

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,563	1,816	3,748	23,127	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,563	1,816	3,748	23,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.00%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2014 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 56 and days of care provided 3,073

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Aperion Care Bridgeport, Llc # 0052688 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,491	15,289	10,496	186,276		186,276	6,071	192,347		1
2	Food Purchase		139,756		139,756		139,756	(63)	139,693		2
3	Housekeeping	103,788	17,908		121,696		121,696		121,696		3
4	Laundry	25,462	9,381		34,843		34,843		34,843		4
5	Heat and Other Utilities			83,328	83,328		83,328	(6,471)	76,857		5
6	Maintenance	30,228	20,336	67,156	117,720		117,720	(4,810)	112,910		6
7	Other (specify):*							2,063	2,063		7
8	TOTAL General Services	319,969	202,670	160,980	683,619		683,619	(3,211)	680,408		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,068,018	111,412	19,470	1,198,900		1,198,900	15,201	1,214,101		10
10a	Therapy	72,293	4,350		76,643		76,643		76,643		10a
11	Activities	78,946	3,889	4,148	86,983		86,983		86,983		11
12	Social Services	61,260			61,260		61,260		61,260		12
13	CNA Training										13
14	Program Transportation			2,373	2,373		2,373		2,373		14
15	Other (specify):*							3,088	3,088		15
16	TOTAL Health Care and Programs	1,280,517	119,651	34,991	1,435,159		1,435,159	18,289	1,453,448		16
	C. General Administration										
17	Administrative	94,400		204,367	298,767		298,767	(167,492)	131,275		17
18	Directors Fees										18
19	Professional Services			248,743	248,743	(104)	248,639	(147,627)	101,012		19
20	Dues, Fees, Subscriptions & Promotions			97,707	97,707		97,707	(64,399)	33,308		20
21	Clerical & General Office Expenses	95,897	(2)	115,731	211,626		211,626	9,305	220,931		21
22	Employee Benefits & Payroll Taxes			208,724	208,724		208,724		208,724		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,703	5,703		5,703	1,057	6,760		24
25	Other Admin. Staff Transportation			8,765	8,765		8,765	1,636	10,401		25
26	Insurance-Prop.Liab.Malpractice			71,080	71,080		71,080	1,238	72,318		26
27	Other (specify):*							10,388	10,388		27
28	TOTAL General Administration	190,297	(2)	960,820	1,151,115	(104)	1,151,011	(355,894)	795,117		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,790,783	322,319	1,156,791	3,269,893	(104)	3,269,789	(340,816)	2,928,973		29

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

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

#0052688

Report Period Beginning:

01/01/17

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,244	20,244		20,244	75,660	95,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,670	34,670		34,670	155,322	189,992			32
33	Real Estate Taxes			29,100	29,100	104	29,204	880	30,084			33
34	Rent-Facility & Grounds			304,510	304,510		304,510	(304,000)	510			34
35	Rent-Equipment & Vehicles			9,010	9,010		9,010	2,787	11,797			35
36	Other (specify):*			10,552	10,552		10,552	(10,552)				36
37	TOTAL Ownership			408,086	408,086	104	408,190	(79,903)	328,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,133	462,186	645,319		645,319	(18,014)	627,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,174	176,174		176,174		176,174			42
43	Other (specify):*			30,405	30,405		30,405	(30,405)				43
44	TOTAL Special Cost Centers		183,133	668,765	851,898		851,898	(48,419)	803,479			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,790,783	505,452	2,233,642	4,529,877		4,529,877	(469,139)	4,060,738			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 Bridgeport, Llc

0052688

Report Period Beginning:

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,138)	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	(27,941)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	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				18
19	Entertainment	(15)	21		19
20	Contributions	(62,923)	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	(69,359)	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	(88,221)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (255,707)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(213,432)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (213,432)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (469,139)		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

BHF USE ONLY							
48		49		50		51	52

Aperion Care Bridgeport, Llc

ID# 0052688

Report Period Beginning: 01/01/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing Fees	\$ (59)	21	1
2	Advertising & Marketing	(28,219)	43	2
3	Marketing Food	(150)	43	3
4	Promotional Products	(2,036)	43	4
5	Bank Charges	(3,279)	21	5
6	PAC Dues	(6,608)	20	6
7	Theft & Damage Loss	(205)	21	7
8	Amortization	(10,552)	36	8
9	Unclassified Income	(600)	21	9
10	Building Company Amortization	(19,445)	31	10
11	Building Company Legal Fees	(55)	19	11
12	Building Company Accounting Fees	(8,025)	19	12
13	Building Company Bookkeeping Fees	(5,000)	19	13
14	Building Company Licenses & Permits	(282)	20	14
15	Additional R&M	1,504	06	15
16	Non-Allowable Legal Expense	(1,244)	19	16
17	Settlement	(3,450)	21	17
18	Non-Allowable Professional Fees	(152)	19	18
19	Non-Allowable Seminar	(364)	24	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	(88,221)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Bridgeport, Llc# 0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				6,071								6,071	1
2	Food Purchase	(110)		45		2							(63)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,138)		(8)			675						(6,471)	5
6	Maintenance	1,504		684	(8,355)		1,356						(4,810)	6
7	Other (specify):*			28	1,826		209						2,063	7
8	TOTAL General Services	(5,744)		749	(458)	2	2,240						(3,211)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			5,182	10,019								15,201	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			262	2,826								3,088	15
16	TOTAL Health Care and Programs			5,444	12,845								18,289	16
	C. General Administration													
17	Administrative			(169,289)		1,798							(167,492)	17
18	Directors Fees													18
19	Professional Services	(14,476)	13,080	(48,796)	(3,567)	(94,874)	4,763		(3,758)				(147,627)	19
20	Fees, Subscriptions & Promotions	(69,813)	282	3,457	1,313	354	8						(64,399)	20
21	Clerical & General Office Expenses	(76,967)		24,631	4,694	55,762	1,185						9,305	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(364)		838	488	95							1,057	24
25	Other Admin. Staff Transportation			659	931	46							1,636	25
26	Insurance-Prop.Liab.Malpractice			1,238									1,238	26
27	Other (specify):*			2,849	624	6,915							10,388	27
28	TOTAL General Administration	(161,620)	13,362	(184,413)	4,483	(29,905)	5,956		(3,758)				(355,894)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(167,364)	13,362	(178,220)	16,870	(29,903)	8,196		(3,758)				(340,816)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bridgeport, Llc # 0052688 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(27,941)	92,913	896	161	198	9,433						75,660	30
31	Amortization of Pre-Op. & Org.	(19,445)	19,445											31
32	Interest		150,896	2,289	11	(278)	2,404						155,322	32
33	Real Estate Taxes						880						880	33
34	Rent-Facility & Grounds		(276,000)				(28,000)						(304,000)	34
35	Rent-Equipment & Vehicles			1,743	255	238	551						2,787	35
36	Other (specify):*	(10,552)											(10,552)	36
37	TOTAL Ownership	(57,938)	(12,746)	4,928	427	158	(14,732)						(79,903)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(18,014)					(18,014)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(30,405)											(30,405)	43
44	TOTAL Special Cost Centers	(30,405)						(18,014)					(48,419)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(255,707)	616	(173,292)	17,297	(29,745)	(6,536)	(18,014)	(3,758)				(469,139)	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 276,000	900 East Corporation Street LLC	100.00%	\$	\$ (276,000)	1
2	V	33 Real Estate Tax Income	29,100	900 East Corporation Street LLC	100.00%		(29,100)	2
3	V	31 Amortization		900 East Corporation Street LLC	100.00%	19,445	19,445	3
4	V	30 Depreciation		900 East Corporation Street LLC	100.00%	92,913	92,913	4
5	V	32 Interest Expense		900 East Corporation Street LLC	100.00%	150,912	150,912	5
6	V	33 RE Tax Expense		900 East Corporation Street LLC	100.00%	29,100	29,100	6
7	V	19 Legal Fees		900 East Corporation Street LLC	100.00%	55	55	7
8	V	19 Accounting Fees		900 East Corporation Street LLC	100.00%	8,025	8,025	8
9	V	19 Bookkeeping Fees		900 East Corporation Street LLC	100.00%	5,000	5,000	9
10	V	20 Licenses & Permits		900 East Corporation Street LLC	100.00%	282	282	10
11	V	32 Interest Income	16	900 East Corporation Street LLC	100.00%		(16)	11
12	V							12
13	V							13
14	Total		\$ 305,116			\$ 305,732	\$ * 616	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 FOOD	\$	APERION CARE, INC.	100.00%	\$ 45	\$	45	15
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	(8)		(8)	16
17	V	6 MAINTENANCE SALARY		APERION CARE, INC.	100.00%	562		562	17
18	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	122		122	18
19	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	28		28	19
20	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	5,182		5,182	20
21	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	262		262	21
22	V	17 ADMINISTRATIVE SALARIES		APERION CARE, INC.	100.00%	30,899		30,899	22
23	V	17 MANAGEMENT FEES		APERION CARE, INC.	100.00%	4,179		4,179	23
24	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	2,732		2,732	24
25	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	3,457		3,457	25
26	V	21 CLERICAL SALARY		APERION CARE, INC.	100.00%	23,764		23,764	26
27	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	867		867	27
28	V	24 SEMINARS		APERION CARE, INC.	100.00%	838		838	28
29	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	659		659	29
30	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,238		1,238	30
31	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	2,849		2,849	31
32	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	896		896	32
33	V	32 INTEREST		APERION CARE, INC.	100.00%	2,289		2,289	33
34	V	35 AUTO LEASE		APERION CARE, INC.	100.00%	1,728		1,728	34
35	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	15		15	35
36	V	17 MANAGEMENT FEE	204,367	APERION CARE, INC.	100.00%			(204,367)	36
37	V	19 HOME OFFICE	51,528	APERION CARE, INC.	100.00%			(51,528)	37
38	V								38
39	Total		\$ 255,894			\$ 82,603	\$ *	(173,292)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1		APERION CONSULTING, LLC	100.00%	\$ 6,071	\$	6,071	15
16	V	6		APERION CONSULTING, LLC	100.00%	6,805		6,805	16
17	V	6		APERION CONSULTING, LLC	100.00%	3		3	17
18	V	7		APERION CONSULTING, LLC	100.00%	1,826		1,826	18
19	V	10		APERION CONSULTING, LLC	100.00%	24,969		24,969	19
20	V	15		APERION CONSULTING, LLC	100.00%	2,826		2,826	20
21	V	19		APERION CONSULTING, LLC	100.00%	883		883	21
22	V	20		APERION CONSULTING, LLC	100.00%	1,313		1,313	22
23	V	21		APERION CONSULTING, LLC	100.00%	4,694		4,694	23
24	V	24		APERION CONSULTING, LLC	100.00%	488		488	24
25	V	25		APERION CONSULTING, LLC	100.00%	931		931	25
26	V	27		APERION CONSULTING, LLC	100.00%	624		624	26
27	V	30		APERION CONSULTING, LLC	100.00%	161		161	27
28	V	32		APERION CONSULTING, LLC	100.00%	11		11	28
29	V	35		APERION CONSULTING, LLC	100.00%	255		255	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	10	14,950	APERION CONSULTING, LLC	100.00%			(14,950)	34
35	V	01		APERION CONSULTING, LLC	100.00%				35
36	V	02		APERION CONSULTING, LLC	100.00%				36
37	V	06	15,163	APERION CONSULTING, LLC	100.00%			(15,163)	37
38	V	19	4,450	APERION CONSULTING, LLC	100.00%			(4,450)	38
39	Total		\$ 34,563			\$ 51,860	\$ *	17,297	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	APERION FINANCIAL, LLC	100.00%	\$ 2	\$	2	15
16	V	17	ADMINISTRATIVE	APERION FINANCIAL, LLC	100.00%	1,798		1,798	16
17	V	19	PROFESSIONAL FEES	APERION FINANCIAL, LLC	100.00%	820		820	17
18	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC	100.00%	354		354	18
19	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC	100.00%	55,762		55,762	19
20	V	24	SEMINARS	APERION FINANCIAL, LLC	100.00%	95		95	20
21	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC	100.00%	46		46	21
22	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC	100.00%	6,915		6,915	22
23	V	30	DEPRECIATION	APERION FINANCIAL, LLC	100.00%	198		198	23
24	V	32	INTEREST	APERION FINANCIAL, LLC	100.00%	(278)		(278)	24
25	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC	100.00%	238		238	25
26	V			APERION FINANCIAL, LLC	100.00%				26
27	V			APERION FINANCIAL, LLC	100.00%				27
28	V			APERION FINANCIAL, LLC	100.00%				28
29	V			APERION FINANCIAL, LLC	100.00%				29
30	V			APERION FINANCIAL, LLC	100.00%				30
31	V			APERION FINANCIAL, LLC	100.00%				31
32	V			APERION FINANCIAL, LLC	100.00%				32
33	V			APERION FINANCIAL, LLC	100.00%				33
34	V	19	HOME OFFICE EXPENSE	APERION FINANCIAL, LLC	100.00%			(95,694)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 95,694			\$ 65,949	\$ *	(29,745)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 675	\$	675	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,356		1,356	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		209		209	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		4,763		4,763	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		8		8	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,185		1,185	20
21	V	26 INSURANCE		CHASE OFFICE,LLC					21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		9,433		9,433	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,404		2,404	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		880		880	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		551		551	25
26	V	34 RENTAL INCOME	28,000	CHASE OFFICE,LLC				(28,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 28,000			\$ 21,464	\$ *	(6,536)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 446,997	Renewal Rehab	100.00%	\$ 428,983	\$ (18,014)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 446,997			\$ 428,983	\$ * (18,014)

* 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 Sevices	\$ 15,657	ProPay HR LLC	24.00%	\$ 11,899	\$ (3,758)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 15,657			\$ 11,899	\$ * (3,758)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	FREDRICK S. FRANKEL	1.50%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	1
2	STEVEN TUROFSKY	1.50%	Aperion Care Burbank	Burbank	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	2
3	DAVID BERKOWITZ TRUST	48.50%	Aperion Care Chicago Heights	Chicago Heights	Propay	Evanston	Payroll Services	3
4	YOSEF MEYSEL TRUST	48.50%	Aperion Care Demotte	Demotte,IN	Renewal Rehab	Skokie	Therapy Services	4
5			Aperion Care Dolton	Dolton	Aperion Care, Inc.	Skokie	Corporate Manager	5
6			Aperion Care Elgin	Elgin	Aperion Consulting, Inc.	Skokie	Consulting Co.	6
7			Aperion Care Evanston	Evanston	Aperion Financial, Inc.	Skokie	Bookkeeping	7
8			Aperion Care Forest Park	Forest Park	Eco-Brite	Skokie	Laundry	8
9			Aperion Care Plum Grove	Palatine	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Galesburg	Galesburg	Pointe Property, LLC	Boston, MA	Property Management	10
11			Aperion Care Hidden Lake	St. Louis, MO	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Highwood	Highwood	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care International	Chicago	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Jacksonville	Jacksonville	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Kokomo	Kokomo, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Litchfield	Litchfield	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Midlothian	Midlothian	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Moline	East Moline	900 East Corporation Street LLC	Bridgeport, IL	Building Co.	18
19			Aperion Care Oak Lawn	Oak Lawn				19
20			Aperion Care Peru	Peru, IN				20
21			Aperion Care Spring Valley	Spring Valley				21
22			Aperion Care Springfield	Springfield				22
23			Aperion Care St. Elmo	St. Elmo				23
24			Aperion Care Tolleston Park	Gary, IN				24
25			Aperion Care Toluca	Toluca				25
26			Aperion Care Valparaiso	Valparaiso, IN				26
27			Aperion Care Wilmington	Wilmington				27
28			Burgin Manor	Olney				28
29			The Arbors at Michigan City	Michigan City, IN				29
30			Aperion Care Cairo	Cairo				30

Facility Name & ID Number

Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	\$ 4,179	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.4	1.00%	Alloc. Salary	604	17-7	2	
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.2	1.00%	Alloc. Salary	85	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.038	1.14%	Alloc. Salary	318	21-7	4	
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	4,179	17-7	5	
6	Fred Frankel	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	3,833	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.8	2.00%	Alloc. Salary	4,179	17-7	7	
8	Nosson Factor	Relative	Clerical	0.00%	See Attached	0.7	2.13%	Alloc. Salary	1,434	21-7	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 18,811		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 Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 2,158	\$ 23,127	\$ 45	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)	23,127	(8)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	23,127	562	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855	23,127	122	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359	23,127	28	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	23,127	5,182	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526	23,127	262	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	23,127	30,899	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000	23,127	4,179	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754	23,127	2,732	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435	23,127	3,457	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	23,127	23,764	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500	23,127	867	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097	23,127	838	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545	23,127	659	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232	23,127	1,238	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354	23,127	2,849	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899	23,127	896	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529	23,127	2,289	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699	23,127	1,728	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707	23,127	15	21
22									22
23									23
24									24
25	TOTALS					\$ 3,953,315	\$ 2,891,038	\$ 82,603	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETITIAN SALARY	PATIENT DAYS	1,106,839	47	\$ 290,566	\$ 290,566	23,127	\$ 6,071	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	325,675	23,127	6,805	2
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162		23,127	3	3
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378		23,127	1,826	4
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	1,194,994	23,127	24,969	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233		23,127	2,826	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241		23,127	883	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820		23,127	1,313	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	200,283	23,127	4,694	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340		23,127	488	10
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550		23,127	931	11
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866		23,127	624	12
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685		23,127	161	13
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508		23,127	11	14
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204		23,127	255	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,481,871	\$ 2,011,519		\$ 51,860	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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 (

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 92	\$ 23,127	\$ 2	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	86,036	23,127	1,798
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233	23,127	820	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932	23,127	354	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	2,630,420	23,127	55,762
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567	23,127	95	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179	23,127	46	7
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931	23,127	6,915	8
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460	23,127	198	9
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)	23,127	(278)	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395	23,127	238	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,156,251	\$ 2,716,455	\$ 65,949	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 262-3800

Fax Number

(

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	\$ 32,299	\$ 23,127	\$ 675	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905	23,127	1,356	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989	23,127	209	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965	23,127	4,763	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387	23,127	8	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714	23,127	1,185	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47		23,127		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435	23,127	9,433	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060	23,127	2,404	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109	23,127	880	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374	23,127	551	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,027,237	\$	\$ 21,464	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Renewal Rehab
 Street Address 4655 W Chase Ave
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	43	\$	\$		\$ 428,983	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				\$	\$		\$ 428,983	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

(

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 11,899	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				\$	\$		\$ 11,899	25

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Midwest Bank		X	Mortgage			\$	2,775,000			\$	150,912						
2																		
3																		
4																		
5																		
Working Capital																		
6	Insurance Policies		X									2,349						
7	First Midwest Bank		X	Line of Credit				551,685				32,321						
8	See Supplemental Schedule											4,426						
9	TOTAL Facility Related						\$	3,326,685			\$	190,008						
B. Non-Facility Related*																		
10	Interest Income- Bldg Co.		X									(16)						
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$				\$	(16)						
15	TOTALS (line 9+line14)						\$	3,326,685			\$	189,992						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	<u>28,925</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>27,996</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(929)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>30,909</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>104</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>30,084</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012		8
	2013	<u>26,032</u>	9
	2014	<u>27,716</u>	10
	2015	<u>27,327</u>	11
	2016	<u>27,116</u>	12

2017 Accrual = \$27,116 X 1.13 = \$30,909

Allocated From Chase Building: \$880

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2014</u>	<u>\$ 180,000</u>	<u>1</u>
2	<u>Allocated From Chase Office</u>			<u>1,297</u>	<u>2</u>
3	TOTALS			\$ 181,297	3

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	99		2014	1976	\$ 2,438,000	\$ 92,913	39	\$ 62,513	\$ (30,400)	\$ 250,052	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)		74,432	4,930		3,437	(1,493)	5,072
69	Financial Statement Depreciation			20,244			(20,244)	
70	TOTAL (lines 4 thru 69)		\$ 2,512,432	\$ 118,087		\$ 65,950	\$ (52,137)	\$ 255,124

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,512,432	\$ 118,087		\$ 65,950	\$ (52,137)	\$ 255,124	1
2	Data & Voip Line Installation	2014	6,000		20	600	600	2,000	2
3	Computer Installation And Back-Up	2014	4,910		20	982	982	3,273	3
4	New Phone System	2014	2,598		20	260	260	844	4
5	Remodel Design Work	2014	3,150		20	158	158	486	5
6	Installed 2 New Mixing Valves	2014	4,950		20	248	248	784	6
7	Electrical Rewiring To Room 47 & 49	2015	2,500		20	125	125	292	7
8	New Cooling System With Refrigeration Lines & Pads	2015	15,000		20	3,000	3,000	7,250	8
9	Mobilization & Drilling Of Test Borings	2016	2,980		20	149	149	224	9
10	New Light System	2016	4,618		20	231	231	289	10
11	Electrical In Rooms 14 & 50- Removed Old Ductless Split Unit An	2017	4,934		20	206	206	206	11
12	Carpet, Tiling, Cove Base- Living Room And Activity Room	2017	4,023		20	201	201	201	12
13	Water Heater- Boiler Room	2017	5,910		20	222	222	222	13
14	Air Conditioner- Indoor And Outdoor Unit	2017	3,482		20	87	87	87	14
15	Kitchen- Basket Strainer, Drain Piping, New Trap, Other Piping,	2017	3,445		20	29	29	29	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)		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	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		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	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)	\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	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		\$ 2,580,931	\$ 118,087		\$ 72,446	\$ (45,641)	\$ 271,309	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Chase Office	2016	11,676	299	39	299		424	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Aperion Care	2010	622	100	20	31	(69)	249	10
11	Allocated From Aperion Care	2012	176	14	20	9	(5)	53	11
12	Allocated From Aperion Care	2013	75	8	20	4	(4)	19	12
13									13
14	Allocated From Chase Office	2017	2,703	178	20	135	(43)	135	14
15	Allocated From Chase Office	2016	59,180	4,331	20	2,959	(1,372)	4,192	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)		\$ 74,432	\$ 4,930		\$ 3,437	\$ (1,493)	\$ 5,072	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 74,432	\$ 4,930		\$ 3,437	\$ (1,493)	\$ 5,072	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)	\$ 74,432	\$ 4,930		\$ 3,437	\$ (1,493)	\$ 5,072	34

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

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 194,388	\$ 5,273	\$ 20,247	\$ 14,974	10	\$ 70,134	71
72	Current Year Purchases	17,678	298	2,974	2,676	10	2,974	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 212,066	\$ 5,571	\$ 23,221	\$ 17,650		\$ 73,108	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Aperion Care	2017	\$ 699	\$ 106	\$ 140	\$ 34	5	\$ 454	76
77		Allocated From Aperion Consulti	2017	484	80	97	17	5	291	77
78										78
79										79
80	TOTALS			\$ 1,183	\$ 186	\$ 237	\$ 51		\$ 745	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)	\$ 2,975,477	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,844	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,903	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (27,941)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 345,162	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	Resident Rms/Design & Plans	\$ 61,700	92
93	Architect Fees, Project Mgmt	349,409	93
94	Kitchen, Laundry, Plumbing		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: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Unit				510			5
6								6
7	TOTAL				\$ 510			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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 9,814 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From Aperion Care		\$	1,728	17
18	Allocated From Aperion Consulting			255	18
19					19
20					20
21	TOTAL		\$	1,983	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 170,442				\$ 170,442	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				119,281				119,281	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				157,136				157,136	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					171,121			171,121	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): _____						15,327	12,012			27,339	13
14	TOTAL						\$ 462,186	\$ 183,133			\$ 645,319	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(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	\$ 72,794	\$ 72,925	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	729,024	729,024	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,315	54,315	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	700,000	700,000	8
9	Other(specify): <u>See Attached Schedule</u>	5,249	88,970	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,561,382	\$ 1,645,234	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,438,000	14
15	Leasehold Improvements, at Historical Cost	51,735	51,735	15
16	Equipment, at Historical Cost	80,588	232,588	16
17	Accumulated Depreciation (book methods)	(47,020)	(408,324)	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>	1,719,276	2,717,828	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,804,579	\$ 5,211,827	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,365,961	\$ 6,857,061	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 327,404	\$ 327,403	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	551,685	551,685	29
30	Accrued Salaries Payable	144,195	144,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,837	5,837	31
32	Accrued Real Estate Taxes(Sch.IX-B)		30,909	32
33	Accrued Interest Payable	2,424	15,875	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	26,283	26,283	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,057,828	\$ 1,102,187	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,775,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	2,219,135	2,811,272	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,219,135	\$ 5,586,272	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,276,963	\$ 6,688,459	46
47	TOTAL EQUITY(page 18, line 24)	\$ 88,998	\$ 168,602	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,365,961	\$ 6,857,061	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (259,075)	1
2	Restatements (describe):		2
3	Rounding Adjustment	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (259,074)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	373,072	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(25,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 348,072	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)	\$ 88,998	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Bridgeport, Llc

0052688

Report Period Beginning: 01/01/17

Ending:

12/31/17

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	\$ 3,945,862	1
2	Discounts and Allowances for all Levels	797,311	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,743,173	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,859	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 149,859	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	780	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	177	19
20	Radiology and X-Ray	56	20
21	Other Medical Services	8,304	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,317	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,902,949	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	683,619	31
32	Health Care	1,435,159	32
33	General Administration	1,151,115	33
B. Capital Expense			
34	Ownership	408,086	34
C. Ancillary Expense			
35	Special Cost Centers	675,724	35
36	Provider Participation Fee	176,174	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,529,877	40
41	Income before Income Taxes (line 30 minus line 40)**	373,072	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 373,072	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,664,667	44
45	Private Pay - Net Inpatient Revenue	309,672	45
46	Medicare - Net Inpatient Revenue	1,567,674	46
47	Other-(specify) <u>Insurance & Managed Care</u>	201,160	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,743,173	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 Bridgeport, Llc

0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,976	2,080	\$ 71,572	\$ 34.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,012	4,443	117,649	26.48	3
4	Licensed Practical Nurses	14,784	15,668	341,290	21.78	4
5	CNAs & Orderlies	43,376	46,211	527,613	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,539	3,817	72,293	18.94	8
9	Activity Director	1,836	2,080	26,682	12.83	9
10	Activity Assistants	5,481	5,677	52,264	9.21	10
11	Social Service Workers	1,992	2,300	36,791	16.00	11
12	Dietician					12
13	Food Service Supervisor	1,880	2,080	36,120	17.37	13
14	Head Cook	5,963	6,472	62,863	9.71	14
15	Cook Helpers/Assistants	6,044	6,500	61,508	9.46	15
16	Dishwashers					16
17	Maintenance Workers	1,890	2,080	30,228	14.53	17
18	Housekeepers	9,994	10,636	103,788	9.76	18
19	Laundry	2,560	2,757	25,462	9.24	19
20	Administrator	1,860	2,080	94,400	45.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,816	4,200	95,897	22.83	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	826	866	9,894	11.42	31
32	Other Health Care(specify)					32
33	Other(specify)	2,158	2,302	24,469	10.63	33
34	TOTAL (lines 1 - 33)	113,987	122,249	\$ 1,790,783 *	\$ 14.65	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	195	\$ 10,496	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	14,950	10-03	38
39	Pharmacist Consultant	Monthly	4,520	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	40	4,148	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	235	\$ 43,114		49

C. CONTRACT NURSES

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

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>Lori Haynes</u>	<u>Administrator</u>	<u>0.00%</u>	\$ <u>94,400</u>	<u>Workers' Compensation Insurance</u>	\$ <u>15,694</u>	<u>IDPH License Fee</u>	\$ <u>3,980</u>		
				<u>Unemployment Compensation Insurance</u>	<u>13,604</u>	<u>Advertising: Employee Recruitment</u>	<u>1,543</u>		
				<u>FICA Taxes</u>	<u>133,816</u>	<u>Health Care Worker Background Check</u>	<u>702</u>		
				<u>Employee Health Insurance</u>	<u>19,772</u>	(Indicate # of checks performed <u>70</u>)			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>72</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>License & Permits</u>	<u>396</u>		
				<u>401K Expense</u>	<u>368</u>	<u>Dues and Subscriptions</u>	<u>20,835</u>		
				<u>Employee Physicals</u>	<u>160</u>				
				<u>Other Employee Benefits</u>	<u>25,310</u>				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>94,400</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>208,724</u>		
(List each licensed administrator separately.)				TOTAL (agree to Sch. V, line 20, col. 8)			\$ <u>33,308</u>		
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>Aperion Care - Management Fees</u>			\$ <u>204,367</u>				<u>Out-of-State Travel</u>	\$	
							<u>In-State Travel</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>204,367</u>	TOTAL					
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>5,338</u>	
C. Professional Services				TOTAL				See Supplemental Schedule	
Vendor/Payee	Type		Amount						
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>95,694</u>				<u>Entertainment Expense</u>	()	
<u>Aperion Care, Inc</u>	<u>Home Office Expense</u>		<u>51,528</u>				(agree to Sch. V,		
<u>ProPay HR</u>	<u>Payroll Processing</u>		<u>15,657</u>				line 24, col. 8)		
<u>Marcum</u>	<u>Accounting Services</u>		<u>24,368</u>					\$ <u>6,759</u>	
<u>See Attached</u>	<u>Legal Services</u>		<u>1,850</u>						
<u>Aperion Consulting</u>	<u>Managed Care Consulting</u>		<u>4,450</u>						
<u>Healthcare Construction Services</u>	<u>Energy Procurement</u>		<u>400</u>						
<u>The Pension Specialists</u>	<u>401K/Profit Sharing Consulting</u>		<u>251</u>						
<u>Interbuild</u>	<u>Project Mgmt/Architects</u>		<u>1,006</u>						
<u>Point Click Care</u>	<u>E.H.R Software</u>		<u>23,376</u>						
<u>Creative Technology Solutions</u>	<u>Data Processing</u>		<u>12,454</u>						
<u>See Supplemental Schedule</u>			<u>17,709</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>248,743</u>						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Bridgeport, Llc# 0052688

Report Period Beginning:

01/01/17

Ending:

12/31/17**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC \$13,215
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,137 Line 10-2
- (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. \$ 176,174
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees