

Facility Name & ID Number Aperion Care Elgin

0054031 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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	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			2,091	2,091	8
9	SNF/PED					9
10	ICF	6,227	1,043	22,339	29,609	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,227	1,043	24,430	31,700	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.15%

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 12/01/2015

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/2015 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 52 and days of care provided 2,091

Medicare Intermediary CGS

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 Elgin # 0054031 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	305,826	18,125	14,840	338,791		338,791	(6,518)	332,273		1
2	Food Purchase		188,492		188,492	(2,146)	186,346	3	186,348		2
3	Housekeeping	163,731	31,777		195,508		195,508		195,508		3
4	Laundry		2,579	80,887	83,466		83,466	(5,192)	78,274		4
5	Heat and Other Utilities			72,579	72,579		72,579	(3,580)	68,999		5
6	Maintenance	104,658	41,702	51,522	197,882		197,882	(1,254)	196,628		6
7	Other (specify):*							2,828	2,828		7
8	TOTAL General Services	574,215	282,675	219,828	1,076,718	(2,146)	1,074,572	(13,713)	1,060,858		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	1,654,285	115,759	48,085	1,818,129		1,818,129	1,116	1,819,245		10
10a	Therapy	94,552			94,552		94,552		94,552		10a
11	Activities	93,943	11,448	2,420	107,811		107,811		107,811		11
12	Social Services	127,411		3,273	130,684		130,684		130,684		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,232	4,232		15
16	TOTAL Health Care and Programs	1,970,191	127,207	67,778	2,165,176		2,165,176	5,348	2,170,524		16
	C. General Administration										
17	Administrative	134,373		281,849	416,222		416,222	(231,304)	184,918		17
18	Directors Fees										18
19	Professional Services			164,099	164,099	(143)	163,956	(1,893)	162,063		19
20	Dues, Fees, Subscriptions & Promotions			56,047	56,047		56,047	(33,926)	22,121		20
21	Clerical & General Office Expenses	139,805		60,453	200,258		200,258	109,047	309,305		21
22	Employee Benefits & Payroll Taxes			432,452	432,452	2,146	434,598		434,598		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,859	6,859		6,859	851	7,710		24
25	Other Admin. Staff Transportation			3,594	3,594		3,594	2,242	5,836		25
26	Insurance-Prop.Liab.Malpractice			128,968	128,968		128,968	1,696	130,664		26
27	Other (specify):*							14,238	14,238		27
28	TOTAL General Administration	274,178		1,134,321	1,408,499	2,003	1,410,502	(139,049)	1,271,453		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,818,584	409,882	1,421,927	4,650,393	(143)	4,650,250	(147,414)	4,502,836		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 Elgin

#0054031

Report Period Beginning:

01/01/17

Ending:

12/31/17

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			38,201	38,201		38,201	(8,090)	30,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,461	40,461		40,461	(11,647)	28,814			32
33	Real Estate Taxes			88,026	88,026	143	88,169	1,206	89,375			33
34	Rent-Facility & Grounds			618,698	618,698		618,698	(28,000)	590,698			34
35	Rent-Equipment & Vehicles			10,060	10,060		10,060	3,820	13,880			35
36	Other (specify):*											36
37	TOTAL Ownership			795,446	795,446	143	795,589	(42,710)	752,879			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,256	416,299	541,555		541,555	(15,157)	526,398			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,572	235,572		235,572		235,572			42
43	Other (specify):*			26,436	26,436		26,436	(26,436)				43
44	TOTAL Special Cost Centers		125,256	678,307	803,563		803,563	(41,593)	761,970			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,818,584	535,138	2,895,680	6,249,402		6,249,402	(231,718)	6,017,684			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 Elgin**

0054031

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	(4,494)	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	(22,739)	30		9
10	Interest and Other Investment Income	(17,713)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(62)	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	(1,392)	21		18
19	Entertainment	(2,984)	21		19
20	Contributions	(38,919)	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				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	(27,797)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,100)		\$	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)	(115,618)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (115,618)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (231,718)		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	
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Aperion Care Elgin

ID# 0054031

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising & Marketing	\$ (19,901)	43	1
2	Promotional Products	(6,010)	43	2
3	Bank Charges	(4,705)	21	3
4	Non-Allowable Seminar	(1,096)	24	4
5	Jury Duty Income	(12)	10	5
6	Sales and Use Tax	(126)	21	6
7	Additional R&M	12,533	06	7
8	Capitalized R&M	(2,972)	06	8
9	Non-Allowable Legal	(3,468)	19	9
10	PAC Dues	(2,040)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,797)		49

Aperion Care Elgin

ID# 0054031
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

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 Elgin# 0054031

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				(6,518)								(6,518)	1
2	Food Purchase	(62)		62		3							3	2
3	Housekeeping													3
4	Laundry								(5,192)				(5,192)	4
5	Heat and Other Utilities	(4,494)		(11)			925						(3,580)	5
6	Maintenance	9,561		938	(13,612)		1,859						(1,254)	6
7	Other (specify):*			39	2,503		286						2,828	7
8	TOTAL General Services	5,005		1,028	(17,627)	3	3,070		(5,192)				(13,713)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12)		7,103	(5,975)								1,116	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			359	3,873								4,232	15
16	TOTAL Health Care and Programs	(12)		7,462	(2,102)								5,348	16
	C. General Administration													
17	Administrative			(233,768)		2,464							(231,304)	17
18	Directors Fees													18
19	Professional Services	(3,468)		3,745	(6,140)	1,124	6,529			(3,683)			(1,893)	19
20	Fees, Subscriptions & Promotions	(40,959)		4,738	1,799	485	11						(33,926)	20
21	Clerical & General Office Expenses	(9,207)		33,763	6,434	76,433	1,624						109,047	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,096)		1,148	668	131							851	24
25	Other Admin. Staff Transportation			903	1,276	62							2,242	25
26	Insurance-Prop.Liab.Malpractice			1,696									1,696	26
27	Other (specify):*			3,905	855	9,478							14,238	27
28	TOTAL General Administration	(54,730)		(183,870)	4,892	90,177	8,164			(3,683)			(139,049)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,737)		(175,380)	(14,837)	90,180	11,234		(5,192)	(3,683)			(147,414)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Elgin # 0054031 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(22,739)		1,229	220	271	12,929						(8,090)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17,713)		3,137	15	(381)	3,295						(11,647)	32
33	Real Estate Taxes						1,206						1,206	33
34	Rent-Facility & Grounds						(28,000)						(28,000)	34
35	Rent-Equipment & Vehicles			2,389	350	326	755						3,820	35
36	Other (specify):*													36
37	TOTAL Ownership	(40,452)		6,755	585	216	(9,814)						(42,710)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(15,157)					(15,157)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(25,911)			(525)								(26,436)	43
44	TOTAL Special Cost Centers	(25,911)			(525)			(15,157)					(41,593)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,100)		(168,625)	(14,777)	90,397	1,420	(15,157)	(5,192)	(3,683)			(231,718)	45

Facility Name & ID Number

Aperion Care Elgin

0054031

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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%	\$ 62	\$ 62 15
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	(11)	(11) 16
17	V	6 MAINTENANCE SALARY		APERION CARE, INC.	100.00%	770	770 17
18	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	168	168 18
19	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	39	39 19
20	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	7,103	7,103 20
21	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	359	359 21
22	V	17 ADMINISTRATIVE SALARIES		APERION CARE, INC.	100.00%	42,353	42,353 22
23	V	17 MANAGEMENT FEES		APERION CARE, INC.	100.00%	5,728	5,728 23
24	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	3,745	3,745 24
25	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	4,738	4,738 25
26	V	21 CLERICAL SALARY		APERION CARE, INC.	100.00%	32,574	32,574 26
27	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	1,189	1,189 27
28	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,148	1,148 28
29	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	903	903 29
30	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,696	1,696 30
31	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	3,905	3,905 31
32	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	1,229	1,229 32
33	V	32 INTEREST		APERION CARE, INC.	100.00%	3,137	3,137 33
34	V	35 AUTO LEASE		APERION CARE, INC.	100.00%	2,369	2,369 34
35	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	20	20 35
36	V	17 MANAGEMENT FEE	281,849	APERION CARE, INC.	100.00%		(281,849) 36
37	V			APERION CARE, INC.	100.00%		
38	V						
39	Total		\$ 281,849			\$ 113,224	\$ * (168,625) 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%	\$ 8,322	\$ 8,322
16	V	6		APERION CONSULTING, LLC	100.00%	9,327	9,327
17	V	6		APERION CONSULTING, LLC	100.00%	5	5
18	V	7		APERION CONSULTING, LLC	100.00%	2,503	2,503
19	V	10		APERION CONSULTING, LLC	100.00%	34,225	34,225
20	V	15		APERION CONSULTING, LLC	100.00%	3,873	3,873
21	V	19		APERION CONSULTING, LLC	100.00%	1,210	1,210
22	V	20		APERION CONSULTING, LLC	100.00%	1,799	1,799
23	V	21		APERION CONSULTING, LLC	100.00%	6,434	6,434
24	V	24		APERION CONSULTING, LLC	100.00%	668	668
25	V	25		APERION CONSULTING, LLC	100.00%	1,276	1,276
26	V	27		APERION CONSULTING, LLC	100.00%	855	855
27	V	30		APERION CONSULTING, LLC	100.00%	220	220
28	V	32		APERION CONSULTING, LLC	100.00%	15	15
29	V	35		APERION CONSULTING, LLC	100.00%	350	350
30	V						
31	V						
32	V						
33	V	19	7,350	APERION CONSULTING, LLC	100.00%		(7,350)
34	V	10	40,200	APERION CONSULTING, LLC	100.00%		(40,200)
35	V	01	14,840	APERION CONSULTING, LLC	100.00%		(14,840)
36	V	43	525	APERION CONSULTING, LLC	100.00%		(525)
37	V	06	17,525	APERION CONSULTING, LLC	100.00%		(17,525)
38	V	06	5,419	APERION CONSULTING, LLC	100.00%		(5,419)
39	Total		\$ 85,859			\$ 71,082	\$ * (14,777)

* 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%	\$ 3	\$ 3
16	V	17	ADMINISTRATIVE	APERION FINANCIAL, LLC	100.00%	2,464	2,464
17	V	19	PROFESSIONAL FEES	APERION FINANCIAL, LLC	100.00%	1,124	1,124
18	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC	100.00%	485	485
19	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC	100.00%	76,433	76,433
20	V	24	SEMINARS	APERION FINANCIAL, LLC	100.00%	131	131
21	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC	100.00%	62	62
22	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC	100.00%	9,478	9,478
23	V	30	DEPRECIATION	APERION FINANCIAL, LLC	100.00%	271	271
24	V	32	INTEREST	APERION FINANCIAL, LLC	100.00%	(381)	(381)
25	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC	100.00%	326	326
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		\$			\$ 90,397	\$ * 90,397

* 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%	\$ 925	\$	925	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,859		1,859	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		286		286	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		6,529		6,529	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		11		11	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,624		1,624	20
21	V	26 INSURANCE		CHASE OFFICE,LLC					21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		12,929		12,929	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		3,295		3,295	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,206		1,206	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		755		755	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			\$ 29,420	\$ *	1,420	39

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

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning: 01/01/17

Ending: 12/31/17

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	\$ 376,091	Renewal Rehab	100.00%	\$ 360,934	\$ (15,157)
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		\$ 376,091			\$ 360,934	\$ * (15,157)

* 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	04 Laundry Service	\$ 80,887	EcoBrite Linen	100.00%	\$ 75,695	\$ (5,192)
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		\$ 80,887			\$ 75,695	\$ * (5,192)

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

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning: 01/01/17

Ending: 12/31/17

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 Service	\$ 15,345	ProPay HR LLC	24.00%	\$ 11,662	\$ (3,683)
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		\$ 15,345			\$ 11,662	\$ * (3,683)

* 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		\$			\$	\$	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:	
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.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Revocable Trust	21.50%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	1
2	David Berkowitz Delta Trust	21.50%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	2
3	David Berkowitz Revocable Trust	21.50%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	3
4	Yosef Meystel Delta Trust	21.50%	Aperion Care Chicago Heights	Chicago Heights	Renewal Rehab	Skokie	Therapy Services	4
5	Frederick Frankel	3.00%	Aperion Care Demotte	Demotte,IN	Aperion Care, Inc.	Skokie	Corporate Manager	5
6	Steven Turofsky	3.00%	Aperion Care Dolton	Dolton	Aperion Consulting, Inc.	Skokie	Consulting Co.	6
7	Jeremy Boshes	3.00%	Aperion Care Evanston	Evanston	Aperion Financial, Inc.	Skokie	Bookkeeping	7
8	Michelle Koder	3.00%	Aperion Care Forest Park	Forest Park	Eco-Brite	Skokie	Laundry	8
9	Naftali Wilhelm	2.00%	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				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 Elgin

0054031

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	1.1	2.75%	Alloc Salary	\$ 5,728	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc Salary	828	17-7	2	
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.5	2.50%	Alloc Salary	183	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.081	2.42%	Alloc Salary	681	21-7	4	
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.1	2.75%	Alloc Salary	5,728	17-7	5	
6	Fred Frankel	Owner	Administrative	3.00%	See Attached	1.1	2.75%	Alloc Salary	5,253	17-7	6	
7	Steve Turofsky	Owner	Administrative	3.00%	See Attached	1.1	2.75%	Alloc Salary	5,728	17-7	7	
8	Nosson Factor	Relative	Clerical	0.00%	See Attached	0.9	2.74%	Alloc Salary	1,965	21-7	8	
9	Michelle Koder	Owner	Nursing	3.00%	See Attached	1.1	2.75%	Alloc Salary	3,877	10-7	9	
10	Naftali Wihelm	Owner	Clerical	2.00%	See Attached	1.2	2.89%	Alloc Salary	5,728	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	\$ 35,699		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 Elgin

0054031

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 Elgin

0054031

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 CARE, INC.
 Street Address 4655 W CHASE AVENUE
 City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712
 Phone Number (847) 262-8300
 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	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 2,158	\$ 31,700	\$ 62	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)	31,700	(11)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	26,901	770	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855	31,700	168	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359	31,700	39	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	248,007	7,103	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526	31,700	359	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	1,478,789	42,353	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000	31,700	5,728	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754	31,700	3,745	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435	31,700	4,738	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	1,137,341	32,574	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500	31,700	1,189	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097	31,700	1,148	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545	31,700	903	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232	31,700	1,696	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354	31,700	3,905	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899	31,700	1,229	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529	31,700	3,137	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699	31,700	2,369	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707	31,700	20	21
22									22
23									23
24									24
25	TOTALS					\$ 3,953,315	\$ 2,891,038	\$ 113,224	25

Facility Name & ID Number Aperion Care Elgin

0054031

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	\$ 31,700	\$ 8,322	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	31,700	9,327	2
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162	31,700	5	3
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378	31,700	2,503	4
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	1,194,994	34,225	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233	31,700	3,873	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241	31,700	1,210	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820	31,700	1,799	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	200,283	6,434	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340	31,700	668	10
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550	31,700	1,276	11
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866	31,700	855	12
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685	31,700	220	13
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508	31,700	15	14
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204	31,700	350	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	\$ 71,082	25

Facility Name & ID Number Aperion Care Elgin

0054031

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 FINANCIAL, 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	2	FOOD	ACTUAL CENSUS	1,106,839	47	\$ 92	\$ 31,700	\$ 3	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	86,036	31,700	2,464
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233	31,700	31,700	1,124
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932	31,700	31,700	485
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	2,630,420	31,700	76,433
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567	31,700	31,700	131
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179	31,700	31,700	62
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931	31,700	31,700	9,478
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460	31,700	31,700	271
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)	31,700	31,700	(381)
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395	31,700	31,700	326
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	\$ 90,397	25

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

(

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	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	\$ 32,299	\$ 31,700	\$ 925	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905	31,700	1,859	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989	31,700	286	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965	31,700	6,529	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387	31,700	11	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714	31,700	1,624	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47		31,700		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435	31,700	12,929	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060	31,700	3,295	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109	31,700	1,206	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374	31,700	755	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	\$	\$ 29,420	25

Facility Name & ID Number Aperion Care Elgin

0054031

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	\$	\$		\$ 360,934	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				\$	\$		\$ 360,934	25

Facility Name & ID Number Aperion Care Elgin

0054031

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

EcoBrite Linen

Street Address

4655 W. Chase Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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	4	Laundry Service	Direct		\$	\$		\$ 75,695	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				\$	\$		\$ 75,695	25

Facility Name & ID Number Aperion Care Elgin

0054031

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Service	Direct		\$	\$		\$ 11,662	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				\$	\$		\$ 11,662	25

Facility Name & ID Number Aperion Care Elgin

0054031 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 Elgin

0054031

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 Elgin

0054031

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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	CIBC Bank USA		X	Line of Credit				658,266			38,077	6						
7	Note Payable		X	Note Payable				10,630				7						
8	See Supplemental Schedule										6,066	8						
9	TOTAL Facility Related						\$	\$ 668,896			\$ 44,143	9						
B. Non-Facility Related*																		
10	Interest Income		X								(17,713)	10						
11	Insurance Policies		X								2,384	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (15,329)	14						
15	TOTALS (line 9+line14)						\$	\$ 668,896			\$ 28,814	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 Elgin

0054031

Report Period Beginning:

01/01/17

Ending:

12/31/17

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.		\$	90,000	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.)		\$	90,219	2
3. Under or (over) accrual (line 2 minus line 1).		\$	219	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	89,013	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.)		\$	143	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.		\$	89,375	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012		8
	2013	45,570	9
	2014	42,600	10
	2015	88,712	11
	2016	89,013	12

2017 Accrual = 2016 RE Tax

Allocated From Chase Office: \$1,206

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 Elgin

0054031 Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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>Allocated From Chase Office</u>			\$ <u>1,778</u>	1
2					2
3	TOTALS			\$ <u>1,778</u>	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					\$	\$		\$	\$	\$	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			102,025	6,760		4,711	(2,049)	6,952
69				38,201			(38,201)	
70		\$	\$ 102,025	\$ 44,961		\$ 4,711	\$ (40,250)	\$ 6,952

**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 12A, Carried Forward		\$ 102,025	\$ 44,961		\$ 4,711	\$ (40,250)	\$ 6,952	1
2	32 Channel Security System With Cameras	2016	10,757		20	538	538	1,076	2
3	Seco Refrigeration (Compression)	2016	3,376		20	169	169	295	3
4	Alarm	2016	7,062		20	353	353	441	4
5	Roof Replacement (94,220)	2016	74,848		20	3,742	3,742	4,522	5
6	Installation Of Cat5E Cable	2016	6,535		20	327	327	654	6
7	Landscaping - Side Of Courtyard	2016	6,974		20	349	349	494	7
8	Springkler System - Installed Compressor & Replaced Piping	2016	5,595		20	280	280	536	8
9	Window Replacement- Main Floor (Original Cost \$106,242)	2017	101,238		20	5,312	5,312	5,312	9
10	Phone System And Cable- Nurse Station, Admin Office, Boiler Ro	2017	3,034		20	114	114	114	10
11	Lobby/Dining/Therapy-Walls/Roof/Fire Alarm/Plumbing (\$5,700)	2017	5,432		20	95	95	95	11
12	Alarm System	2017	8,210		20	137	137	137	12
13	Alarm System	2017	5,269		20	66	66	66	13
14	Nursing Stations- Quartz Countertops	2017	16,000		20	800	800	800	14
15	Boiler Repair- Tubes & Smokebox	2017	2,972		20	149	149	149	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)		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$ 359,327	\$ 44,961		\$ 17,141	\$ (27,820)	\$ 21,642	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
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 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

**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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Chase Office	2016	16,005	410	39	410		581	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Aperion Care	2010	853	137	20	43	(94)	341	10
11	Allocated From Aperion Care	2012	242	19	20	12	(7)	73	11
12	Allocated From Aperion Care	2013	103	12	20	5	(7)	26	12
13									13
14	Allocated From Chase Office	2017	3,705	243	20	185	(58)	185	14
15	Allocated From Chase Office	2016	81,117	5,939	20	4,056	(1,883)	5,746	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)		\$ 102,025	\$ 6,760		\$ 4,711	\$ (2,049)	\$ 6,952	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		\$ 102,025	\$ 6,760		\$ 4,711	\$ (2,049)	\$ 6,952	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)	\$ 102,025	\$ 6,760		\$ 4,711	\$ (2,049)	\$ 6,952	34

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

Facility Name & ID Number Aperion Care Elgin

0054031

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	\$ 61,934	\$ 7,226	\$ 6,262	\$ (964)	10	\$ 10,845	71
72	Current Year Purchases	58,312	408	6,383	5,975	10	6,383	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 120,246	\$ 7,634	\$ 12,645	\$ 5,011		\$ 17,228	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	\$ 958	\$ 145	\$ 192	\$ 47	5	\$ 622	76
77		Allocated From Aperion Consulti	2017	664	109	133	24	5	398	77
78										78
79										79
80	TOTALS			\$ 1,622	\$ 254	\$ 325	\$ 71		\$ 1,020	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)	\$ 482,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,110	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,739)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 39,891	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	Interior Remodel	\$ 1,451,560	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.

Facility Name & ID Number

Aperion Care Elgin

0054031

Report Period Beginning:

01/01/17

Ending:

12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SEGULA PROPERTIES/CHASE

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:		102		\$ 590,698			3
4	Additions							4
5								5
6								6
7	TOTAL		102		\$ 590,698			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: \$ 11,161 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		\$ _____	\$ 2,369	17
18	Allocated From Aperion Consulting			350	18
19					19
20					20
21	TOTAL		\$ _____	\$ 2,719	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	\$		\$	155,000	\$		\$	155,000	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				65,974				65,974	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				154,905				154,905	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					108,689			108,689	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): _____						40,420	16,567			56,987	13
14	TOTAL			\$		\$	416,299	\$	125,256	\$	541,555	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.

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	\$ 100	\$	1
2	Cash-Patient Deposits	255		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	888,583		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	257,646		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	230,714		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,377,298	\$	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	245,737		15
16	Equipment, at Historical Cost	115,513		16
17	Accumulated Depreciation (book methods)	(48,787)		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>	1,463,312		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,775,775	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,153,073	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 855,547	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	668,896		29
30	Accrued Salaries Payable	240,325		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,853		31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,013		32
33	Accrued Interest Payable	2,971		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	12,824		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,876,429	\$	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>	1,441,344		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,441,344	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,317,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (164,700)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,153,073	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (184,657)	1
2	Restatements (describe):		2
3	Prior Year Depreciation and Bad Debt Expenses	(96,496)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (281,153)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,453	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	(50,000)	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)	\$ 116,453	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)	\$ (164,700)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Elgin# 0054031Report Period Beginning: 01/01/17Ending: 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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,948,597	1
2	Discounts and Allowances for all Levels	(715,564)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,233,033	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	154,857	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 154,857	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	853	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,006	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,903	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,713	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,713	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	8,349	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,349	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,415,855	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,076,718	31
32	Health Care	2,165,176	32
33	General Administration	1,408,499	33
B. Capital Expense			
34	Ownership	795,446	34
C. Ancillary Expense			
35	Special Cost Centers	567,991	35
36	Provider Participation Fee	235,572	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,249,402	40
41	Income before Income Taxes (line 30 minus line 40)**	166,453	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 166,453	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,041,017	44
45	Private Pay - Net Inpatient Revenue	224,245	45
46	Medicare - Net Inpatient Revenue	1,185,425	46
47	Other-(specify) <u>Insurance and Managed Care</u>	3,782,346	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,233,033	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 Elgin

0054031

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	2,032	2,080	\$ 98,027	\$ 47.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,244	16,510	559,184	33.87	3
4	Licensed Practical Nurses	13,548	13,826	403,657	29.20	4
5	CNAs & Orderlies	42,378	43,070	561,628	13.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,920	3,998	94,552	23.65	8
9	Activity Director	2,031	2,071	31,170	15.05	9
10	Activity Assistants	5,759	5,877	62,773	10.68	10
11	Social Service Workers	4,762	4,858	127,411	26.23	11
12	Dietician					12
13	Food Service Supervisor	4,229	4,325	99,272	22.95	13
14	Head Cook	11,422	11,604	170,298	14.68	14
15	Cook Helpers/Assistants	2,308	2,366	36,256	15.32	15
16	Dishwashers					16
17	Maintenance Workers	4,080	4,176	104,658	25.06	17
18	Housekeepers	12,356	12,595	163,731	13.00	18
19	Laundry					19
20	Administrator	2,032	2,080	121,461	58.39	20
21	Assistant Administrator	552	568	12,912	22.73	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,176	8,349	139,805	16.75	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	2,032	2,080	31,789	15.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,861	140,433	\$ 2,818,584 *	\$ 20.07	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	\$ 14,840	01-03	35
36	Medical Director	Monthly	14,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	40,200	10-03	38
39	Pharmacist Consultant	Monthly	7,885	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	Monthly	2,420	11-03	44
45	Social Service Consultant	Monthly	3,273	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 82,618		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

Facility Name & ID Number **Aperion Care Elgin**

0054031

Report Period Beginning: **01/01/17**

Ending: **12/31/17**

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		
Jamie Lloyd	Administrator	0.00%	\$ 121,461	Workers' Compensation Insurance	\$ 29,596	IDPH License Fee	\$ 834		
Zev Brody	Asst. Admin.	0.00%	12,912	Unemployment Compensation Insurance	63,288	Advertising: Employee Recruitment	4,891		
				FICA Taxes	207,859	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	112,491	Patient Background Checks	115 1,150		
				Employee Meals	2,146	Dues and Subscriptions	6,605		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	1,608		
				401K Expense	1,210				
				Employee Physicals	400				
				Employee Meals	74				
				Other Employee Benefits	17,534				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 134,373	TOTAL (agree to Schedule V, line 22, col.8)		\$ 434,598			
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	
Management Fees- Aperion Care			\$ 281,849				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 281,849				Seminar Expense	5,762	
C. Professional Services				TOTAL				\$	
Vendor/Payee	Type		Amount				See Supplemental Schedule	1,947	
ProPay HR	Payroll Processing		\$ 15,345				Entertainment Expense	()	
Marcum	Accounting		21,192				(agree to Sch. V, line 24, col. 8)		
See Attached	Legal		44,298				TOTAL	\$ 7,709	
MTS Consulting	WOTC		997						
Point Click Care	Data Processing		33,795						
Aperion Consulting	Managed Care Consulting		7,350						
Healthcare Construction Services	Energy Procurement		850						
Personnel Planners	Unemployment Consulting		943						
Cassell Plan Audits	401K Audit		421						
Coalfire	Healthcare Consulting		302						
Interbuild	Energy Procurement		987						
See Supplemental Schedule			37,619						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 164,099						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Elgin# 0054031

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. IL Council on LTC \$4,080
- (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. \$ 18,108 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. \$ 235,572
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,146 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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