

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734 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	110	Skilled (SNF)	110	40,150	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	110	TOTALS	110	40,150	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	12,271	128	11,879	24,278	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,271	128	11,879	24,278	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.47%

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)
N/A

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 11/1/2017

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/1/2017 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 110 and days of care provided 2,292

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc # 0054734 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
	A. General Services										
1	Dietary	173,755	13,592	12,357	199,704		199,704	(1,448)	198,256		1
2	Food Purchase		142,312		142,312		142,312	(2,923)	139,389		2
3	Housekeeping	101,920	19,866		121,786		121,786		121,786		3
4	Laundry	39,519	12,270		51,789		51,789		51,789		4
5	Heat and Other Utilities			101,239	101,239		101,239	(17,438)	83,801		5
6	Maintenance	50,794	2,089	68,367	121,250		121,250	6,342	127,592		6
7	Other (specify):*							2,024	2,024		7
8	TOTAL General Services	365,988	190,129	181,963	738,080		738,080	(13,443)	724,637		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,588,681	111,143	116,105	1,815,929		1,815,929	(6,710)	1,809,219		10
10a	Therapy	44,360			44,360		44,360		44,360		10a
11	Activities	73,873	1,393	680	75,946		75,946		75,946		11
12	Social Services	63,509		1,782	65,291		65,291		65,291		12
13	CNA Training										13
14	Program Transportation			4,849	4,849		4,849		4,849		14
15	Other (specify):*							3,256	3,256		15
16	TOTAL Health Care and Programs	1,770,423	112,536	144,416	2,027,375		2,027,375	(3,454)	2,023,921		16
	C. General Administration										
17	Administrative	122,640		197,041	319,681		319,681	(161,032)	158,649		17
18	Directors Fees										18
19	Professional Services			239,864	239,864	(17)	239,847	(113,948)	125,898		19
20	Dues, Fees, Subscriptions & Promotions			55,118	55,118		55,118	(25,060)	30,058		20
21	Clerical & General Office Expenses	135,276		138,269	273,545		273,545	7,689	281,234		21
22	Employee Benefits & Payroll Taxes			343,584	343,584		343,584		343,584		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,447	3,447		3,447	1,259	4,706		24
25	Other Admin. Staff Transportation			855	855		855	4,003	4,858		25
26	Insurance-Prop.Liab.Malpractice			160,051	160,051		160,051	1,229	161,280		26
27	Other (specify):*							15,257	15,257		27
28	TOTAL General Administration	257,916		1,138,229	1,396,145	(17)	1,396,128	(270,603)	1,125,525		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,394,327	302,665	1,464,608	4,161,600	(17)	4,161,583	(287,500)	3,874,083		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,218	9,218		9,218	819	10,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,816	68,816		68,816	6,456	75,272			32
33	Real Estate Taxes			42,999	42,999	17	43,016	845	43,861			33
34	Rent-Facility & Grounds			220,910	220,910		220,910	(12,000)	208,910			34
35	Rent-Equipment & Vehicles			23,984	23,984		23,984	1,604	25,588			35
36	Other (specify):*			12,321	12,321		12,321	(12,321)				36
37	TOTAL Ownership			378,248	378,248	17	378,265	(14,597)	363,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,050	351,275	479,325		479,325	(26,113)	453,212			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,955	189,955		189,955		189,955			42
43	Other (specify):*			11,991	11,991		11,991	(11,991)				43
44	TOTAL Special Cost Centers		128,050	553,221	681,271		681,271	(38,104)	643,167			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,394,327	430,715	2,396,077	5,221,119		5,221,119	(340,200)	4,880,919			45

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(18,066)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,439)	30		9
10	Interest and Other Investment Income	(555)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,734)	21		18
19	Entertainment				19
20	Contributions	(21,295)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,291)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(37,489)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,877)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(172,323)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (172,323)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (340,200)		37

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

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

(See instructions.)

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

Aperion Care Peoria Heights, Llc

ID# 0054734

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Credit Card Processing	\$ (4)	21	1
2	Advertising/Marketing	(8,755)	43	2
3	Marketing - Food	(811)	43	3
4	Promotional Products	(325)	43	4
5	Bank Charges	(6,312)	21	5
6	Theft & Damage Loss	(54)	21	6
7	Amortization	(12,321)	36	7
8	Vending Commissions	(2,991)	02	8
9	PAC Dues	(8,905)	20	9
10	Non-allowable Legal	(2,826)	19	10
11	Additional R&M	10,871	06	11
12	Chamber of Commerce Dues	(300)	20	12
13	Non-allowable Equipment Rental	(566)	35	13
14	Non-allowable Professional Fees	(4,190)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,489)		49

Aperion Care Peoria Heights, Llc

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Peoria Heights, Llc# 0054734

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(1,448)								(1,448)	1
2	Food Purchase	(2,999)		76									(2,923)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(18,066)					628						(17,438)	5
6	Maintenance	10,871		1,343	(7,232)		1,360						6,342	6
7	Other (specify):*			125	1,666		233						2,024	7
8	TOTAL General Services	(10,194)		1,544	(7,015)		2,222						(13,443)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			7,485	(14,196)								(6,710)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			761	2,495								3,256	15
16	TOTAL Health Care and Programs			8,246	(11,700)								(3,454)	16
	C. General Administration													
17	Administrative			(161,032)									(161,032)	17
18	Directors Fees													18
19	Professional Services	(7,016)		(5,311)	1,444	(99,971)	404		(3,499)				(113,948)	19
20	Fees, Subscriptions & Promotions	(30,500)		3,830	762	841	7						(25,060)	20
21	Clerical & General Office Expenses	(88,395)		22,775	1,886	70,166	1,257						7,689	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,012	195	52							1,259	24
25	Other Admin. Staff Transportation			3,854	129	21							4,003	25
26	Insurance-Prop.Liab.Malpractice			1,229									1,229	26
27	Other (specify):*			7,354	181	7,722							15,257	27
28	TOTAL General Administration	(125,911)		(126,288)	4,596	(21,169)	1,668		(3,499)				(270,603)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(136,105)		(116,498)	(14,119)	(21,169)	3,891		(3,499)				(287,500)	29

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Peoria Heights, Llc# 0054734

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)	
	D. Ownership													
30	Depreciation	(8,439)		987	178	181	7,912						819	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(555)		4,712	9		2,290						6,456	32
33	Real Estate Taxes						845						845	33
34	Rent-Facility & Grounds						(12,000)						(12,000)	34
35	Rent-Equipment & Vehicles	(566)		1,148	197	203	622						1,604	35
36	Other (specify):*	(12,321)											(12,321)	36
37	TOTAL Ownership	(21,881)		6,847	384	384	(331)						(14,597)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(26,113)					(26,113)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,891)			(2,100)								(11,991)	43
44	TOTAL Special Cost Centers	(9,891)			(2,100)			(26,113)					(38,104)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(167,877)		(109,652)	(15,835)	(20,785)	3,560	(26,113)	(3,499)				(340,200)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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		
	V		\$			\$	\$	1
	V							2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$			\$	\$ *	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 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	2	FOOD	\$	APERION CARE, INC.	\$ 76	\$ 76	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.	1,228	1,228	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	115	115	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	125	125	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.	2	2	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	7,483	7,483	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	761	761	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	36,009	36,009	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.	6,211	6,211	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	3,830	3,830	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.	21,617	21,617	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.	1,158	1,158	26
27	V	24	SEMINARS		APERION CARE, INC.	1,012	1,012	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.	3,854	3,854	28
29	V	26	INSURANCE		APERION CARE, INC.	1,229	1,229	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	7,354	7,354	30
31	V	30	DEPRECIATION		APERION CARE, INC.	987	987	31
32	V	32	INTEREST		APERION CARE, INC.	4,712	4,712	32
33	V	35	AUTO LEASE		APERION CARE, INC.	1,148	1,148	33
34	V	17	MANAGEMENT FEE	197,041	APERION CARE, INC.		(197,041)	34
35	V	19	HOME OFFICE	11,522	APERION CARE, INC.		(11,522)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 208,562			\$ 98,911	\$ * (109,652)	39

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc# 0054734Report Period Beginning: 01/01/18Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	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	<u>1</u> DIETITIAN SALARY	\$	<u>APERION CONSULTING, LLC</u>		\$ 9,222	\$ 9,222 15
16	V	<u>6</u> MAINTENANCY SALARY		<u>APERION CONSULTING, LLC</u>		5,876	5,876 16
17	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		<u>APERION CONSULTING, LLC</u>		1,666	1,666 17
18	V	<u>10</u> SALARY NURSE		<u>APERION CONSULTING, LLC</u>		22,302	22,302 18
19	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		2,495	2,495 19
20	V	<u>19</u> PROFESSIONAL FEES		<u>APERION CONSULTING, LLC</u>		1,444	1,444 20
21	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>APERION CONSULTING, LLC</u>		762	762 21
22	V	<u>21</u> CLERICAL & GENERAL		<u>APERION CONSULTING, LLC</u>		1,886	1,886 22
23	V	<u>24</u> SEMINARS		<u>APERION CONSULTING, LLC</u>		195	195 23
24	V	<u>25</u> AUTO AND TRAVEL		<u>APERION CONSULTING, LLC</u>		129	129 24
25	V	<u>27</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		181	181 25
26	V	<u>30</u> DEPRECIATION		<u>APERION CONSULTING, LLC</u>		178	178 26
27	V	<u>32</u> INTEREST		<u>APERION CONSULTING, LLC</u>		9	9 27
28	V	<u>35</u> AUTO LEASE		<u>APERION CONSULTING, LLC</u>		197	197 28
29	V						29
30	V						30
31	V						31
32	V	<u>10</u> RN CONSULTING	36,497	<u>APERION CONSULTING, LLC</u>			(36,497) 32
33	V	<u>01</u> DIETICIAN	10,670	<u>APERION CONSULTING, LLC</u>			(10,670) 33
34	V	<u>06</u> PROJECT MANAGER	13,108	<u>APERION CONSULTING, LLC</u>			(13,108) 34
35	V	<u>43</u> MARKETING	2,100	<u>APERION CONSULTING, LLC</u>			(2,100) 35
36	V						36
37	V						37
38	V						38
39	Total		\$ 62,376			\$ 46,541	\$ * (15,835) 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		3,724	\$ 3,724
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		841	841
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		70,166	70,166
18	V	24 SEMINARS		APERION FINANCIAL, LLC		52	52
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		21	21
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		7,722	7,722
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		181	181
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		203	203
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V	19 HOME OFFICE EXPENSE	103,695	APERION FINANCIAL, LLC			(103,695)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 103,695			\$ 82,910	\$ * (20,785)

* 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		\$ 628	\$	628	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,360		1,360	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		233		233	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		404		404	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		7		7	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,257		1,257	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		7,912		7,912	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,290		2,290	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		845		845	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		622		622	24
25	V	34 RENTAL INCOME	12,000	CHASE OFFICE,LLC				(12,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,000			\$ 15,560	\$ *	3,560	39

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	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	\$ 349,101	Renewal Rehab		\$ 322,988	\$ (26,113)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 349,101			\$ 322,988	\$ * (26,113)	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	\$ 13,364	ProPay HR LLC		\$ 9,865	\$ (3,499)	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		\$ 13,364			\$ 9,865	\$ * (3,499)	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	\$ 144,881	Aperion Incorporated Cell		\$ 144,881	\$	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		\$ 144,881			\$ 144,881	\$ *	39

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Aperion Care Peoria Heights, Llc

0054734

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 A. Berkowitz Revocable Trust	30.00%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	David Berkowitz as Trustee of the Yosef Meystel Delta Trust	15.00%	Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	Frederick S. Frankel as the Trustee of the David Berkowitz Delta Tru	15.00%	Aperion Care Burbank	Burbank	Renewal Rehab	LIncolnwood	Therapy Services	4
5	Steven Turofsky	1.50%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	Frederick S. Frankel	1.50%	Aperion Care Capitol	Capitol	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7	Naftali Wilhelm	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8	Jennifer Spector	1.50%	Aperion Care Demotte	Demotte, IN	Eco-Brite	Skokie	Laundry	8
9	257 Limited Partnership	1.34%	Aperion Care Dolton	Dolton	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10	1219 Limited Partnership	1.33%	Aperion Care Elgin	Elgin	Pointe Property, LLC	Boston, MA	Property Management	10
11	42170 Limited Partnership	1.33%	Aperion Care Evanston	Evanston	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Fairfield	Fairfield	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Galesburg	Galesburg	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Hidden Lake	St. Louis, MO	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Highwood	Highwood	Aperion Incorporated Cell	Burlington, VT	Insurance	18
19			Aperion Care International	Chicago				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 Mascoutah	Mascoutah				25
26			Aperion Care Midlothian	Midlothian				26
27			Aperion Care Moline	East Moline				27
28			Aperion Care Morton Terrace	Morton				28
29			Aperion Care Morton Villa	Morton				29
30			Aperion Care Oak Lawn	Oak Lawn				30

Facility Name & ID Number Aperion Care Peoria Heights, Llc # 0054734 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%	See Attached	0.69	1.73%	Alloc. Salary	\$ 4,330	17-7	1	
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.35	0.87%	Alloc. Salary	535	21-7	2	
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.27	1.15%	Alloc. Salary	214	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.09	2.30%	Alloc. Salary	304	21-7	4	
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.69	1.73%	Alloc. Salary	4,330	17-7	5	
6	Jennifer Spector	Owner	Clerical	0%	See Attached	0.69	1.73%	Alloc. Salary	1,981	21-7	6	
7	Dovid Spector	Relative	Clerical	0%	See Attached	0.69	1.73%	Alloc. Salary	970	21-7	7	
8	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.69	1.73%	Alloc. Salary	3,573	17-7	8	
9	Fred Frankel	Owner	Administrative	1.50%	See Attached	0.69	1.73%	Alloc. Salary	3,896	17-7	9	
10	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.7	1.73%	Alloc. Salary	4,330	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	\$ 24,463		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 Peoria Heights, Llc

0054734

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 Peoria Heights, Llc

0054734

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	\$ 24,278	\$ 76	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	24,278	1,228	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	24,278	115	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,401,635	55	5,656	24,278	125	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128	24,278	2	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	24,278	7,483	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957	24,278	761	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	24,278	36,009	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	24,278	6,211	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	24,278	3,830	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	24,278	21,617	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	24,278	1,158	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	24,278	1,012	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	24,278	3,854	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	24,278	1,229	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	24,278	7,354	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	24,278	987	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	24,278	4,712	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	24,278	1,148	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,718,302	\$ 3,836,913		\$ 98,911	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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

APERION CONSULTING, LLC
4655 W CHASE AVE
LINCOLNWOOD, ILLINOIS 60712
(847) 262-3800
(

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETITIAN SALARY	PATIENT DAYS	1,401,635	55	\$ 424,292	\$ 424,292	24,278	\$ 9,222	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	24,278	5,876	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,401,635	55	81,117		24,278	1,666	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	24,278	22,302	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437		24,278	2,495	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		24,278	1,444	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		24,278	762	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	24,278	1,886	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		24,278	195	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		24,278	129	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636		24,278	181	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		24,278	178	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		24,278	9	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		24,278	197	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		\$ 46,541	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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	24,278	3,724	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	24,278	841	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	70,166	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	24,278	52	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	24,278	21	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	24,278	7,722	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	24,278	181	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	24,278	203	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	\$ 82,910	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 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	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 24,278	\$ 628	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	24,278	1,360	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	24,278	233	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	24,278	404	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	24,278	7	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	24,278	1,257	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	24,278	7,912	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	24,278	2,290	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	24,278	845	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	24,278	622	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	\$	\$ 15,560	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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		\$	\$		\$ 322,988	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				\$	\$		\$ 322,988	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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

ProPay HR LLC

Street Address

2201 W. Main St.

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905 3268

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	Payroll Services	Direct		\$	\$		\$ 9,865	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	TOTALS				\$	\$		\$ 9,865	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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		\$	\$		\$ 144,881	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				\$	\$		\$ 144,881	25

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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 Peoria Heights, Llc

0054734

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 Peoria Heights, Llc

0054734

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Congressional Bank		X	Line of Credit				1,949,259		68,877	6									
7										7										
8										8										
9	TOTAL Facility Related							\$ 1,949,259		\$ 68,877	9									
B. Non-Facility Related*																				
10	Interest Income		X							(555)	10									
11	Interest - Insurance Policies		X							(61)	11									
12	Allocated from Aperion Care	X								4,712	12									
13	See Supplemental Schedule									2,299	13									
14	TOTAL Non-Facility Related									\$ 6,395	14									
15	TOTALS (line 9+line14)							\$ 1,949,259		\$ 75,272	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 Peoria Heights, Llc

0054734

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.	\$	<u>7,505</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>8,059</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>554</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>43,289</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	<u>17</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. 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.	\$	<u>43,860</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>50,950</u>	8
	2014	<u>50,624</u>	9
	2015	<u>41,603</u>	10
	2016	<u>43,079</u>	11
	2017	<u>43,289</u>	12

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

2018 Accrual = 2017 Real Estate Tax

The real estate tax expense on line 2 represents 2/12 of the 2017 tax bill, since current owners began operations on 11/1/2017

Allocated Chase office, LLC = \$845

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 Peoria Heights, Llc COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0054734

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>14-15-426-004</u>	<u>Long Term Care Property</u>	\$ <u>43,289.00</u>	\$ <u>43,289.00</u>
2. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office LLC</u>	\$ <u>45,392.90</u>	\$ <u>786.26</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>88,681.90</u></u>	\$ <u><u>44,075.26</u></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 Peoria Heights, Llc COUNTY Peoria
 FACILITY IDPH LICENSE NUMBER 0054734
 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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior Cement Block Frame Metal Beam Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	<u>Allocated from Chase Office LLC</u>			<u>1,076</u>	2
3	TOTALS			\$ 1,076	3

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

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					\$	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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								68
69								69
70								70
		\$	\$		\$	\$	\$	
		61,748	4,100		2,852	(1,248)	7,020	
			9,218			(9,218)		
		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	

**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		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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)		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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	Totals from Page 12B, Carried Forward		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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)		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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	Totals from Page 12C, Carried Forward		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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)		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	34

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	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)		\$ 61,748	\$ 13,318		\$ 2,852	\$ (10,466)	\$ 7,020	34

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

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

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	Totals from Page 12F, Carried Forward	\$	\$		\$	\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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	9,680	248	20	248		600	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	516	83	20	26	(57)	206	9
10	Allocated from Aperion Care	2012	146	11	20	7	(4)	44	10
11	Allocated from Aperion Care	2013	62	7	20	3	(4)	16	11
12									12
13	Allocated from Chase Office LLC	2018	44		20	2	2	2	13
14	Allocated from Chase Office LLC	2017	2,241	159	20	112	(47)	224	14
15	Allocated from Chase Office LLC	2016	49,059	3,592	20	2,453	(1,139)	5,928	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)		\$ 61,748	\$ 4,100		\$ 2,852	\$ (1,248)	\$ 7,020	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	Totals from Page 12H, Carried Forward		\$ 61,748	\$ 4,100		\$ 2,852	\$ (1,248)	\$ 7,020	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 61,748	\$ 4,100		\$ 2,852	\$ (1,248)	\$ 7,020	34

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

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	\$ 36,788	\$ 4,757	\$ 3,745	\$ (1,012)	10	\$ 7,701	71
72	Current Year Purchases	12,524	244	1,170	926	10	1,170	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 49,312	\$ 5,001	\$ 4,915	\$ (87)		\$ 8,871	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 Ford Goshen Bus	2018	\$ 15,534	\$	\$ 2,071	\$ 2,071	5	\$ 2,071	76
77		Allocated from Aperion Care	2018	579	88	116	28	5	376	77
78		Allocated from Aperion Consultin	2018	423	70	85	15	5	338	78
79										79
80	TOTALS			\$ 16,536	\$ 158	\$ 2,272	\$ 2,114		\$ 2,785	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)	\$ 128,672	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,477	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,038	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,439)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,676	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: American Realty Cap Healthcare Trust Inc.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>110</u>		\$ <u>208,910</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>110</u>		\$ <u>208,910</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 19,203 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>Patient Transportation</u>	<u>2013 Ford E350 Goshen Bu</u>	\$ _____	\$ <u>5,040</u>	17
18	<u>Allocated from Aperion Care</u>			<u>1,148</u>	18
19	<u>Allocated from Aperion Consulting</u>			<u>197</u>	19
20					20
21	TOTAL		\$ _____	\$ <u>6,385</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.

Facility Name & ID Number Aperion Care Peoria Heights, Llc # 0054734 Report Period Beginning: 01/01/18 Ending: 12/31/18
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 163,266	\$		\$ 163,266	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,247			36,247	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			149,588			149,588	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				87,722		87,722	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					2,174	40,328		42,502	13
14	TOTAL			\$		\$ 351,275	\$ 128,050		\$ 479,325	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 Peoria Heights, Llc**# **0054734**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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 44,944	\$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,439,289		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,729		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	47,320		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,591,282	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	5,565		15
16	Equipment, at Historical Cost	44,593		16
17	Accumulated Depreciation (book methods)	(9,477)		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>	198,423		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 239,104	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,830,386	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 401,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,949,259		29
30	Accrued Salaries Payable	140,816		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,196		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,289		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	75,839		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,617,697	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	387		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 387	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,618,084	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (787,698)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,830,386	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (181,477)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (181,477)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(606,221)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (606,221)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (787,698)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Peoria Heights, Llc

0054734

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,774,473	1
2	Discounts and Allowances for all Levels	(287,120)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,487,353	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,706	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 119,706	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	493	19
20	Radiology and X-Ray	164	20
21	Other Medical Services	(1,356)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,293	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	555	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 555	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,991	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,991	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,614,898	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	738,080	31
32	Health Care	2,027,375	32
33	General Administration	1,396,145	33
B. Capital Expense			
34	Ownership	378,248	34
C. Ancillary Expense			
35	Special Cost Centers	491,316	35
36	Provider Participation Fee	189,955	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,221,119	40
41	Income before Income Taxes (line 30 minus line 40)**	(606,221)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (606,221)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,812,930	44
45	Private Pay - Net Inpatient Revenue	23,855	45
46	Medicare - Net Inpatient Revenue	1,167,424	46
47	Other-(specify) Insurance	334,393	47
48	Other-(specify) Managed Care	1,148,751	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,487,353	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 Peoria Heights, Llc

0054734

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	1,905	2,158	\$ 90,443	\$ 41.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,943	8,434	273,780	32.46	3
4	Licensed Practical Nurses	17,037	18,242	515,897	28.28	4
5	CNAs & Orderlies	43,153	45,704	699,972	15.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,287	1,359	44,360	32.64	8
9	Activity Director	1,934	2,092	29,507	14.10	9
10	Activity Assistants	3,271	3,680	44,366	12.06	10
11	Social Service Workers	1,627	1,715	40,660	23.71	11
12	Dietician					12
13	Food Service Supervisor	1,894	2,000	39,376	19.69	13
14	Head Cook	17	17	151	8.88	14
15	Cook Helpers/Assistants	13,418	14,486	134,228	9.27	15
16	Dishwashers					16
17	Maintenance Workers	2,715	2,959	50,794	17.17	17
18	Housekeepers	8,733	9,549	101,920	10.67	18
19	Laundry	4,096	4,368	39,519	9.05	19
20	Administrator	1,992	2,080	122,640	58.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,984	2,080	52,375	25.18	23
24	Clerical	5,496	5,873	82,901	14.12	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	676	744	8,589	11.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,701	1,733	22,849	13.18	33
34	TOTAL (lines 1 - 33)	120,879	129,273	\$ 2,394,327 *	\$ 18.52	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	Monthly	\$ 12,357	01-03	35
36	Medical Director	91	21,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	36,497	10-03	38
39	Pharmacist Consultant	Per unit	5,606	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	680	11-03	44
45	Social Service Consultant	26	1,782	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	127	\$ 77,922		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	50	
51	Licensed Practical Nurses	12	470	10-03	51
52	Certified Nurse Assistants/Aides	2,231	73,532	10-03	52
53	TOTAL (lines 50 - 52)	2,243	\$ 74,002		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	
<u>Randi Lienhart</u>	<u>Administrator</u>		\$ <u>122,640</u>	<u>Workers' Compensation Insurance</u>	\$ <u>68,889</u>	<u>IDPH License Fee</u>	\$ <u>2,568</u>	
				<u>Unemployment Compensation Insurance</u>	<u>41,350</u>	<u>Advertising: Employee Recruitment</u>	<u>250</u>	
				<u>FICA Taxes</u>	<u>176,724</u>	<u>Health Care Worker Background Check</u>	<u>677</u>	
				<u>Employee Health Insurance</u>	<u>49,234</u>	<u>(Indicate # of checks performed <u>68</u>)</u>		
				<u>Employee Meals</u>	<u>1,901</u>	<u>Patient Background Checks <u>240.2</u></u>	<u>2,402</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues</u>	<u>13,085</u>	
				<u>Employee Physicals</u>	<u>320</u>	<u>Subscriptions</u>	<u>3,817</u>	
				<u>Employee Benefits - Other</u>	<u>5,166</u>	<u>Licenses and Permits</u>	<u>1,819</u>	
						<u>Allocated from Aperion Care</u>	<u>3,830</u>	
						<u>See Supplemental Schedule</u>	<u>1,610</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>122,640</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>343,584</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>30,058</u>	
(List each licensed administrator separately.)								
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
<u>Management Fees - Aperion Care Inc.</u>			\$ <u>197,041</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>197,041</u>	TOTAL		\$	<u>Seminar Expense</u>	<u>3,446</u>
(Attach a copy of any management service agreement)							<u>Allocated from Aperion Care</u>	<u>1,012</u>
							<u>Allocated from Aperion Consulting</u>	<u>195</u>
							<u>See Supplemental Schedule</u>	<u>52</u>
							<u>Entertainment Expense</u>	<u>()</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
							TOTAL	\$ <u>4,705</u>
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>See Attached</u>	<u>Legal Fees</u>		\$ <u>2,875</u>					
<u>Aperion Care Inc</u>	<u>Data Processing</u>		<u>28,533</u>					
<u>APEX Global Solutions LLC</u>	<u>Website Development (Adj)</u>		<u>2,640</u>					
<u>COMS Interactive LLC</u>	<u>Care Management Software</u>		<u>8,517</u>					
<u>Creative Technology Solutions</u>	<u>IT Consulting</u>		<u>6,580</u>					
<u>DGTELL LLC</u>	<u>Surveillance</u>		<u>1,335</u>					
<u>PointClickCare Technologies Inc.</u>	<u>EMR / Billing Software</u>		<u>23,389</u>					
<u>Provinet Solutions</u>	<u>Data Processing</u>		<u>791</u>					
<u>Aperion Care Inc</u>	<u>Home Office Expense</u>		<u>11,522</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>103,695</u>					
<u>Propay HR</u>	<u>Payroll Processing</u>		<u>13,364</u>					
<u>See Supplemental Schedule</u>			<u>36,623</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>239,863</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Peoria Heights, Llc# 0054734

Report Period Beginning:

01/01/18Ending: 12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$17,809
- (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. \$ 22,184 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. \$ 189,955
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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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