		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: 0052761

Facility Name: APERION CARE GALESBURG

Address: 1145 Frank Street (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 342-2103 **Fax #** (309) 342-1819

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2013

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)
** Subject to the attached Accountants' Consulting Report* (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 GALESBURG # 0052761 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	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	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	3,255	892	3,780	7,927	8
9	SNF/PED					9
10	ICF	14,452	103	10,078	24,633	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,707	995	13,858	32,560	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.60%

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 11/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,703

Medicare Intermediary National Government Services

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.

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	204,085	22,150	14,990	241,225		241,225	(2,623)	238,602			1
2	Food Purchase		199,488		199,488		199,488	42	199,530			2
3	Housekeeping	132,709	31,953		164,662		164,662		164,662			3
4	Laundry	64,946	15,858		80,804		80,804		80,804			4
5	Heat and Other Utilities			99,100	99,100		99,100	(7,010)	92,090			5
6	Maintenance	70,377	22,415	44,125	136,917		136,917	15,929	152,846			6
7	Other (specify):*							2,714	2,714			7
8	**TOTAL General Services**	472,117	291,864	158,215	922,196		922,196	9,053	931,249			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,668,759	136,371	57,404	1,862,534		1,862,534	(7,774)	1,854,760			10
10a	Therapy	54,378			54,378		54,378		54,378			10a
11	Activities	92,795	1,078	922	94,795		94,795		94,795			11
12	Social Services	222,677		17,869	240,546		240,546		240,546			12
13	CNA Training											13
14	Program Transportation			11,158	11,158		11,158		11,158			14
15	Other (specify):*							4,368	4,368			15
16	**TOTAL Health Care and Programs**	2,038,609	137,449	105,353	2,281,411		2,281,411	(3,406)	2,278,005			16
	C. General Administration											
17	Administrative	68,993		221,828	290,821		290,821	(86,872)	203,949			17
18	Directors Fees											18
19	Professional Services			239,285	239,285	(5,213)	234,072	(58,806)	175,266			19
20	Dues, Fees, Subscriptions & Promotions			131,114	131,114		131,114	(71,888)	59,226			20
21	Clerical & General Office Expenses	61,605		83,731	145,336		145,336	82,842	228,178			21
22	Employee Benefits & Payroll Taxes			317,071	317,071		317,071		317,071			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,937	4,937		4,937	1,689	6,626			24
25	Other Admin. Staff Transportation			2,267	2,267		2,267	5,369	7,636			25
26	Insurance-Prop.Liab.Malpractice			199,997	199,997		199,997	1,649	201,646			26
27	Other (specify):*							20,461	20,461			27
28	**TOTAL General Administration**	130,598		1,200,230	1,330,828	(5,213)	1,325,615	(105,556)	1,220,059			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,641,324	429,313	1,463,798	4,534,435	(5,213)	4,529,222	(99,909)	4,429,313			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 GALESBURG #0052761 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			108,110	108,110		108,110	44,160	152,270			30
31	Amortization of Pre-Op. & Org.			17,670	17,670		17,670	(17,670)				31
32	Interest			64,031	64,031		64,031	213,952	277,983			32
33	Real Estate Taxes			75,473	75,473	5,213	80,686	1,133	81,819			33
34	Rent-Facility & Grounds			390,000	390,000		390,000	(390,000)				34
35	Rent-Equipment & Vehicles			12,060	12,060		12,060	2,910	14,970			35
36	Other (specify):*											36
37	TOTAL Ownership			667,344	667,344	5,213	672,557	(145,515)	527,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	166,624	152,621	362,217	681,462		681,462	(26,135)	655,327			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			244,751	244,751		244,751		244,751			42
43	Other (specify):*			8,933	8,933		8,933	(8,933)				43
44	TOTAL Special Cost Centers	166,624	152,621	615,901	935,146		935,146	(35,068)	900,078			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,807,948	581,934	2,747,043	6,136,925		6,136,925	(280,492)	5,856,433			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 GALESBURG # 0052761 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	(7,853)	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	(55,579)	30		9
10	Interest and Other Investment Income	(807)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	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	(325)	21		18
19	Entertainment				19
20	Contributions	(76,166)	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	(30,361)	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	(79,791)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (250,942)		$	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)	(29,550)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (29,550)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (280,492)		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 GALESBURG

ID# 0052761

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (14,688)	21	1
2	Theft & Damage	(210)	21	2
3	Amortization	(17,670)	31	3
4	Building Co - Accounting Fees	(7,983)	19	4
5	Building Co - Amortization	(20,499)	36	5
6	Building Co - Legal Fees	(452)	19	6
7	Building Co - Licenses & Permits	(168)	20	7
8	Building Co - State Replacement Tax	(243)	21	8
9	Building Co - Bank Charges	(3,508)	21	9
10	Building Co - Other Professional Fees	(5,460)	19	10
11	PAC Dues	(3,017)	20	11
12	Additional R&M	10,880	06	12
13	Non-allowable Legal	(205)	19	13
14	Credit Card Processing Fees	(435)	21	14
15	Advertising /Marketing	(4,821)	43	15
16	Marketing Food	(1,130)	43	16
17	Promotional Products	(2,982)	43	17
18	Collections	(7,200)	19	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**	(79,791)		49

APERION CARE GALESBURG

ID# 0052761

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 GALESBURG # 0052761 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				(2,623)								(2,623)	1
2	Food Purchase	(60)		102									42	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,853)					843						(7,010)	5
6	Maintenance	10,880		1,802	1,423		1,824						15,929	6
7	Other (specify):*			167	2,234		313						2,714	7
8	**TOTAL General Services**	2,967		2,071	1,035		2,980						9,053	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			10,039	(17,813)								(7,774)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,021	3,347								4,368	15
16	**TOTAL Health Care and Programs**			11,060	(14,466)								(3,406)	16
	C. General Administration													
17	Administrative			(86,872)									(86,872)	17
18	Directors Fees													18
19	Professional Services	(21,300)	13,895	2,198	1,936	(50,196)	542		(5,880)				(58,806)	19
20	Fees, Subscriptions & Promotions	(79,351)	168	5,137	1,021	1,128	9						(71,888)	20
21	Clerical & General Office Expenses	(49,770)	3,751	30,544	2,529	94,102	1,686						82,842	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,358	262	69							1,689	24
25	Other Admin. Staff Transportation			5,168	173	28							5,369	25
26	Insurance-Prop.Liab.Malpractice			1,649									1,649	26
27	Other (specify):*			9,863	242	10,356							20,461	27
28	**TOTAL General Administration**	(150,421)	17,814	(30,955)	6,163	55,487	2,238		(5,880)				(105,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(147,454)	17,814	(17,824)	(7,269)	55,487	5,218		(5,880)				(99,909)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APERION CARE GALESBURG # 0052761 **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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(55,579)	87,322	1,324	239	243	10,611						44,160	30
31	Amortization of Pre-Op. & Org.	(17,670)											(17,670)	31
32	Interest	(807)	205,355	6,320	12		3,072						213,952	32
33	Real Estate Taxes						1,133						1,133	33
34	Rent-Facility & Grounds		(360,000)				(30,000)						(390,000)	34
35	Rent-Equipment & Vehicles			1,539	264	273	834						2,910	35
36	Other (specify):*	(20,499)	20,499											36
37	**TOTAL Ownership**	(94,555)	(46,824)	9,183	515	516	(14,350)						(145,515)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(26,135)					(26,135)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(8,933)											(8,933)	43
44	**TOTAL Special Cost Centers**	(8,933)						(26,135)					(35,068)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(250,942)	(29,010)	(8,641)	(6,754)	56,002	(9,132)	(26,135)	(5,880)				(280,492)	45

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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. [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)	
1	V	34	Rent	$ 360,000	1145 Frank St. LLC		$	$ (360,000)	1
2	V	33	Rent Income - RE Tax	75,472	1145 Frank St. LLC			(75,472)	2
3	V	19	Accounting Fees		1145 Frank St. LLC		7,983	7,983	3
4	V	36	Amortization		1145 Frank St. LLC		20,499	20,499	4
5	V	21	Bank Charges		1145 Frank St. LLC		3,508	3,508	5
6	V	30	Depreciation		1145 Frank St. LLC		87,322	87,322	6
7	V	32	Interest	20	1145 Frank St. LLC		205,375	205,355	7
8	V	19	Legal Fees		1145 Frank St. LLC		452	452	8
9	V	20	Licenses & Permits		1145 Frank St. LLC		168	168	9
10	V	33	Real Estate Tax - Prior Year		1145 Frank St. LLC		(2,040)	(2,040)	10
11	V	33	Real Estate Tax		1145 Frank St. LLC		77,512	77,512	11
12	V	21	State Replacement Tax		1145 Frank St. LLC		243	243	12
13	V	19	Other Professional Fees		1145 Frank St. LLC		5,460	5,460	13
14	Total			$ 435,492			$ 406,482	$ * (29,010)	14

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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.		$ 102	$ 102	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.		1,647	1,647	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.		155	155	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.		167	167	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.		3	3	19
20	V	10	SALARY- NURSE		APERION CARE, INC.		10,036	10,036	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.		1,021	1,021	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.		48,293	48,293	22
23	V	17	MANAGEMENT FEES		APERION CARE, INC.		86,663	86,663	23
24	V	19	PROFESSIONAL FEES		APERION CARE, INC.		8,330	8,330	24
25	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.		5,137	5,137	25
26	V	21	CLERICAL SALARY		APERION CARE, INC.		28,991	28,991	26
27	V	21	CLERICAL & GENERAL		APERION CARE, INC.		1,553	1,553	27
28	V	24	SEMINARS		APERION CARE, INC.		1,358	1,358	28
29	V	25	AUTO AND TRAVEL		APERION CARE, INC.		5,168	5,168	29
30	V	26	INSURANCE		APERION CARE, INC.		1,649	1,649	30
31	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.		9,863	9,863	31
32	V	30	DEPRECIATION		APERION CARE, INC.		1,324	1,324	32
33	V	32	INTEREST		APERION CARE, INC.		6,320	6,320	33
34	V	35	AUTO LEASE		APERION CARE, INC.		1,539	1,539	34
35	V	17	MANAGEMENT FEE	221,828	APERION CARE, INC.			(221,828)	35
36	V	19	HOME OFFICE	6,132	APERION CARE, INC.			(6,132)	36
37	V								37
38	V								38
39	Total			$ 227,961			$ 219,319	$ * (8,641)	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 12,367	$ 12,367	15
16	V	6	MAINTENANCY SALARY		APERION CONSULTING, LLC		7,881	7,881	16
17	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC		2,234	2,234	17
18	V	10	SALARY NURSE		APERION CONSULTING, LLC		29,910	29,910	18
19	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		3,347	3,347	19
20	V	19	PROFESSIONAL FEES		APERION CONSULTING, LLC		1,936	1,936	20
21	V	20	FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC		1,021	1,021	21
22	V	21	CLERICAL & GENERAL		APERION CONSULTING, LLC		2,529	2,529	22
23	V	24	SEMINARS		APERION CONSULTING, LLC		262	262	23
24	V	25	AUTO AND TRAVEL		APERION CONSULTING, LLC		173	173	24
25	V	27	PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		242	242	25
26	V	30	DEPRECIATION		APERION CONSULTING, LLC		239	239	26
27	V	32	INTEREST		APERION CONSULTING, LLC		12	12	27
28	V	35	AUTO LEASE		APERION CONSULTING, LLC		264	264	28
29	V								29
30	V								30
31	V								31
32	V	10	RN CONSULTING	47,722	APERION CONSULTING, LLC			(47,722)	32
33	V	01	DIETICIAN	14,990	APERION CONSULTING, LLC			(14,990)	33
34	V	06	PROJECT MANAGER	6,458	APERION CONSULTING, LLC			(6,458)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 69,171			$ 62,417	$ * (6,754)	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		4,994	$ 4,994	15
16	V	20	FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		1,128	1,128	16
17	V	21	CLERICAL & GENERAL		APERION FINANCIAL, LLC		94,102	94,102	17
18	V	24	SEMINARS		APERION FINANCIAL, LLC		69	69	18
19	V	25	AUTO AND TRAVEL		APERION FINANCIAL, LLC		28	28	19
20	V	27	EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		10,356	10,356	20
21	V	30	DEPRECIATION		APERION FINANCIAL, LLC		243	243	21
22	V	35	EQUIPMENT RENTAL		APERION FINANCIAL, LLC		273	273	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	19	HOME OFFICE EXPENSE	55,190	APERION FINANCIAL, LLC			(55,190)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 55,190			$ 111,192	$ * 56,002	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 843	$ 843	15
16	V	6	REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,824	1,824	16
17	V	7	HOUSEKEEPING		CHASE OFFICE,LLC		313	313	17
18	V	19	PROFESSIONAL FEES		CHASE OFFICE,LLC		542	542	18
19	V	20	DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		9	9	19
20	V	21	OFFICE EXPENSE		CHASE OFFICE,LLC		1,686	1,686	20
21	V	30	DEPRECIATION		CHASE OFFICE,LLC		10,611	10,611	21
22	V	32	INTEREST EXPENSE		CHASE OFFICE,LLC		3,072	3,072	22
23	V	33	REAL ESTATE TAXES		CHASE OFFICE,LLC		1,133	1,133	23
24	V	35	EQUIPMENT RENTAL		CHASE OFFICE,LLC		834	834	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			$ 20,868	$ * (9,132)	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	$ 349,399	Renewal Rehab		$ 323,264	$ (26,135)	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			$ 349,399			$ 323,264	$ * (26,135)	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	$ 22,461	ProPay HR LLC		$ 16,581	$ (5,880)	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			$ 22,461			$ 16,581	$ * (5,880)	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	26	Insurance	$ 140,283	Aperion Incorporated Cell		$ 140,283	$	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			$ 140,283			$ 140,283	$ *	39

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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 GALESBURG # 0052761 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 GALESBURG # 0052761 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	MICHAEL ROSEN TRUST	29.50%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	YOSEF MEYSTEL TRUST	32.00%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	FREDRICK S. FRANKEL	1.00%	Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	DAVID BERKOWITZ TRUST	32.00%	Aperion Care Burbank	Burbank	Renewal Rehab	LIncolnwood	Therapy Services	4
5	STEVEN TUROFSKY	1.00%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	HOWARD BORENSTEIN	4.50%	Aperion Care Capitol	Capitol	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8			Aperion Care Demotte	Demotte,IN	Eco-Brite	Skokie	Laundry	8
9			Aperion Care Dolton	Dolton	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Elgin	Elgin	Pointe Property, LLC	Boston, MA	Property Management	10
11			Aperion Care Evanston	Evanston	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Fairfield	Fairfield	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Frankfort	Frankfort, IN	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	1145 Frank St. LLC		Building Co.	18
19			Aperion Care Jacksonville	Jacksonville	Aperion Incorporated Cell	Burlington, VT	Insurance	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 GALESBURG # 0052761 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 GALESBURG # 0052761 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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative		See Attached	0.93	2.32%	Alloc. Salary	$ 5,808	17-7	1
2	Jay Meystel	Relative	Clerical		See Attached	0.46	1.16%	Alloc. Salary	718	21-07	2
3	Cynthia Meystel	Relative	Clerical		See Attached	0.13	3.09%	Alloc. Salary	408	21-07	3
4	David Berkowitz	Relative	Administrative		See Attached	0.93	2.32%	Alloc. Salary	5,808	17-7	4
5	Fredrick Frankel	Owner	Administrative	1.00%	See Attached	0.93	2.32%	Alloc. Salary	5,225	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.93	2.32%	Alloc. Salary	4,792	17-7	6
7	Elisheva Adest	Relative	Clerical		See Attached	0.36	1.54%	Alloc. Salary	287	21-07	7
8	Michael Rosen	Relative	Administrative		See Attached	13.87	34.67%	Alloc. Mgt Fee	86,663	17-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 109,709		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 GALESBURG # 0052761 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 GALESBURG # 0052761 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	$	32,560	$ 102	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	55,615	32,560	1,647	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652		32,560	155	3
4	7	EMP. BEN.-GEN. SERV. & DIET	ACTUAL CENSUS	1,401,635	55	5,656		32,560	167	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128		32,560	3	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	422,414	32,560	10,036	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957		32,560	1,021	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	2,112,862	32,560	48,293	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,401,635	55	250,000		32,560	86,663	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581		32,560	8,330	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133		32,560	5,137	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	1,246,022	32,560	28,991	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841		32,560	1,553	13
14	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453		32,560	1,358	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488		32,560	5,168	15
16	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976		32,560	1,649	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828		32,560	9,863	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000		32,560	1,324	18
19	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060		32,560	6,320	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252		32,560	1,539	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,968,302	$ 3,836,913		$ 219,319	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	32,560	$ 12,367	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	32,560	7,881	2
3	7	EMP. BEN.-GEN. SERV. & DIET	PATIENT DAYS	1,401,635	55	81,117		32,560	2,234	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	32,560	29,910	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437		32,560	3,347	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		32,560	1,936	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		32,560	1,021	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	32,560	2,529	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		32,560	262	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		32,560	173	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636		32,560	242	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		32,560	239	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		32,560	12	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		32,560	264	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		$ 62,417	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		32,560	4,994	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576		32,560	1,128	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	32,560	94,102	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987		32,560	69	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197		32,560	28	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805		32,560	10,356	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463		32,560	243	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738		32,560	273	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		$ 111,192	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	$	32,560	$ 843	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537		32,560	1,824	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463		32,560	313	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338		32,560	542	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402		32,560	9	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586		32,560	1,686	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791		32,560	10,611	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223		32,560	3,072	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786		32,560	1,133	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907		32,560	834	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	$		$ 20,868	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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 Avenue, Suite 160
City / State / Zip Code: Lincolnwood, IL 60712
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			$	$		$ 323,264	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					$	$		$ 323,264	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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			$	$		$ 16,581	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					$	$		$ 16,581	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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			$	$		$ 140,283	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					$	$		$ 140,283	25

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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 GALESBURG # 0052761 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 GALESBURG # 0052761 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Midwest Bank		X	Mortgage			$	$ 3,337,500			$ 205,375	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				1,125,639			62,741	6
7	Insurance Policies		X								1,290	7
8												8
9	TOTAL Facility Related						$	$ 4,463,139			$ 269,406	9
	B. Non-Facility Related*											
10	Interest Income		X								(807)	10
11	Interest Income - Bldg Co		X								(20)	11
12												12
13	See Supplemental Schedule										9,404	13
14	TOTAL Non-Facility Related						$	$			$ 8,577	14
15	TOTALS (line 9+line14)						$	$ 4,463,139			$ 277,983	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 GALESBURG # 0052761 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.**	$ 77,513	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.)		$ 76,605	2
3. Under or (over) accrual (line 2 minus line 1).		$ (908)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 77,513	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 5,213	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.		$ 81,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	24,740	8
	2014	25,294	9
	2015	25,973	10
	2016	77,513	11
	2017	75,472	12

2018 Accrual = $75,472 x 1.027 = $77,513

Allocated from Chase Office $1,133

	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 GALESBURG COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

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.	99-09-202-017	Long Term Care Facility	$ 75,472.38	$ 75,472.38
2.	See Attached	Allocated from Chase Office	$ 45,392.90	$ 1,054.48
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 120,865.28	$ 76,526.86

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 GALESBURG COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052761

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 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 GALESBURG # 0052761 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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2015	$ 308,847	1
2	Allocated from Chase Office		2016	1,442	2
3	TOTALS			$ 310,289	3

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	108		2015	1972	$ 2,758,153	$ 87,322	35	$ 78,804	$ (8,518)	$ 295,946	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	174,677		20	13,166	13,166	57,891	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 GALESBURG # 0052761 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
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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)		82,812	5,498		3,824	(1,674)	9,415	68
69	Financial Statement Depreciation			108,110			(108,110)		69
70	TOTAL (lines 4 thru 69)		$ 3,015,642	$ 200,930		$ 95,795	$ (105,135)	$ 363,252	70

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 3,015,642	$ 200,930		$ 95,795	$ (105,135)	$ 363,252	1
2	10 Windows Near Egress	2015	4,841		20	242	242	867	2
3	B-Wing Corridor - Install Wallcovering & Paint	2015	17,689		20	884	884	3,538	3
4	Guest Bathroom-Replace Flr & Wall Tile,Toilet,Sink,Faucet,Fixtur	2015	4,260		20	213	213	852	4
5	Nurses Station-2 Custom Nurse Stations With Sink & Faucet	2015	28,376		20	1,419	1,419	5,675	5
6	Vestibule & Dining-Wallcovering, New Divider Wall, Light Fixture	2015	21,725		20	1,086	1,086	4,345	6
7	Therapy Room-Laminate Workstation; Admissions Office-Shades	2015	9,970		20	499	499	1,994	7
8	Paint Library, Activity Rm, Doorframes, Therapy Rm, Dining Rm (	2015	28,018		20	1,401	1,401	5,604	8
9	2 N & 2 S Corridors - Millwork Base, Signage, Lighting	2015	43,324		20	2,166	2,166	8,665	9
10	Guest Bathrm & Vestibule- Tile,Mirror,Remove Windows	2015	2,561		20	128	128	502	10
11	Nurse Station- Demo, Electrical Power To New Station	2015	4,243		20	212	212	831	11
12	Library/Group & Conference Rm- Cove Base & Shades	2015	3,374		20	169	169	661	12
13	Lounge - New Vinyl Tile, Light Fixtures	2015	8,402		20	420	420	1,645	13
14	Therapy Rm & Misc - New Workstation, Dumpster	2015	5,563		20	278	278	1,089	14
15	Corridors- Reroute Power & New Light Fixtures, 6 Outlets	2015	39,362		20	1,968	1,968	7,708	15
16	Fence	2015	4,340		20	217	217	814	16
17	Corridors - Signage, Cornice - Dining Room & Resident Rooms...	2016	16,578		20	829	829	2,487	17
18	Heat Pump	2016	4,150		20	208	208	519	18
19	Installation Of Entrance Sign & Cabinet Faces	2016	4,722		20	236	236	531	19
20	Basio Plumbing-Heat Exchanger	2016	3,714		20	186	186	387	20
21	Guest Bath & Nursing Station	2017	5,082		20	254	254	508	21
22	Ao Smith 100 Gal Commercial Waterheater	2017	5,799		20	290	290	411	22
23	Garrison Ptac	2018	3,600		20	40	40	40	23
24	Kitchen Floor Replacement (16,424)	2018	15,940		20	411	411	411	24
25	Fire Door (2,966)	2018	2,845		20	74	74	74	25
26	Repaired Parking Lot/Sealcoat (12,490)	2018	11,280		20	208	208	208	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	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
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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)		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,315,400	$ 200,930		$ 109,833	$ (91,097)	$ 413,618	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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
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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 GALESBURG # 0052761 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
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	12,982	333	20	333		804	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	692	111	20	35	(77)	277	9
10	Allocated from Aperion Care	2012	196	15	20	10	(5)	59	10
11	Allocated from Aperion Care	2013	83	9	20	4	(5)	21	11
12									12
13	Allocated from Chase Office LLC	2018	59		20	3	3	3	13
14	Allocated from Chase Office LLC	2017	3,005	213	20	150	(62)	300	14
15	Allocated from Chase Office LLC	2016	65,794	4,817	20	3,290	(1,527)	7,950	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)		$ 82,812	$ 5,498		$ 3,824	$ (1,674)	$ 9,415	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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		$ 82,812	$ 5,498		$ 3,824	$ (1,674)	$ 9,415	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 82,812	$ 5,498		$ 3,824	$ (1,674)	$ 9,415	34

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	$ 303,453	$ 6,380	$ 34,020	$ 27,640	10	$ 108,904	71
72	Current Year Purchases	18,430	328	1,490	1,162	10	1,490	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 321,884	$ 6,708	$ 35,510	$ 28,802		$ 110,394	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		2013 GMC SAVANA	2013	$ 54,662	$	$ 6,659	$ 6,659	5	$ 42,176	76
77		Allocated from Aperion Care	2018	777	118	155	38	5	504	77
78		Allocated from Aperion Consultin	2018	567	93	113	20	5	454	78
79										79
80	TOTALS			$ 56,006	$ 211	$ 6,928	$ 6,716		$ 43,134	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)	$ 4,003,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 207,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,270	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (55,579)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 567,146	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	Door Replacement	$ 500	92
93			93
94			94
95		$ 500	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 GALESBURG # 0052761 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: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 13,167 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		$	$ 1,539	17
18	Allocated from Aperion Consulting			264	18
19					19
20					20
21	TOTAL		$	$ 1,803	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 GALESBURG # 0052761 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 GALESBURG

STATE OF ILLINOIS
0052761 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 152,234	$		$ 152,234	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,614			4,614	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			192,468			192,468	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				70,819		70,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):			166,624		12,901	81,802		261,327	13
14	TOTAL			$ 166,624		$ 362,217	$ 152,621		$ 681,462	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.

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	$ 85,908	$ 87,556	1
2	Cash-Patient Deposits	1,200	1,200	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,519,296	1,519,296	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,365	89,365	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	52,864	52,864	8
9	Other(specify): See Attached Schedule	628,536	751,241	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,377,169	$ 2,501,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		308,847	13
14	Buildings, at Historical Cost		2,758,153	14
15	Leasehold Improvements, at Historical Cost	382,080	382,080	15
16	Equipment, at Historical Cost	333,582	416,582	16
17	Accumulated Depreciation (book methods)	(383,394)	(693,351)	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	1,327,465	1,514,613	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,659,733	$ 4,686,924	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,036,902	$ 7,188,446	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 429,975	$ 429,975	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,125,639	1,125,639	29
30	Accrued Salaries Payable	177,694	177,694	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,419	7,419	31
32	Accrued Real Estate Taxes(Sch.IX-B)		77,513	32
33	Accrued Interest Payable	5,699	24,750	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	14,234	14,234	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,760,660	$ 1,857,224	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,337,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,708,929	394,273	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,708,929	$ 3,731,773	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,469,589	$ 5,588,997	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 567,313	$ 1,599,449	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,036,902	$ 7,188,446	48

*(See instructions.)

Facility Name & ID Number APERION CARE GALESBURG # 0052761 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 676,609	1
2	Restatements (describe):		2
3	**Prior Year Bad Debts**	(86,782)	3
4	**Rounding**	(5)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 589,822	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,491	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	(25,000)	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)**	$ (22,509)	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)**	$ 567,313	24 *

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 5,854,081	1
2	Discounts and Allowances for all Levels	107,991	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,962,072	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	171,347	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 171,347	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	3,098	17
18	Sale of Supplies to Non-Patients	1,326	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	766	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,190	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	807	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 807	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)**	$ 6,139,416	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	922,196	31
32	Health Care	2,281,411	32
33	General Administration	1,330,828	33
	B. Capital Expense		
34	Ownership	667,344	34
	C. Ancillary Expense		
35	Special Cost Centers	690,395	35
36	Provider Participation Fee	244,751	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,136,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,491	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,491	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,810,067	44
45	Private Pay - Net Inpatient Revenue	182,568	45
46	Medicare - Net Inpatient Revenue	888,955	46
47	Other-(specify) **Insurance**	198,563	47
48	Other-(specify) **Managed Care**	1,881,919	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,962,072	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number APERION CARE GALESBURG # 0052761 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,353	1,761	$ 57,337	$ 32.56	1
2	Assistant Director of Nursing	2,092	2,268	60,400	26.63	2
3	Registered Nurses	5,933	7,421	186,115	25.08	3
4	Licensed Practical Nurses	23,437	25,672	554,378	21.59	4
5	CNAs & Orderlies	55,741	60,335	793,509	13.15	5
6	CNA Trainees					6
7	Licensed Therapist	6,445	6,801	166,624	24.50	7
8	Rehab/Therapy Aides	2,735	3,138	54,378	17.33	8
9	Activity Director	2,008	2,080	38,082	18.31	9
10	Activity Assistants	3,714	4,180	54,713	13.09	10
11	Social Service Workers	7,017	7,543	191,951	25.45	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,011	40,037	19.91	13
14	Head Cook	3,451	3,644	45,125	12.38	14
15	Cook Helpers/Assistants	10,315	11,001	118,923	10.81	15
16	Dishwashers					16
17	Maintenance Workers	4,130	4,573	70,377	15.39	17
18	Housekeepers	11,175	12,088	132,709	10.98	18
19	Laundry	5,340	5,679	64,946	11.44	19
20	Administrator	1,816	1,971	68,993	35.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,466	3,751	61,605	16.42	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	1,110	1,193	17,020	14.27	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,024	2,225	30,726	13.81	33
34	TOTAL (lines 1 - 33)	155,198	169,335	$ 2,807,948 *	$ 16.58	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	$ 14,990	01-03	35
36	Medical Director	252	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	47,722	10-03	38
39	Pharmacist Consultant	124	9,286	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	15	922	11-03	44
45	Social Service Consultant	57	3,869	12-03	45
46	Other(specify)				46
47	Psychiatric Consultant	109	14,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	557	$ 108,789		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	9	396	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	$ 396		53

Facility Name & ID Number APERION CARE GALESBURG # 0052761 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Paxton 1/1/18 - 2/27/18	Administrator	0	$ 13,276
Dustin McDonald 2/26/18 - 4/11/18	Administrator	0	10,127
Robin Carlson 5/21/18 - 12/31/18	Administrator	0	45,590
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,993

B. Administrative - Other

Description	Amount
Aperion Care- Management Fees	$ 221,828
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 221,828

C. Professional Services

Vendor/Payee	Type	Amount
PointClick Care Tecnologies Inc.	EMR / Billing Software	$ 33,481
Creative Technology Solutions	IT Consulting	7,196
COMS Interactive	Care Management Software	8,438
DGTELL LLC	Surveillance	750
Ability Network Inc.	Healthcare Software	6,073
Aperion Care Inc.	Data Processing	16,623
Skidelsky & Assoc	Real Estate Appeal	190
Aperion Care Inc.	Home Office	6,132
Aperion Financial	Home Office	55,190
Propay HR	Payroll Processing	22,461
Marcum LLP	Accounting Fees	23,690
See Supplemental Schedule		59,061
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 239,285

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,214
Unemployment Compensation Insurance	27,407
FICA Taxes	209,745
Employee Health Insurance	(21,356)
Employee Meals	1,814
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,040
Employee Benefits - Other	12,810
401K Expense	1,397
TOTAL (agree to Schedule V, line 22, col.8)	$ 317,071

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	$ 3,980
Advertising: Employee Recruitment	902
Health Care Worker Background Check	
(Indicate # of checks performed 242)	2,417
Patient Background Checks 122	1,220
Dues and Subscriptions	42,299
License and Permits	1,112
Allocated from Aperion Care	
Allocated from Aperion Consulting	
See Supplemental Schedule	7,295
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,225

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,937
Allocated from Aperion Care	1,358
Allocated from Aperion Consulting	262
Allocated from Aperion Financial	69
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,626

**See instructions.

Facility Name & ID Number APERION CARE GALESBURG # 0052761 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. **HCCI-$6,034**

(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. $ **7,153** 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. $ **244,751**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A**

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

(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.