		FOR BHF USE					

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053983

Facility Name: Aperion Care Bloomington, Llc

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

County: Mclean

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,705	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,422	1,422	8
9	SNF/PED					9
10	ICF	14,230		6,977	21,207	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,230		8,399	22,629	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.99%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/2015

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 1,422

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,120	14,056	14,450	227,626		227,626	(5,855)	221,771			1
2	Food Purchase		137,038		137,038		137,038	71	137,109			2
3	Housekeeping	60,740	19,664	32,596	113,000		113,000		113,000			3
4	Laundry	32,754	6,535	21,731	61,020		61,020	(506)	60,514			4
5	Heat and Other Utilities			112,591	112,591		112,591	(4,559)	108,032			5
6	Maintenance	44,197	11,450	64,465	120,112		120,112	6,354	126,466			6
7	Other (specify):*							1,886	1,886			7
8	**TOTAL General Services**	336,811	188,743	245,833	771,387		771,387	(2,609)	768,778			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,437,775	81,750	126,497	1,646,022		1,646,022	(31,846)	1,614,176			10
10a	Therapy											10a
11	Activities	90,697	4,084	4,059	98,840		98,840		98,840			11
12	Social Services	64,459		6,875	71,334		71,334		71,334			12
13	CNA Training											13
14	Program Transportation			190	190		190		190			14
15	Other (specify):*							3,035	3,035			15
16	**TOTAL Health Care and Programs**	1,592,931	85,834	154,421	1,833,186		1,833,186	(28,811)	1,804,375			16
	C. General Administration											
17	Administrative	68,642		176,109	244,751		244,751	(142,545)	102,206			17
18	Directors Fees											18
19	Professional Services			152,663	152,663	(16)	152,647	(2,300)	150,347			19
20	Dues, Fees, Subscriptions & Promotions			60,637	60,637		60,637	(24,028)	36,609			20
21	Clerical & General Office Expenses	117,023		277,889	394,912		394,912	(153,650)	241,262			21
22	Employee Benefits & Payroll Taxes			323,867	323,867		323,867		323,867			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,932	5,932		5,932	(40)	5,892			24
25	Other Admin. Staff Transportation			2,854	2,854		2,854	3,731	6,585			25
26	Insurance-Prop.Liab.Malpractice			192,203	192,203		192,203	1,146	193,349			26
27	Other (specify):*							14,220	14,220			27
28	**TOTAL General Administration**	185,665		1,192,154	1,377,819	(16)	1,377,803	(303,466)	1,074,337			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,115,407	274,577	1,592,408	3,982,392	(16)	3,982,376	(334,886)	3,647,490			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aperion Care Bloomington, Llc #0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			43,088	43,088		43,088	(14,455)	28,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,277	23,277		23,277	1,879	25,156			32
33	Real Estate Taxes			25,253	25,253	16	25,269	788	26,057			33
34	Rent-Facility & Grounds			666,219	666,219		666,219	(30,000)	636,219			34
35	Rent-Equipment & Vehicles			27,706	27,706		27,706	2,022	29,728			35
36	Other (specify):*											36
37	**TOTAL Ownership**			785,543	785,543	16	785,559	(39,766)	745,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,570	298,163	394,733		394,733	(21,801)	372,932			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,653	193,653		193,653		193,653			42
43	Other (specify):*			15,179	15,179		15,179	(15,179)				43
44	**TOTAL Special Cost Centers**		96,570	506,995	603,565		603,565	(36,980)	566,585			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,115,407	371,147	2,884,946	5,371,500		5,371,500	(411,632)	4,959,868			45

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,145)	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	(23,085)	30		9
10	Interest and Other Investment Income	(4,656)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(101,947)	21		18
19	Entertainment				19
20	Contributions	(25,295)	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	(136,650)	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	(26,422)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (323,200)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,432)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (88,432)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (411,632)		37

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

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

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

Aperion Care Bloomington, Llc

ID# 0053983

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (4,125)	21	1
2	Marketing Expenses	(12,197)	43	2
3	Theft & Damage Loss	(485)	21	3
4	Additional R&M	6,415	06	4
5	Non Allowable Seminar	(1,214)	24	5
6	Non Allowable Legal	(7,356)	19	6
7	PAC Dues	(3,803)	20	7
8	Website Development	(2,457)	43	8
9	Prior Year Professional Fees	(1,200)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,422)		49

Aperion Care Bloomington, Llc

ID# 0053983

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(5,855)								(5,855)	1
2	Food Purchase			71									71	2
3	Housekeeping													3
4	Laundry									(506)			(506)	4
5	Heat and Other Utilities	(5,145)					586						(4,559)	5
6	Maintenance	6,415		1,252	(2,581)		1,268						6,354	6
7	Other (specify):*			116	1,553		217						1,886	7
8	**TOTAL General Services**	1,270		1,439	(6,883)		2,071			(506)			(2,609)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			6,977	(38,823)								(31,846)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			709	2,326								3,035	15
16	**TOTAL Health Care and Programs**			7,686	(36,497)								(28,811)	16
	C. General Administration													
17	Administrative			(142,545)									(142,545)	17
18	Directors Fees													18
19	Professional Services	(8,556)		5,789	1,346	3,471	377		(4,727)				(2,300)	19
20	Fees, Subscriptions & Promotions	(29,098)		3,570	710	784	6						(24,028)	20
21	Clerical & General Office Expenses	(243,207)		21,227	1,758	65,400	1,172						(153,650)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,214)		944	182	48							(40)	24
25	Other Admin. Staff Transportation			3,592	120	19							3,731	25
26	Insurance-Prop.Liab.Malpractice			1,146									1,146	26
27	Other (specify):*			6,855	168	7,197							14,220	27
28	**TOTAL General Administration**	(282,075)		(99,422)	4,284	76,919	1,555		(4,727)				(303,466)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(280,805)		(90,297)	(39,096)	76,919	3,626		(4,727)	(506)			(334,886)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(23,085)		920	166	169	7,375						(14,455)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,656)		4,392	8		2,135						1,879	32
33	Real Estate Taxes						788						788	33
34	Rent-Facility & Grounds						(30,000)						(30,000)	34
35	Rent-Equipment & Vehicles			1,070	184	190	580						2,022	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(27,741)		6,382	358	359	(19,123)						(39,766)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(21,801)					(21,801)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(14,654)			(525)								(15,179)	43
44	**TOTAL Special Cost Centers**	(14,654)			(525)			(21,801)					(36,980)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(323,200)		(83,916)	(39,263)	77,278	(15,497)	(21,801)	(4,727)	(506)			(411,632)	45

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$	APERION CARE, INC.		$ 71	$ 71	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.		1,145	1,145	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.		107	107	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.		116	116	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.		2	2	19
20	V	10	SALARY- NURSE		APERION CARE, INC.		6,975	6,975	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.		709	709	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.		33,563	33,563	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.		5,789	5,789	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.		3,570	3,570	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.		20,148	20,148	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.		1,079	1,079	26
27	V	24	SEMINARS		APERION CARE, INC.		944	944	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.		3,592	3,592	28
29	V	26	INSURANCE		APERION CARE, INC.		1,146	1,146	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.		6,855	6,855	30
31	V	30	DEPRECIATION		APERION CARE, INC.		920	920	31
32	V	32	INTEREST		APERION CARE, INC.		4,392	4,392	32
33	V	35	AUTO LEASE		APERION CARE, INC.		1,070	1,070	33
34	V	17	MANAGEMENT FEE	176,109	APERION CARE, INC.			(176,109)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 176,109			$ 92,193	$ * (83,916)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETITIAN SALARY	$	APERION CONSULTING, LLC		$ 8,595	$ 8,595	15
16	V	6	MAINTENANCY SALARY		APERION CONSULTING, LLC		5,477	5,477	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC		1,553	1,553	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC		20,787	20,787	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		2,326	2,326	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC		1,346	1,346	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC		710	710	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC		1,758	1,758	22
23	V	24	SEMINARS		APERION CONSULTING, LLC		182	182	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC		120	120	24
25	V	27	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		168	168	25
26	V	30	DEPRECIATION		APERION CONSULTING, LLC		166	166	26
27	V	32	INTEREST		APERION CONSULTING, LLC		8	8	27
28	V	35	AUTO LEASE		APERION CONSULTING, LLC		184	184	28
29	V								29
30	V								30
31	V								31
32	V	10	RN CONSULTING	59,610	APERION CONSULTING, LLC			(59,610)	32
33	V	01	DIETICIAN	14,450	APERION CONSULTING, LLC			(14,450)	33
34	V	06	PROJECT MANAGER	8,058	APERION CONSULTING, LLC			(8,058)	34
35	V	43	MARKETING	525	APERION CONSULTING, LLC			(525)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,643			$ 43,380	$ * (39,263)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		APERION FINANCIAL, LLC		3,471	$ 3,471	15
16	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		784	784	16
17	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC		65,400	65,400	17
18	V	24	SEMINARS		APERION FINANCIAL, LLC		48	48	18
19	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC		19	19	19
20	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		7,197	7,197	20
21	V	30	DEPRECIATION		APERION FINANCIAL, LLC		169	169	21
22	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC		190	190	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 77,278	$ * 77,278	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	CHASE OFFICE,LLC		$ 586	$ 586	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,268	1,268	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		217	217	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		377	377	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		6	6	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		1,172	1,172	20
21	V	30	DEPRECIATION		CHASE OFFICE,LLC		7,375	7,375	21
22	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		2,135	2,135	22
23	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		788	788	23
24	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		580	580	24
25	V	34	RENTAL INCOME	30,000	CHASE OFFICE,LLC			(30,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,000			$ 14,503	$ * (15,497)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 291,465	Renewal Rehab		$ 269,664	$ (21,801)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 291,465			$ 269,664	$ * (21,801)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 18,056	ProPay HR		$ 13,329	$ (4,727)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,056			$ 13,329	$ * (4,727)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 21,731	EcoBrite Linen		$ 21,225	$ (506)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,731			$ 21,225	$ * (506)	39

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Revocable Trust	23.00%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	David Berkowitz Delta Trust	21.50%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	David Berkowitz Revocable Trust	23.00%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	3
4	Yosef Meystel Delta Trust	21.50%	Aperion Care Cairo	Cairo	Renewal Rehab	LIncolnwood	Therapy Services	4
5	Frederick Frankel	3.00%	Aperion Care Capitol	Capitol	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	Steven Turofsky	3.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7	Michelle Koder	3.00%	Aperion Care Demotte	Demotte,IN	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8	Naftali Wilhelm	2.00%	Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	8
9			Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	10
11			Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Highwood	Highwood	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care International	Chicago	Aperion Incorporated Cell	Burlington, VT	Insurance	18
19			Aperion Care Jacksonville	Jacksonville				19
20			Aperion Care Kokomo	Kokomo, IN				20
21			Aperion Care Litchfield	Litchfield				21
22			Aperion Care Marion	Marion, IN				22
23			Aperion Care Marseilles	Marseilles				23
24			Aperion Care Mascoutah	Mascoutah				24
25			Aperion Care Midlothian	Midlothian				25
26			Aperion Care Moline	East Moline				26
27			Aperion Care Morton Terrace	Morton				27
28			Aperion Care Morton Villa	Morton				28
29			Aperion Care Oak Lawn	Oak Lawn				29
30			Aperion Care Olney	Olney				30

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Peoria Heights	Peoria Heights				1
2			Aperion Care Peru	Peru, IN				2
3			Aperion Care Plum Grove	Palatine				3
4			Aperion Care Princeton	Princeton				4
5			Aperion Care Spencer	Spencer, IN				5
6			Aperion Care Spring Valley	Spring Valley				6
7			Aperion Care Springfield	Springfield				7
8			Aperion Care St. Elmo	St. Elmo				8
9			Aperion Care Tolleston Park	Gary, IN				9
10			Aperion Care Toluca	Toluca				10
11			Aperion Care University Park	Fort Wayne, IN				11
12			Aperion Care Valparaiso	Valparaiso, IN				12
13			Aperion Care Waldron	Wilmington				13
14			Aperion Care West Chicago	Springfield				14
15			Aperion Care Wilmington	Wilmington				15
16			Glennon Place (MO)	Bolivar, MO				16
17			Huntington Nursing & Rehab	Huntington, IN				17
18			Legend Healthcare (KS)	Tonganoxie, KS				18
19			The Arbors at Michigan City	Michigan City, IN				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.65	1.61%	Alloc Salary	$ 4,036	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.32	0.81%	Alloc Salary	499	21-7	2
3	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.09	2.14%	Alloc Salary	284	21-7	3
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.65	1.61%	Alloc Salary	4,036	17-7	4
5	Fred Frankel	Owner	Administrative	3.00%	See Attached	0.65	1.61%	Alloc Salary	3,631	17-7	5
6	Steve Turofsky	Owner	Administrative	3.00%	See Attached	0.65	1.61%	Alloc Salary	3,331	17-7	6
7	Naftali Wihelm	Relative	Clerical	2.00%	See Attached	0.60	1.61%	Alloc Salary	4,036	21-7	7
8	Michelle Koder	Owner	Nursing	3.00%	See Attached	0.65	1.61%	Alloc Salary	2,136	10-7	8
9	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.25	1.07%	Alloc Salary	200	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 22,189		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,401,635	55	$ 4,383	$	22,629	$ 71	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	55,615	22,629	1,145	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652		22,629	107	3
4	7	EMP. BEN.-GEN. SERV. & DIET	ACTUAL CENSUS	1,401,635	55	5,656		22,629	116	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128		22,629	2	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	422,414	22,629	6,975	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957		22,629	709	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	2,112,862	22,629	33,563	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581		22,629	5,789	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133		22,629	3,570	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	1,246,022	22,629	20,148	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841		22,629	1,079	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453		22,629	944	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488		22,629	3,592	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976		22,629	1,146	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828		22,629	6,855	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000		22,629	920	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060		22,629	4,392	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252		22,629	1,070	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,718,302	$ 3,836,913		$ 92,193	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETITIAN SALARY	PATIENT DAYS	1,401,635	55	$ 424,292	$ 424,292	22,629	$ 8,595	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	22,629	5,477	2
3	7	EMP. BEN.-GEN. SERV. & DIET	PATIENT DAYS	1,401,635	55	81,117		22,629	1,553	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	22,629	20,787	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437		22,629	2,326	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		22,629	1,346	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		22,629	710	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	22,629	1,758	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		22,629	182	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		22,629	120	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636		22,629	168	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		22,629	166	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		22,629	8	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		22,629	184	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,920,744	$ 2,458,073		$ 43,380	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001		22,629	3,471	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576		22,629	784	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	22,629	65,400	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987		22,629	48	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197		22,629	19	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805		22,629	7,197	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463		22,629	169	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738		22,629	190	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					$ 4,817,960	$ 4,033,980		$ 77,278	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	$ 36,284	$	22,629	$ 586	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537		22,629	1,268	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463		22,629	217	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338		22,629	377	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402		22,629	6	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586		22,629	1,172	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791		22,629	7,375	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223		22,629	2,135	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786		22,629	788	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907		22,629	580	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					$ 898,317	$		$ 14,503	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Renewal Rehab
Street Address: 7358 N. Lincoln Ave., Suite 160
City / State / Zip Code: Lincolnwood, IL
Phone Number: (847) 938-8750
Fax Number: (847) 410-9720

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct			$	$		$ 269,664	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					$	$		$ 269,664	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 13,329	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					$	$		$ 13,329	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry	Direct			$	$		$ 21,225	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					$	$		$ 21,225	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Aperion Incorporated Cell
Street Address: 30 Main Street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 151,973	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					$	$		$ 151,973	25

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Retirement Home TV Corp		X	Capitalized Lease				5,765				6
7	The Private Bank		X	Line of Credit				487,058			22,928	7
8												8
9	TOTAL Facility Related						$	$ 492,823			$ 22,928	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,656)	10
11	Insurance Policies		X								349	11
12	Allocated from Aperion Care	X									4,392	12
13	See Supplemental Schedule										2,143	13
14	TOTAL Non-Facility Related						$	$			$ 2,228	14
15	TOTALS (line 9+line14)						$	$ 492,823			$ 25,156	15

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 25,165	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.)		$ 25,997	2
3. Under or (over) accrual (line 2 minus line 1).		$ 832	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,209	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 16	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 26,057	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015	24,562	10
2016	25,165	11
2017	25,209	12

2018 Accrual = 2017 RE Tax
Allocated From Chase Office: $788

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bloomington, Llc COUNTY Mclean

FACILITY IDPH LICENSE NUMBER 0053983

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-32-427-020	Long Term Care Property	$ 25,209.18	$ 25,209.18
2.	10-27-307-027-0000	Allocated From Chase Office	$ 45,392.90	$ 732.86
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,602.08	$ 25,942.04

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bloomington, Llc COUNTY Mclean

FACILITY IDPH LICENSE NUMBER 0053983

CONTACT PERSON REGARDING THIS REPORT

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 2017 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 2017.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated From Chase Office			$ 1,002	1
2					2
3	TOTALS			$ 1,002	3

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		57,554	3,821		2,658	(1,163)	6,543	68
69	Financial Statement Depreciation			43,088			(43,088)		69
70	TOTAL (lines 4 thru 69)		$ 57,554	$ 46,909		$ 2,658	$ (44,251)	$ 6,543	70

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 57,554	$ 46,909		$ 2,658	$ (44,251)	$ 6,543	1
2	Satellite	2015	16,989		20	849	849	2,619	2
3	Cameras, Cables, Monitors, Etc.	2016	10,318		20	516	516	1,548	3
4	Cable For Data	2016	6,506		20	325	325	976	4
5	Remove Old Flooring And Reset Framework	2016	2,540		20	127	127	318	5
6	New Doors	2016	5,030		20	252	252	608	6
7	Kitchen Door	2016	2,786		20	139	139	337	7
8	Parking Lot Done (56,000)	2016	44,486		20	2,224	2,224	5,005	8
9	Water Main Work, Replaced Main Gate Valve	2016	6,004		20	300	300	901	9
10	Heating / Cooling Thermostat Installation	2016	4,771		20	239	239	696	10
11	Roof Exhauster Installation	2016	3,330		20	167	167	402	11
12	Roof Replacement (307,000)	2017	292,540		20	14,627	14,627	25,597	12
13	Installed One Inch Gas Line From Utility Room To Kitchen	2017	2,837		20	142	142	154	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)		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 455,691	$ 46,909		$ 22,565	$ (24,344)	$ 45,702	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 LLC	2016	9,022	231	20	231		559	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	481	77	20	24	(53)	192	9
10	Allocated from Aperion Care	2012	136	11	20	7	(4)	41	10
11	Allocated from Aperion Care	2013	58	7	20	3	(4)	15	11
12									12
13	Allocated from Chase Office LLC	2018	41		20	2	2	2	13
14	Allocated from Chase Office LLC	2017	2,088	148	20	104	(43)	209	14
15	Allocated from Chase Office LLC	2016	45,727	3,348	20	2,286	(1,061)	5,525	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)		$ 57,554	$ 3,821		$ 2,658	$ (1,163)	$ 6,543	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 57,554	$ 3,821		$ 2,658	$ (1,163)	$ 6,543	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 57,554	$ 3,821		$ 2,658	$ (1,163)	$ 6,543	34

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 52,371	$ 4,434	$ 5,299	$ 864	10	$ 11,847	71
72	Current Year Purchases	9,633	228	582	355	10	582	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 62,004	$ 4,662	$ 5,881	$ 1,219		$ 12,430	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	2018	$ 540	$ 82	$ 108	$ 26	5	$ 350	76
77		Allocated from Aperion Consultin	2018	394	65	79	14	5	315	77
78										78
79										79
80	TOTALS			$ 934	$ 147	$ 187	$ 40		$ 666	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)	$ 519,631	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,718	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 28,632	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (23,085)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 58,797	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Architech/Planning Fees	$ 243,464	92
93	Facility Renovation		93
94			94
95		$ 243,464	95

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Segula Properties, LLC

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		117		$ 636,219			3
4	Additions							4
5								5
6								6
7	TOTAL		117		$ 636,219 **			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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 16,006 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2015 GMC Savana	$ 1,039	$ 12,470	17
18		Passenger			18
19	Allocated from Aperion Care			1,070	19
20	Allocated from Aperion Consulting			184	20
21	TOTAL		$ 1,039	$ 13,724	21

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

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

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 119,529	$		$ 119,529	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			24,130			24,130	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			147,807			147,807	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				62,278		62,278	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,697	34,292		40,989	13
14	TOTAL			$		$ 298,163	$ 96,570		$ 394,733	14

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

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Bloomington, Llc # 0053983 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 100	$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	879,154		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,789		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	404,470		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,354,513	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	407,855		15
16	Equipment, at Historical Cost	58,946		16
17	Accumulated Depreciation (book methods)	(88,187)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	364,042		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 742,656	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,097,169	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 441,896	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	492,823		29
30	Accrued Salaries Payable	142,618		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,820		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,209		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	3,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,111,366	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	3,209,334		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,209,334	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,320,700	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,223,531)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,097,169	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (938,634)	1
2	Restatements (describe):		2
3	**Bad Debt Expense**	(32,016)	3
4	**Rounding**	(1)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (970,651)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,252,880)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,252,880)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,223,531)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,057,682	1
2	Discounts and Allowances for all Levels	(1,131,282)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,926,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,551	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 178,551	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54	19
20	Radiology and X-Ray	24	20
21	Other Medical Services	2,964	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,013	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,656	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,656	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,118,620	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	771,387	31
32	Health Care	1,833,186	32
33	General Administration	1,377,819	33
	B. Capital Expense		
34	Ownership	785,543	34
	C. Ancillary Expense		
35	Special Cost Centers	409,912	35
36	Provider Participation Fee	193,653	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,371,500	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,252,880)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,252,880)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,168,380	44
45	Private Pay - Net Inpatient Revenue	(37,570)	45
46	Medicare - Net Inpatient Revenue	674,316	46
47	Other-(specify) Insurance	158,029	47
48	Other-(specify) Managed Care	963,245	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,926,400	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,160	$ 106,889	$ 49.49	1
2	Assistant Director of Nursing	88	88	4,019	45.67	2
3	Registered Nurses	9,235	9,558	341,900	35.77	3
4	Licensed Practical Nurses	10,154	10,865	312,673	28.78	4
5	CNAs & Orderlies	45,732	49,020	646,516	13.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,914	2,080	30,831	14.82	9
10	Activity Assistants	3,350	3,622	45,031	12.43	10
11	Social Service Workers	2,778	2,975	64,459	21.67	11
12	Dietician					12
13	Food Service Supervisor	1,874	1,944	38,849	19.98	13
14	Head Cook	4,174	4,502	56,306	12.51	14
15	Cook Helpers/Assistants	9,457	10,020	103,965	10.38	15
16	Dishwashers					16
17	Maintenance Workers	2,008	2,182	44,197	20.26	17
18	Housekeepers	5,497	5,671	60,740	10.71	18
19	Laundry	2,495	2,612	32,754	12.54	19
20	Administrator	1,672	1,758	68,642	39.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,303	1,835	46,499	25.34	23
24	Clerical	3,705	3,991	70,524	17.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,837	2,054	25,778	12.55	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,054	1,235	14,835	12.01	33
34	TOTAL (lines 1 - 33)	110,279	118,172	$ 2,115,407 *	$ 17.90	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,450	01-03	35
36	Medical Director	174	16,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	59,610	10-03	38
39	Pharmacist Consultant	322	7,808	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	66	4,059	11-03	44
45	Social Service Consultant	95	6,875	12-03	45
46	Other(specify)				46
47	Psychiatric MD	106	13,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	762	$ 122,602		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	274	11,844	10-03	51
52	Certified Nurse Assistants/Aides	1,138	34,235	10-03	52
53	TOTAL (lines 50 - 52)	1,411	$ 46,079		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Arnold	Administrator	0	$ 68,642
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,642

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	$ 176,109
TOTAL (agree to Schedule V, line 17, col. 3)	$ 176,109
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ProPay HR	Payroll Processing	$ 18,056
Marcum LLP	Accounting	23,948
See Attached	Legal Fees	13,067
Interbuild	Energy Procurement	904
GCHMO	Mngd Care Contract Consult	7,500
Personnel Planners	Unemployment Consultant	746
Consonus Pact	Data Analytics	3,063
Pinnacle Financial Services	Financial Consulting	2,400
Integra Scripts, LLC	Pharmacy Software	1,053
MTS Consulting	Tax Consulting	1,782
PointClickCare	EMR / Billing Software	39,875
See Supplemental Schedule		40,270
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 152,663

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,162
Unemployment Compensation Insurance	41,360
FICA Taxes	159,135
Employee Health Insurance	30,422
Employee Meals	1,788
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	160
Employee Benefits - Other	9,840
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,867

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	16,575
Health Care Worker Background Check	
(Indicate # of checks performed 43)	430
Patient Background Checks 114	1,149
Dues	9,951
Licenses & Permits	1,444
Allocated from Aperion Care	3,570
Allocated from Aperion Consulting	710
See Supplemental Schedule	790
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,609

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,718
Allocated from Aperion Care	944
Allocated from Aperion Consulting	182
See Supplemental Schedule	48
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,892

**See instructions.

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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. **Healthcare Council of IL $7,605**

(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. $ **12,864** 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. $ **193,653**
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. $ **1,788** Has any meal income been offset against related costs? **Yes** 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? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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