830</u>	<u>2014</u>	<u>\$ 90,000</u>	<u>1</u>
2	<u>Allocated from Chase Office</u>		<u>2016</u>	<u>700</u>	<u>2</u>
3	<b>TOTALS</b>	<b>51,830</b>		<b>\$ 90,700</b>	<b>3</b>

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60		2014	1968	\$ 1,108,000	\$ 56,811	39	\$ 28,410	\$ (28,401)	\$ 113,641	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			40,186	2,663	1,857	(806)	2,738	68
69				44,199		(44,199)		69
70			\$ 1,148,186	\$ 103,673	\$ 30,267	\$ (73,406)	\$ 116,379	70

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

Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,148,186	\$ 103,673		\$ 30,267	\$ (73,406)	\$ 116,379	1
2	Labor & Materials To Install New Light Fixtures & Exit Signs	2014	20,758		20	1,038	1,038	3,633	2
3	Furnish & Install New Sign With Lexan Face Panels	2014	3,220		20	215	215	751	3
4	New Ceiling In Kitchen & Replace Front Roof Area	2014	9,000		20	450	450	1,725	4
5	New Cat5E Lines For New & Existing Computers	2014	4,800		20	960	960	3,600	5
6	Computer Back Up On Generator	2014	4,025		20	805	805	2,683	6
7	Light Fixtures	2014	2,818		20	141	141	470	7
8	New Architectural 30 Year Shingle Roof	2014	86,290		20	4,315	4,315	14,022	8
9	Soffit & Fascia	2014	9,200		20	460	460	1,457	9
10	Cabling For Vip System	2014	4,000		20	800	800	2,533	10
11	New Windows, Paint 28 Rms, New Vct Tile In 5 Rms, 25 Ptac Unit	2014	116,700		20	5,835	5,835	17,991	11
12	Electrical Work For 28 New Ptac Units; Includes New 400 Amp M	2014	33,460		20	1,673	1,673	5,158	12
13	Don Office Floor Tile, 4 Resident Rooms-Remove Wallpaper, New	2015	10,507		20	525	525	1,357	13
14	Corridor Handrails, End Caps, Bumper Guards & End Caps	2015	8,756		20	438	438	1,167	14
15	New Condensing Unit	2016	4,692		20	235	235	313	15
16	Repaired Windows, Soffits & Timbers For Front Entry	2016	3,134		20	209	209	313	16
17	Patched Parking Lot, Seal Coated & Re-Striped	2016	4,137		20	207	207	345	17
18	Dining Room Wall Improvements	2017	6,994		20	350	350	350	18
19	Install Drywall On Ceiling	2017	3,020		20	151	151	151	19
20	Ao Smith Commercial Water Heater	2017	3,965		20	727	727	727	20
21	Basement Sump Pump System	2017	13,613		20	567	567	567	21
22	4 Ton Heat Pump System	2017	6,572		20	137	137	137	22
23	Wall Base & Floor Prep In Dining Room	2017	3,210		20	67	67	67	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	34

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



**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	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)	\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	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)	\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	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)	\$ 1,511,057	\$ 103,673		\$ 50,570	\$ (53,103)	\$ 175,897	34

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office	2016	6,304	162	39	162		229	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	336	54	20	17	(37)	134	9
10	Allocated from Aperion Care	2012	95	7	20	5	(2)	29	10
11	Allocated from Aperion Care	2013	41	5	20	2	(3)	10	11
12									12
13	Allocated from Chase Office	2017	1,459	96	20	73	(23)	73	13
14	Allocated from Chase Office	2016	31,951	2,339	20	1,598	(741)	2,263	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)		\$ 40,186	\$ 2,663		\$ 1,857	\$ (806)	\$ 2,738	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 40,186	\$ 2,663		\$ 1,857	\$ (806)	\$ 2,738	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)	\$ 40,186	\$ 2,663		\$ 1,857	\$ (806)	\$ 2,738	34

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

Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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	\$ 166,036	\$ 2,846	\$ 17,214	\$ 14,368	10	\$ 64,150	71
72	Current Year Purchases	12,897	162	1,702	1,540	10	1,702	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 178,933	\$ 3,008	\$ 18,916	\$ 15,908		\$ 65,852	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		\$ 377	\$ 57	\$ 75	\$ 18	5	\$ 245	76
77		Allocated from Aperion Consulting		262	43	52	9	5	157	77
78										78
79										79
80	TOTALS			\$ 639	\$ 100	\$ 127	\$ 27		\$ 402	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,781,329	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,781	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,614	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (37,167)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 242,151	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	Floor replacement	\$ 600	92
93			93
94			94
95		\$	95

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

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



Facility Name & ID Number Aperion Care St. Elmo, Llc

# 0052696

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: N/A

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

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.	<u>/2018</u>	\$	_____
13.	<u>/2019</u>	\$	_____
14.	<u>/2020</u>	\$	_____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 6,467

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Aperion Care</u>		\$	<u>933</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>138</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$	<b>1,071</b>	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 98,770	\$		\$ 98,770	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,504			4,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			80,044			80,044	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				67,019		67,019	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					11,813	2,347		14,160	13
14	TOTAL			\$		\$ 195,131	\$ 69,366		\$ 264,497	14

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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 56,662	\$ 82,043	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	442,234	442,234	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,899	42,899	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	410,000	960,000	8
9	Other(specify): <u>See Attached Schedule</u>	3,181	17,607	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 954,976	\$ 1,544,783	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,000	13
14	Buildings, at Historical Cost		1,108,000	14
15	Leasehold Improvements, at Historical Cost	362,534	362,534	15
16	Equipment, at Historical Cost	42,005	184,005	16
17	Accumulated Depreciation (book methods)	(125,894)	(347,217)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	646,333	1,353,149	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 924,978	\$ 2,750,471	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,879,954	\$ 4,295,254	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 195,434	\$ 195,435	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	381,153	381,153	29
30	Accrued Salaries Payable	81,560	81,560	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,118	4,118	31
32	Accrued Real Estate Taxes(Sch.IX-B)		24,540	32
33	Accrued Interest Payable	1,601	12,071	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	11,751	11,751	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 675,617	\$ 710,628	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,160,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	1,831,331	1,038,027	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,831,331	\$ 3,198,027	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,506,948	\$ 3,908,655	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (626,994)	\$ 386,599	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,879,954	\$ 4,295,254	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(311,107)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(311,107)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(315,887)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(315,887)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(626,994)</b>	<b>24</b> *

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

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,124,951	1
2	Discounts and Allowances for all Levels	402,118	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,527,069	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	64,271	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 64,271	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,470	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,501	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	153	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 153	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,595,996	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	465,678	31
32	Health Care	967,785	32
33	General Administration	743,177	33
<b>B. Capital Expense</b>			
34	Ownership	345,150	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	290,481	35
36	Provider Participation Fee	99,612	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,911,883	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(315,887)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (315,887)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,208,495	44
45	Private Pay - Net Inpatient Revenue	602,450	45
46	Medicare - Net Inpatient Revenue	619,439	46
47	Other-(specify) <u>Insurance/Managed Care</u>	96,685	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,527,069	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 St. Elmo, Llc

# 0052696

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,255	\$ 73,691	\$ 32.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,254	4,470	162,496	36.35	3
4	Licensed Practical Nurses	10,918	12,238	207,241	16.93	4
5	CNAs & Orderlies	29,481	31,758	349,239	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,786	2,066	23,802	11.52	9
10	Activity Assistants	2,167	2,261	23,740	10.50	10
11	Social Service Workers	1,949	2,144	32,780	15.29	11
12	Dietician					12
13	Food Service Supervisor	529	707	7,783	11.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,125	8,698	91,631	10.53	15
16	Dishwashers					16
17	Maintenance Workers	1,811	2,069	37,624	18.18	17
18	Housekeepers	5,551	6,068	59,895	9.87	18
19	Laundry	3,260	3,640	34,926	9.60	19
20	Administrator	1,872	2,004	66,635	33.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,142	1,166	25,946	22.25	23
24	Clerical	610	676	8,906	13.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	186	186	2,244	12.06	33
34	TOTAL (lines 1 - 33)	75,593	82,406	\$ 1,208,579 *	\$ 14.67	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	69	\$ 3,437	01-03	35
36	Medical Director	Monthly	11,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	25,413	10-03	38
39	Pharmacist Consultant	Monthly	2,140	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	104	5,191	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	\$ 47,181		49

**C. CONTRACT NURSES**

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





Facility Name & ID Number Aperion Care St. Elmo, Llc# 0052696

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. ICLTC \$8008.8
- (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. \$ 8,363 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 99,612  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees