

		FOR BHF USE					

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0054700</u></p> <p><b>Facility Name:</b> <u>Aperion Care Mascoutah, Llc</u></p> <p><b>Address:</b> <u>901 North Tenth Street</u> <u>Mascoutah</u> <u>62258</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>St. Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 566-2183</u> <b>Fax #</b> <u>(618) 566-4462</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/1/2017</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 282-6300</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: 1px solid black; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) _____</td> </tr> <tr> <td style="border: 1px solid black; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																	
	(Type or Print Name) _____																	
	(Title) _____																	
Paid Preparer	(Signed) _____ (Date) _____																	
	(Print Name and Title) _____																	
	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>																	
	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																	

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,216	2,133	3,625	14,974	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,216	2,133	3,625	14,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.59%

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

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

I. On what date did you start providing long term care at this location?  
Date started 9/1/2017

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 9/1/2017 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 55 and days of care provided 860

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Aperion Care Mascoutah, Llc # 0054700 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	139,150	10,600	6,704	156,454		156,454	5,688	162,142		1
2	Food Purchase		84,773		84,773		84,773	(74)	84,699		2
3	Housekeeping	40,202	14,090		54,292		54,292		54,292		3
4	Laundry	36,235	9,302		45,537		45,537		45,537		4
5	Heat and Other Utilities			71,990	71,990		71,990	(15,050)	56,940		5
6	Maintenance	28,088	14,330	77,788	120,206		120,206	(18,688)	101,518		6
7	Other (specify):*							1,248	1,248		7
8	<b>TOTAL General Services</b>	243,675	133,095	156,482	533,252		533,252	(26,876)	506,376		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,500	11,500		11,500		11,500		9
10	Nursing and Medical Records	856,784	84,148	102,213	1,043,145		1,043,145	(56,300)	986,845		10
10a	Therapy			465	465		465		465		10a
11	Activities	40,224	3,573	2,789	46,586		46,586		46,586		11
12	Social Services	50,634		840	51,474		51,474		51,474		12
13	CNA Training										13
14	Program Transportation			1,842	1,842		1,842		1,842		14
15	Other (specify):*							2,008	2,008		15
16	<b>TOTAL Health Care and Programs</b>	947,642	87,721	119,649	1,155,012		1,155,012	(54,292)	1,100,720		16
	<b>C. General Administration</b>										
17	Administrative	78,197		86,821	165,018		165,018	(64,611)	100,407		17
18	Directors Fees										18
19	Professional Services			222,910	222,910	(11)	222,899	(122,077)	100,823		19
20	Dues, Fees, Subscriptions & Promotions			61,311	61,311		61,311	(42,649)	18,662		20
21	Clerical & General Office Expenses	39,190		70,955	110,145		110,145	8,128	118,273		21
22	Employee Benefits & Payroll Taxes			177,455	177,455		177,455		177,455		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,947	2,947		2,947	776	3,723		24
25	Other Admin. Staff Transportation			4,589	4,589		4,589	2,469	7,058		25
26	Insurance-Prop.Liab.Malpractice			91,186	91,186		91,186	758	91,944		26
27	Other (specify):*							9,410	9,410		27
28	<b>TOTAL General Administration</b>	117,387		718,174	835,561	(11)	835,550	(207,795)	627,755		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,308,704	220,816	994,305	2,523,825	(11)	2,523,814	(288,964)	2,234,851		29

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

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

Facility Name &amp; ID Number

Aperion Care Mascoutah, Llc

#0054700

Report Period Beginning:

01/01/18

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			7,102	7,102		7,102	12,811	19,913			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,472	12,472		12,472	23,692	36,164			32
33	Real Estate Taxes			10,257	10,257	11	10,268	10,490	20,758			33
34	Rent-Facility & Grounds			152,237	152,237		152,237	(152,237)				34
35	Rent-Equipment & Vehicles			5,097	5,097		5,097	1,338	6,435			35
36	Other (specify):*			5,653	5,653		5,653	(5,653)				36
37	<b>TOTAL Ownership</b>			192,818	192,818	11	192,829	(109,559)	83,270			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,291	217,565	265,856		265,856	(13,930)	251,926			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,231	118,231		118,231		118,231			42
43	Other (specify):*			9,698	9,698		9,698	(9,698)				43
44	<b>TOTAL Special Cost Centers</b>		48,291	345,494	393,785		393,785	(23,628)	370,157			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,308,704	269,107	1,532,617	3,110,428		3,110,428	(422,151)	2,688,277			45

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



Aperion Care Mascoutah, Llc

ID# 0054700

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing	\$ (1,549)	21	1
2	Advertising/Marketing	(8,836)	43	2
3	Promotional Products	(337)	43	3
4	Bank Charges	(19,035)	21	4
5	Theft & Damage Loss	(274)	21	5
6	Amortization	(5,653)	36	6
7	Additional Real Estate Tax	9,900	33	7
8	Bldg Co. - Accounting Fees	(7,983)	19	8
9	Bldg Co. - Bank Charges	(335)	21	9
10	Bldg Co. - Other Professional	(8,709)	19	10
11	Additional R&M	3,447	06	11
12	Capitalized R&M	(8,593)	06	12
13	PAC Dues	(4,758)	20	13
14	Prior Year HCCI Dues	(990)	20	14
15	Non-Allowable Legal Expense	(50,030)	19	15
16	Non-Allowable Professional Expense	(1,550)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(105,284)		49

Aperion Care Mascoutah, Llc

Report Period Beginning: ID# 0054700  
 Ending: 01/01/18  
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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Mascoutah, Llc# 0054700

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)	
	<b>A. General Services</b>													
1	Dietary				5,688								5,688	1
2	Food Purchase	(121)		47									(74)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(15,438)					388						(15,050)	5
6	Maintenance	(5,146)		828	(15,209)		839						(18,688)	6
7	Other (specify):*			77	1,028		144						1,248	7
8	<b>TOTAL General Services</b>	<b>(20,705)</b>		<b>952</b>	<b>(8,494)</b>		<b>1,370</b>						<b>(26,876)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			4,617	(60,917)								(56,300)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			469	1,539								2,008	15
16	<b>TOTAL Health Care and Programs</b>			<b>5,086</b>	<b>(59,378)</b>								<b>(54,292)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(64,611)									(64,611)	17
18	Directors Fees													18
19	Professional Services	(68,271)	16,692	(3,640)	891	(64,940)	249		(3,058)				(122,077)	19
20	Fees, Subscriptions & Promotions	(46,004)		2,362	470	519	4						(42,649)	20
21	Clerical & General Office Expenses	(51,469)	335	14,047	1,163	43,276	775						8,128	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			624	120	32							776	24
25	Other Admin. Staff Transportation			2,377	79	13							2,469	25
26	Insurance-Prop.Liab.Malpractice			758									758	26
27	Other (specify):*			4,536	111	4,763							9,410	27
28	<b>TOTAL General Administration</b>	<b>(165,744)</b>	<b>17,027</b>	<b>(43,547)</b>	<b>2,835</b>	<b>(16,337)</b>	<b>1,029</b>		<b>(3,058)</b>				<b>(207,795)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(186,449)</b>	<b>17,027</b>	<b>(37,509)</b>	<b>(65,037)</b>	<b>(16,337)</b>	<b>2,400</b>		<b>(3,058)</b>				<b>(288,964)</b>	<b>29</b>



## STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Mascoutah, Llc# 0054700

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(69,452)	76,552	609	110	112	4,880						12,811	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(337)	19,705	2,906	5		1,413						23,692	32
33	Real Estate Taxes	9,900	69				521						10,490	33
34	Rent-Facility & Grounds		(140,237)				(12,000)						(152,237)	34
35	Rent-Equipment & Vehicles			708	122	125	384						1,338	35
36	Other (specify):*	(5,653)											(5,653)	36
37	<b>TOTAL Ownership</b>	<b>(65,542)</b>	<b>(43,911)</b>	<b>4,223</b>	<b>237</b>	<b>237</b>	<b>(4,803)</b>						<b>(109,559)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(13,930)					(13,930)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,173)			(525)								(9,698)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,173)</b>			<b>(525)</b>			<b>(13,930)</b>					<b>(23,628)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(261,164)</b>	<b>(26,884)</b>	<b>(33,286)</b>	<b>(65,326)</b>	<b>(16,100)</b>	<b>(2,403)</b>	<b>(13,930)</b>	<b>(3,058)</b>				<b>(422,151)</b>	<b>45</b>

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 140,237	Mascoutah Property LLC		\$	(140,237)	1
2	V	33 Real Estate Tax	10,257	Mascoutah Property LLC		10,326	69	2
3	V	32 Interest	1	Mascoutah Property LLC		19,706	19,705	3
4	V	19 Accounting Fees		Mascoutah Property LLC		7,983	7,983	4
5	V	21 Bank Charges		Mascoutah Property LLC		335	335	5
6	V	30 Depreciation		Mascoutah Property LLC		76,552	76,552	6
7	V	19 Other Professional		Mascoutah Property LLC		8,709	8,709	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 150,495			\$ 123,611	\$ * (26,884)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 FOOD	\$	APERION CARE, INC.		\$ 47	\$ 47	15
16	V	6 MAINTENANCE SALARY		APERION CARE, INC.		757	757	16
17	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.		71	71	17
18	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.		77	77	18
19	V	10 NURSING & MEDICAL RECORDS		APERION CARE, INC.		1	1	19
20	V	10 SALARY- NURSE		APERION CARE, INC.		4,616	4,616	20
21	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.		469	469	21
22	V	17 ADMINISTRATIVE SALARIES		APERION CARE, INC.		22,209	22,209	22
23	V	19 PROFESSIONAL FEES		APERION CARE, INC.		3,831	3,831	23
24	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.		2,362	2,362	24
25	V	21 CLERICAL SALARY		APERION CARE, INC.		13,333	13,333	25
26	V	21 CLERICAL & GENERAL		APERION CARE, INC.		714	714	26
27	V	24 SEMINARS		APERION CARE, INC.		624	624	27
28	V	25 AUTO AND TRAVEL		APERION CARE, INC.		2,377	2,377	28
29	V	26 INSURANCE		APERION CARE, INC.		758	758	29
30	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.		4,536	4,536	30
31	V	30 DEPRECIATION		APERION CARE, INC.		609	609	31
32	V	32 INTEREST		APERION CARE, INC.		2,906	2,906	32
33	V	35 AUTO LEASE		APERION CARE, INC.		708	708	33
34	V	17 MANAGEMENT FEE	86,821	APERION CARE, INC.			(86,821)	34
35	V	19 HOME OFFICE	7,471	APERION CARE, INC.			(7,471)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 94,291			\$ 61,005	\$ * (33,286)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETITIAN SALARY	\$	APERION CONSULTING, LLC		\$ 5,688	\$ 5,688	15
16	V	6 MAINTENANCY SALARY		APERION CONSULTING, LLC		3,624	3,624	16
17	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC		1,028	1,028	17
18	V	10 SALARY NURSE		APERION CONSULTING, LLC		13,755	13,755	18
19	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		1,539	1,539	19
20	V	19 PROFESSIONAL FEES		APERION CONSULTING, LLC		891	891	20
21	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC		470	470	21
22	V	21 CLERICAL & GENERAL		APERION CONSULTING, LLC		1,163	1,163	22
23	V	24 SEMINARS		APERION CONSULTING, LLC		120	120	23
24	V	25 AUTO AND TRAVEL		APERION CONSULTING, LLC		79	79	24
25	V	27 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		111	111	25
26	V	30 DEPRECIATION		APERION CONSULTING, LLC		110	110	26
27	V	32 INTEREST		APERION CONSULTING, LLC		5	5	27
28	V	35 AUTO LEASE		APERION CONSULTING, LLC		122	122	28
29	V							29
30	V							30
31	V							31
32	V	10 RN CONSULTING	74,672	APERION CONSULTING, LLC			(74,672)	32
33	V	06 PROJECT MANAGER	18,833	APERION CONSULTING, LLC			(18,833)	33
34	V	43 MARKETING	525	APERION CONSULTING, LLC			(525)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 94,031			\$ 28,705	\$ * (65,326)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC		2,297	\$ 2,297 15
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		519	519 16
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		43,276	43,276 17
18	V	24 SEMINARS		APERION FINANCIAL, LLC		32	32 18
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		13	13 19
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		4,763	4,763 20
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		112	112 21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		125	125 22
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V	19 HOME OFFICE EXPENSE	67,237	APERION FINANCIAL, LLC			(67,237) 31
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 67,237			\$ 51,137	\$ * (16,100) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC		\$ 388	\$ 388	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		839	839	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		144	144	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		249	249	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		4	4	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		775	775	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		4,880	4,880	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		1,413	1,413	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		521	521	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		384	384	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V	34 RENTAL INCOME	12,000	CHASE OFFICE, LLC			(12,000)	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 12,000			\$ 9,597	\$ * (2,403)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy Services	\$ 186,232	Renewal Rehab		\$ 172,302	\$ (13,930)	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		\$ 186,232			\$ 172,302	\$ * (13,930)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Payroll Services	\$ 11,680	ProPay HR LLC		\$ 8,622	\$ (3,058)	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		\$ 11,680			\$ 8,622	\$ *	(3,058) 39

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 71,440	Aperion Incorporated Cell		\$ 71,440	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 71,440			\$ 71,440	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Aperion Care Mascoutah, Llc

# 0054700

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	DAVID BERKOWITZ AS TRUSTEE	20.00%	Aperion Care Angola	Angola, IN	Mascoutah Property LLC	Mascoutah	Building Company	1
2	YOSEF MEYSTEL AS THE TRUSTEE	20.00%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	2
3	DAVID A. BERKOWITZ REVOCABLE TRUST	25.00%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	3
4	DECLARATION OF TRUST OF YOSEF	25.00%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	4
5	STEVEN TUROFSKY	1.50%	Aperion Care Cairo	Cairo	Renewal Rehab	Lincolnwood	Therapy Services	5
6	FREDERICK S. FRANKEL	1.50%	Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	6
7	NAFTALI WILHEIM	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	Lincolnwood	Consulting Co.	7
8	JENNIFER SPECTOR	1.50%	Aperion Care Demotte	Demotte, IN	Aperion Financial, Inc.	Lincolnwood	Bookkeeping	8
9	257 LIMITED PARTNERSHIP	1.34%	Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	9
10	1219 LIMITED PARTNERSHIP	1.33%	Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	10
11	42170 LIMITED PARTNERSHIP	1.33%	Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	11
12			Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	15
16			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	16
17			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	17
18			Aperion Care Highwood	Highwood	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	18
19			Aperion Care International	Chicago	Aperion Incorporated Cell	Burlington, VT	Insurance	19
20			Aperion Care Jacksonville	Jacksonville				20
21			Aperion Care Kokomo	Kokomo, IN				21
22			Aperion Care Litchfield	Litchfield				22
23			Aperion Care Marion	Marion, IN				23
24			Aperion Care Marseilles	Marseilles				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 &amp; ID Number

Aperion Care Mascoutah, Llc

# 0054700

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.43	1.07%	Alloc Salary	\$ 2,671	17-7	1	
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.21	0.53%	Alloc Salary	330	21-7	2	
3	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.06	1.42%	Alloc Salary	188	21-7	3	
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.43	1.07%	Alloc Salary	2,671	17-7	4	
5	Frederick Frankel	Owner	Administrative	1.50%	See Attached	0.43	1.07%	Alloc Salary	2,403	17-7	5	
6	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.43	1.07%	Alloc Salary	2,204	17-7	6	
7	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.4	1.07%	Alloc Salary	2,671	21-7	7	
8	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.16	0.71%	Alloc Salary	132	21-7	8	
9	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.43	1.07%	Alloc Salary	1,222	21-7	9	
10	Dovid Spector	Relative	Clerical	0.00%	See Attached	0.43	1.07%	Alloc Salary	598	21-7	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	\$ 15,090		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 Mascoutah, Llc

# 0054700

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

Name of Related Organization

APERION CARE, INC.

Street Address

4655 W CHASE AVENUE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

( 847) 262-8300

Fax Number

(

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	FOOD	ACTUAL CENSUS	1,401,635	55	\$ 4,383	\$ 14,974	\$ 47	1	
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	14,974	757	2	
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	14,974	71	3	
4	7	EMP. BEN.-GEN. SERV. & DIED	ACTUAL CENSUS	1,401,635	55	5,656	14,974	77	4	
5	10	NURSING & MEDICAL RECORD	ACTUAL CENSUS	1,401,635	55	128	14,974	1	5	
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	422,414	14,974	4,616	6
7	15	PAYROLL TAXES/GROUP INSUR	ACTUAL CENSUS	1,401,635	55	42,957	14,974	469	7	
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	2,112,862	14,974	22,209	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	14,974	3,831	9	
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	14,974	2,362	10	
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	1,246,022	14,974	13,333	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	14,974	714	12	
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	14,974	624	13	
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	14,974	2,377	14	
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	14,974	758	15	
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	14,974	4,536	16	
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	14,974	609	17	
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	14,974	2,906	18	
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	14,974	708	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 5,718,302	\$ 3,836,913	\$ 61,005	25	



Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

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

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETITIAN SALARY	1,401,635	55	\$ 424,292	\$ 424,292	14,974	\$ 5,688	1
2	6	MAINTENANCY SALARY	1,401,635	55	311,197	311,197	14,974	3,624	2
3	7	EMP. BEN.-GEN. SERV. & DIE	1,401,635	55	81,117		14,974	1,028	3
4	10	SALARY NURSE	1,401,635	55	1,640,760	1,640,760	14,974	13,755	4
5	15	PAYROLL TAXES/GROUP INS	1,401,635	55	183,437		14,974	1,539	5
6	19	PROFESSIONAL FEES	1,401,635	55	83,360		14,974	891	6
7	20	FEES, SUBSCRIPTIONS	1,401,635	55	43,964		14,974	470	7
8	21	CLERICAL & GENERAL	1,401,635	55	102,122	81,823	14,974	1,163	8
9	24	SEMINARS	1,401,635	55	11,275		14,974	120	9
10	25	AUTO AND TRAVEL	1,401,635	55	7,427		14,974	79	10
11	27	PAYROLL TAXES/GROUP INS	1,401,635	55	9,636		14,974	111	11
12	30	DEPRECIATION	1,401,635	55	10,275		14,974	110	12
13	32	INTEREST	1,401,635	55	508		14,974	5	13
14	35	AUTO LEASE	1,401,635	55	11,374		14,974	122	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		\$ 28,705	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

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

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001	14,974	2,297	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	14,974	519	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	14,974	43,276	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	14,974	32	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	14,974	13	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	14,974	4,763	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	14,974	112	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	14,974	125	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	\$ 51,137	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

( 847) 262-3800

Fax Number

(

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 14,974	\$ 388	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	14,974	839	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	14,974	144	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	14,974	249	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	14,974	4	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	14,974	775	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	14,974	4,880	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	14,974	1,413	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	14,974	521	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	14,974	384	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	\$	\$ 9,597	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

Renewal Rehab

Street Address

7358 N. Lincoln Ave., Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

( 847) 938-8750

Fax Number

( 847) 410\*-9720

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		\$	\$		\$ 172,302	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				\$	\$		\$ 172,302	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

ProPay HR LLC

Street Address

2201 W. Main St

City / State / Zip Code

Evanston, IL 60202

Phone Number

( 847) 905-3268

Fax Number

( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 8,622	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 8,622	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

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

( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		71,440	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				\$	\$		71,440	25

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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



Facility Name & ID Number

Aperion Care Mascoutah, Llc

# 0054700

Report Period Beginning:

01/01/18

Ending:

12/31/18

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Midwest Bank		X	Mortgage			\$	\$ 311,371		\$ 19,706	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	First Midwest Bank		X	Line of Credit				\$ 195,000		\$ 12,328	6									
7	Insurance Policies		X							\$ 144	7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 506,371		\$ 32,178	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							\$ (337)	10									
11	Interest Income - Bldg Co.		X							\$ (1)	11									
12	Allocated from Aperion Care									\$ 2,906	12									
13	See Supplemental Schedule									\$ 1,418	13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 3,986	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 506,371		\$ 36,164	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 Mascoutah, Llc

# 0054700

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2017 report.

\$ 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.)

\$ 10,490 2

3. Under or (over) accrual (line 2 minus line 1).

\$ 10,490 3

4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ 10,257 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.)**

\$ 11 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ \_\_\_\_\_ For \_\_\_\_\_ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$ \_\_\_\_\_ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ 20,758 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>8,215</u>	8
	2014	<u>8,663</u>	9
	2015	<u>9,217</u>	10
	2016	<u>9,770</u>	11
	2017	<u>9,969</u>	12

2018 Accrual = 9969 x 1.0289

Allocated from Chase Office - \$521

**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 Mascoutah, Llc COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0054700

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-30.0-300-011</u>	<u>Long Term Care Property</u>	\$ <u>9,942.46</u>	\$ <u>9,942.46</u>
2. <u>10-30.0-300-026</u>	<u>Long Term Care Property</u>	\$ <u>26.42</u>	\$ <u>26.42</u>
3. <u>10-27-307-027-0001</u>	<u>Home Office Allocation</u>	\$ <u>45,392.90</u>	\$ <u>484.94</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>55,361.78</u>	\$ <u>10,453.82</u>

**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 Mascoutah, Llc COUNTY St. Clair  
 FACILITY IDPH LICENSE NUMBER 0054700  
 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) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

Report Period Beginning:

01/01/18

Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,712 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2017</u>	<u>\$ 18,145</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>663</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 18,808</b>	<b>3</b>

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	55		2017	1963	\$ 395,749	\$ 76,552	39	\$ 10,147	\$ (66,405)	\$ 13,530	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68			38,084		2,529	1,759	(770)	4,330				
69					7,102		(7,102)					
70		\$	433,833	\$	86,183	\$	11,906	\$	(74,276)	\$	17,859	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 433,833	\$ 86,183		\$ 11,906	\$ (74,276)	\$ 17,859	1
2	Cable And Data Access Points Installation	2018	4,354		20	218	218	218	2
3	Security Camera Installation (13,642)	2018	13,424		20	341	341	341	3
4	Interior Signage	2018	4,122		20	17	17	17	4
5	Installation Of Generator/Annunciator Panel	2018	5,620		20	281	281	281	5
6	Door Repair - Vertical Rod Panics/Rim Cylinders	2018	2,973		20	149	149	149	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)		\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865	34

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



**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865		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	<b>TOTAL (lines 1 thru 33)</b>	\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865		34

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865	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)	\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865	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)	\$ 464,326	\$ 86,183		\$ 12,912	\$ (73,271)	\$ 18,865	34

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
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)	\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	5,970	153	20	153		370	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	318	51	20	16	(35)	127	9
10	Allocated from Aperion Care	2012	90	7	20	5	(2)	27	10
11	Allocated from Aperion Care	2013	38	4	20	2	(2)	10	11
12									12
13	Allocated from Chase Office LLC	2018	27		20	1	1	1	13
14	Allocated from Chase Office LLC	2017	1,382	98	20	69	(29)	138	14
15	Allocated from Chase Office LLC	2016	30,258	2,215	20	1,513	(702)	3,656	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)		\$ 38,084	\$ 2,529		\$ 1,759	\$ (770)	\$ 4,330	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 38,084	\$ 2,529		\$ 1,759	\$ (770)	\$ 4,330	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)	\$ 38,084	\$ 2,529		\$ 1,759	\$ (770)	\$ 4,330	34

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

Facility Name & ID Number Aperion Care Mascoutah, Llc

# 0054700

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	\$ 55,101	\$ 2,934	\$ 5,551	\$ 2,617	10	\$ 9,251	71
72	Current Year Purchases	21,192	151	1,326	1,176	10	1,326	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 76,293	\$ 3,085	\$ 6,877	\$ 3,792		\$ 10,577	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2018	\$ 357	\$ 54	\$ 71	\$ 17	5	\$ 232	76
77		Allocated from Aperion Consultin	2018	261	43	52	9	5	209	77
78										78
79										79
80	<b>TOTALS</b>			\$ 618	\$ 97	\$ 124	\$ 26		\$ 440	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)	\$ 560,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,365	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,912	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (69,452)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 29,883	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92	Nurse Stations, PTAC's	\$ 679,358	92
93			93
94			94
95		\$ 679,358	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.



**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?  YES  NO  
 If NO, see instructions.

		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

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2019</u>	\$ _____
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 5,606 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Aperion Care</u>		\$	<u>708</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>122</u>	18
19					19
20					20
21	TOTAL		\$	<u>830</u>	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)					
					Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 75,038		\$	75,038	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					\$ 40,093			40,093	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs					\$ 71,100			71,100	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts						\$ 37,214		37,214	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):							\$ 31,334	\$ 11,077		42,411	13
14	TOTAL			\$				\$ 217,565	\$ 48,291		\$ 265,856	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 Mascoutah, Llc

# 0054700

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	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 5,959	\$ 5,959	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	395,981	395,981	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,621	33,621	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	12,638	54,161	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 449,199	\$ 490,722	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,975	13
14	Buildings, at Historical Cost		1,376,775	14
15	Leasehold Improvements, at Historical Cost	8,476	8,476	15
16	Equipment, at Historical Cost	45,624	251,874	16
17	Accumulated Depreciation (book methods)	(7,807)	(89,267)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	919,894	977,987	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 966,187	\$ 2,678,820	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,415,386	\$ 3,169,542	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 329,766	\$ 329,765	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	195,000	195,000	29
30	Accrued Salaries Payable	64,271	64,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,314	3,314	31
32	Accrued Real Estate Taxes(Sch.IX-B)		10,257	32
33	Accrued Interest Payable	987	2,764	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 593,338	\$ 605,371	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		311,371	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>	1,606,834	1,565,690	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,606,834	\$ 1,877,061	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,200,172	\$ 2,482,432	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (784,786)	\$ 687,110	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,415,386	\$ 3,169,542	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(93,924)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(93,924)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(615,562)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(75,300)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(690,862)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(784,786)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,231,050	1
2	Discounts and Allowances for all Levels	167,891	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,398,941	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	92,636	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 92,636	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,491	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	125	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,336	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,952	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	337	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 337	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,494,866	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	533,252	31
32	Health Care	1,155,012	32
33	General Administration	835,561	33
<b>B. Capital Expense</b>			
34	Ownership	192,818	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	275,554	35
36	Provider Participation Fee	118,231	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,110,428	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(615,562)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (615,562)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,269,406	44
45	Private Pay - Net Inpatient Revenue	318,893	45
46	Medicare - Net Inpatient Revenue	421,549	46
47	Other-(specify) <u>Insurance/Managed Care</u>	389,093	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,398,941	49

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

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

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

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

Facility Name & ID Number **Aperion Care Mascoutah, Llc**

# **0054700**

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,094	\$ 79,730	\$ 38.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,718	2,858	94,976	33.23	3
4	Licensed Practical Nurses	10,585	11,351	267,947	23.61	4
5	CNAs & Orderlies	25,619	27,026	414,131	15.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,212	35,533	16.06	9
10	Activity Assistants	442	484	4,691	9.69	10
11	Social Service Workers	1,958	2,014	50,634	25.14	11
12	Dietician	260	260	5,227	20.10	12
13	Food Service Supervisor	1,640	1,752	39,443	22.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,812	9,524	94,480	9.92	15
16	Dishwashers					16
17	Maintenance Workers	1,451	1,503	28,088	18.69	17
18	Housekeepers	4,230	4,370	40,202	9.20	18
19	Laundry	3,113	3,433	36,235	10.55	19
20	Administrator	2,040	2,163	78,197	36.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,863	2,103	39,190	18.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,779	73,147	\$ 1,308,704 *	\$ 17.89	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	121	\$ 6,704	01-03	35
36	Medical Director	274	11,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	74,672	10-03	38
39	Pharmacist Consultant	543	1,901	10-03	39
40	Physical Therapy Consultant	Monthly	465	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	2,789	11-03	44
45	Social Service Consultant	12	840	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	989	\$ 98,871		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	87	\$ 4,429	10-03	50
51	Licensed Practical Nurses	189	7,468	10-03	51
52	Certified Nurse Assistants/Aides	556	13,743	10-03	52
53	TOTAL (lines 50 - 52)	832	\$ 25,640		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Robert Krebs	Administrator	0	\$ 46,352	Workers' Compensation Insurance	\$ 40,799	IDPH License Fee	\$ 2,928	
Kimberly Blair-Hutcheson	Administrator	0	4,381	Unemployment Compensation Insurance	22,377	Advertising: Employee Recruitment	940	
Michael D. Olson	Administrator	0	27,464	FICA Taxes	97,147	Health Care Worker Background Check (Indicate # of checks performed <u>79</u> )	790	
				Employee Health Insurance	10,688	Patient Background Checks <u>137</u>	1,370	
				Employee Meals		Dues & Subscriptions	7,722	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and permits	1,557	
				Employee Physicals	640	Allocated from Aperion Care	2,362	
				Employee Meals	826	Allocated from Aperion Consulting	470	
				Employee Benefits - Other	4,978	See Supplemental Schedule	523	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,197	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 177,455		\$ 18,662		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Aperion Care - Management Fee			\$ 86,821				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 86,821				Seminar Expense	2,947
							Allocated From Aperion Care	624
							Allocated from Aperion Consulting	120
							Allocated from Aperion Financial	32
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 222,911	TOTAL		\$	TOTAL	
							\$ 3,723	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Aperion Care Mascoutah, Llc# 0054700

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 - \$9,515
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,859 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. \$ 118,231  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.