

Facility Name & ID Number APERION CARE GALESBURG

0052761 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	28	Skilled (SNF)	28	10,220	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,518	919	3,990	8,427	8
9	SNF/PED					9
10	ICF	15,619	106	9,474	25,199	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,137	1,025	13,464	33,626	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.30%

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 / 11/1/2013 /

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 2,037

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number APERION CARE GALESBURG # 0052761 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	169,583	36,423	23,700	229,706		229,706	(14,873)	214,833		1
2	Food Purchase		192,123		192,123		192,123	10	192,133		2
3	Housekeeping	141,064	25,784		166,848		166,848		166,848		3
4	Laundry	54,811	12,460		67,271		67,271		67,271		4
5	Heat and Other Utilities			101,897	101,897		101,897	(8,614)	93,283		5
6	Maintenance	79,982	31,863	28,776	140,621		140,621	13,864	154,485		6
7	Other (specify):*							2,999	2,999		7
8	TOTAL General Services	445,440	298,653	154,373	898,466		898,466	(6,614)	891,852		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,553,336	148,961	46,656	1,748,953		1,748,953	7,389	1,756,342		10
10a	Therapy	195,328	145		195,473		195,473		195,473		10a
11	Activities	99,619	2,596		102,215		102,215		102,215		11
12	Social Services	159,655		3,886	163,541		163,541		163,541		12
13	CNA Training										13
14	Program Transportation			533	533		533		533		14
15	Other (specify):*							4,489	4,489		15
16	TOTAL Health Care and Programs	2,007,938	151,702	75,075	2,234,715		2,234,715	11,879	2,246,594		16
	C. General Administration										
17	Administrative	81,347		280,031	361,378		361,378	(226,415)	134,963		17
18	Directors Fees										18
19	Professional Services			335,140	335,140	(152)	334,988	(208,320)	126,668		19
20	Dues, Fees, Subscriptions & Promotions			112,995	112,995		112,995	(90,447)	22,548		20
21	Clerical & General Office Expenses	79,209		183,074	262,283		262,283	(18,673)	243,610		21
22	Employee Benefits & Payroll Taxes			343,414	343,414		343,414		343,414		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,163	7,163		7,163	1,983	9,146		24
25	Other Admin. Staff Transportation			12,761	12,761		12,761	2,378	15,139		25
26	Insurance-Prop.Liab.Malpractice			135,635	135,635		135,635	1,799	137,434		26
27	Other (specify):*							15,103	15,103		27
28	TOTAL General Administration	160,556		1,410,213	1,570,769	(152)	1,570,617	(522,592)	1,048,025		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,613,934	450,355	1,639,661	4,703,950	(152)	4,703,798	(517,327)	4,186,471		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			98,882	98,882		98,882	55,044	153,926		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			51,723	51,723		51,723	162,575	214,298		32
33	Real Estate Taxes			128,681	128,681	152	128,833	1,279	130,112		33
34	Rent-Facility & Grounds			388,088	388,088		388,088	(388,000)	88		34
35	Rent-Equipment & Vehicles			6,465	6,465		6,465	4,052	10,517		35
36	Other (specify):*			10,920	10,920		10,920	(10,920)			36
37	TOTAL Ownership			684,759	684,759	152	684,911	(175,969)	508,942		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		70,088	508,845	578,933		578,933	(16,754)	562,179		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			251,805	251,805		251,805		251,805		42
43	Other (specify):*			28,498	28,498		28,498	(28,498)			43
44	TOTAL Special Cost Centers		70,088	789,148	859,236		859,236	(45,252)	813,984		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,613,934	520,443	3,113,568	6,247,945		6,247,945	(738,549)	5,509,396		45

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

APERION CARE GALESBURG

ID# 0052761

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (3,831)	21	1
2	Theft & Damage	(295)	21	2
3	Amortization	(10,920)	36	3
4	Sales Tax/Use Tax	(4,845)	21	4
5	Building Co - Accounting Fees	(8,025)	19	5
6	Building Co - Amortization	(20,499)	36	6
7	Building Co - Bookkeeping Fees	(5,000)	19	7
8	Building Co - Legal Fees	(55)	19	8
9	Building Co - Licenses & Permits	(282)	20	9
10	Building Co - State Replacement Tax	(1,062)	21	10
11	Capitalized R&M	(4,478)	06	11
12	PAC Dues	(2,160)	20	12
13	Additional R&M	9,826	06	13
14	Non-allowable Legal	(668)	19	14
15	Non-allowable Professional Fees	(8,862)	19	15
16	Non-allowable Seminar	(83)	24	16
17	Credit Card Processing Fees	(508)	21	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	(61,748)		49

APERION CARE GALESBURG

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 GALESBURG# 0052761

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				(14,873)								(14,873)	1
2	Food Purchase	(59)		66		3							10	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,584)		(11)			981						(8,614)	5
6	Maintenance	5,348		995	5,549		1,972						13,864	6
7	Other (specify):*			41	2,655		303						2,999	7
8	TOTAL General Services	(4,295)		1,091	(6,669)	3	3,257						(6,614)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			7,535	(146)								7,389	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			381	4,108								4,489	15
16	TOTAL Health Care and Programs			7,916	3,963								11,879	16
	C. General Administration													
17	Administrative			(229,029)		2,614							(226,415)	17
18	Directors Fees													18
19	Professional Services	(22,611)	13,080	(68,405)	(8,917)	(123,938)	6,926		(4,455)				(208,320)	19
20	Fees, Subscriptions & Promotions	(98,189)	282	5,026	1,908	514	12						(90,447)	20
21	Clerical & General Office Expenses	(145,173)	1,062	35,814	6,825	81,076	1,723						(18,673)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(83)		1,218	709	139							1,983	24
25	Other Admin. Staff Transportation			958	1,353	66							2,378	25
26	Insurance-Prop.Liab.Malpractice			1,799									1,799	26
27	Other (specify):*			4,142	907	10,054							15,103	27
28	TOTAL General Administration	(266,056)	14,424	(248,477)	2,786	(29,475)	8,660		(4,455)				(522,592)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(270,351)	14,424	(239,470)	79	(29,472)	11,917		(4,455)				(517,327)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APERION CARE GALESBURG# 0052761

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(47,816)	87,322	1,303	233	287	13,715						55,044	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,351)	181,492	3,328	15	(404)	3,496						162,575	32
33	Real Estate Taxes						1,279						1,279	33
34	Rent-Facility & Grounds		(360,000)				(28,000)						(388,000)	34
35	Rent-Equipment & Vehicles			2,534	371	346	801						4,052	35
36	Other (specify):*	(31,419)	20,499										(10,920)	36
37	TOTAL Ownership	(104,586)	(70,687)	7,165	619	229	(8,709)						(175,969)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(16,754)					(16,754)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(28,198)			(300)								(28,498)	43
44	TOTAL Special Cost Centers	(28,198)			(300)			(16,754)					(45,252)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(403,135)	(56,263)	(232,305)	398	(29,243)	3,208	(16,754)	(4,455)				(738,549)	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 Rent	\$ 360,000	1145 Frank St. LLC	100.00%	\$	\$ (360,000)	1
2	V	33 Rent Income - RE Tax	128,681	1145 Frank St. LLC	100.00%		(128,681)	2
3	V	19 Accounting Fees		1145 Frank St. LLC	100.00%	8,025	8,025	3
4	V	36 Amortization		1145 Frank St. LLC	100.00%	20,499	20,499	4
5	V	19 Bookkeeping Fees		1145 Frank St. LLC	100.00%	5,000	5,000	5
6	V	30 Depreciation		1145 Frank St. LLC	100.00%	87,322	87,322	6
7	V	32 Interest	10	1145 Frank St. LLC	100.00%	181,502	181,492	7
8	V	19 Legal Fees		1145 Frank St. LLC	100.00%	55	55	8
9	V	20 Licenses & Permits		1145 Frank St. LLC	100.00%	282	282	9
10	V	33 Real Estate Tax - Prior Year		1145 Frank St. LLC	100.00%	51,168	51,168	10
11	V	33 Real Estate Tax		1145 Frank St. LLC	100.00%	77,513	77,513	11
12	V	21 State Replacement Tax		1145 Frank St. LLC	100.00%	1,062	1,062	12
13	V							13
14	Total		\$ 488,691			\$ 432,428	\$ * (56,263)	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%	\$ 66	\$	66	15
16	V	5 UTILITIES		APERION CARE, INC.	100.00%	(11)		(11)	16
17	V	6 MAINTENANCE SALARY		APERION CARE, INC.	100.00%	817		817	17
18	V	6 REPAIRS & MAINTENANCE		APERION CARE, INC.	100.00%	178		178	18
19	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	100.00%	41		41	19
20	V	10 SALARY- NURSE		APERION CARE, INC.	100.00%	7,535		7,535	20
21	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	100.00%	381		381	21
22	V	17 ADMINISTRATIVE SALARIES		APERION CARE, INC.	100.00%	44,926		44,926	22
23	V	17 MANAGEMENT FEES		APERION CARE, INC.	100.00%	6,076		6,076	23
24	V	19 PROFESSIONAL FEES		APERION CARE, INC.	100.00%	3,972		3,972	24
25	V	20 FEES, SUBSCRIPTIONS		APERION CARE, INC.	100.00%	5,026		5,026	25
26	V	21 CLERICAL SALARY		APERION CARE, INC.	100.00%	34,553		34,553	26
27	V	21 CLERICAL & GENERAL		APERION CARE, INC.	100.00%	1,261		1,261	27
28	V	24 SEMINARS		APERION CARE, INC.	100.00%	1,218		1,218	28
29	V	25 AUTO AND TRAVEL		APERION CARE, INC.	100.00%	958		958	29
30	V	26 INSURANCE		APERION CARE, INC.	100.00%	1,799		1,799	30
31	V	27 EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	100.00%	4,142		4,142	31
32	V	30 DEPRECIATION		APERION CARE, INC.	100.00%	1,303		1,303	32
33	V	32 INTEREST		APERION CARE, INC.	100.00%	3,328		3,328	33
34	V	35 AUTO LEASE		APERION CARE, INC.	100.00%	2,512		2,512	34
35	V	35 EQUIPMENT RENTAL		APERION CARE, INC.	100.00%	21		21	35
36	V	17 MANAGEMENT FEE	280,031	APERION CARE, INC.	100.00%			(280,031)	36
37	V	19 HOME OFFICE	67,377	APERION CARE, INC.	100.00%			(67,377)	37
38	V	19 LEGAL INCOME	5,000					(5,000)	38
39	Total		\$ 352,408			\$ 120,103	\$ *	(232,305)	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%	\$ 8,827	\$	8,827	15
16	V	6		APERION CONSULTING, LLC	100.00%	9,894		9,894	16
17	V	6		APERION CONSULTING, LLC	100.00%	5		5	17
18	V	7		APERION CONSULTING, LLC	100.00%	2,655		2,655	18
19	V	10		APERION CONSULTING, LLC	100.00%	36,304		36,304	19
20	V	15		APERION CONSULTING, LLC	100.00%	4,108		4,108	20
21	V	19		APERION CONSULTING, LLC	100.00%	1,283		1,283	21
22	V	20		APERION CONSULTING, LLC	100.00%	1,908		1,908	22
23	V	21		APERION CONSULTING, LLC	100.00%	6,825		6,825	23
24	V	24		APERION CONSULTING, LLC	100.00%	709		709	24
25	V	25		APERION CONSULTING, LLC	100.00%	1,353		1,353	25
26	V	27		APERION CONSULTING, LLC	100.00%	907		907	26
27	V	30		APERION CONSULTING, LLC	100.00%	233		233	27
28	V	32		APERION CONSULTING, LLC	100.00%	15		15	28
29	V	35		APERION CONSULTING, LLC	100.00%	371		371	29
30	V								30
31	V								31
32	V								32
33	V	10	36,450	APERION CONSULTING, LLC	100.00%			(36,450)	33
34	V	01		APERION CONSULTING, LLC	100.00%				34
35	V	01	23,700	APERION CONSULTING, LLC	100.00%			(23,700)	35
36	V	06	4,350	APERION CONSULTING, LLC	100.00%			(4,350)	36
37	V	19	10,200	APERION CONSULTING, LLC	100.00%			(10,200)	37
38	V	43	300	APERION CONSULTING, LLC	100.00%			(300)	38
39	Total		\$ 75,000			\$ 75,398	\$ *	398	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		APERION FINANCIAL, LLC	100.00%	\$ 3	\$ 3
16	V	17		APERION FINANCIAL, LLC	100.00%	2,614	2,614
17	V	19		APERION FINANCIAL, LLC	100.00%	1,192	1,192
18	V	20		APERION FINANCIAL, LLC	100.00%	514	514
19	V	21		APERION FINANCIAL, LLC	100.00%	81,076	81,076
20	V	24		APERION FINANCIAL, LLC	100.00%	139	139
21	V	25		APERION FINANCIAL, LLC	100.00%	66	66
22	V	27		APERION FINANCIAL, LLC	100.00%	10,054	10,054
23	V	30		APERION FINANCIAL, LLC	100.00%	287	287
24	V	32		APERION FINANCIAL, LLC	100.00%	(404)	(404)
25	V	35		APERION FINANCIAL, LLC	100.00%	346	346
26	V			APERION FINANCIAL, LLC	100.00%		
27	V			APERION FINANCIAL, LLC	100.00%		
28	V			APERION FINANCIAL, LLC	100.00%		
29	V			APERION FINANCIAL, LLC	100.00%		
30	V			APERION FINANCIAL, LLC	100.00%		
31	V			APERION FINANCIAL, LLC	100.00%		
32	V			APERION FINANCIAL, LLC	100.00%		
33	V			APERION FINANCIAL, LLC	100.00%		
34	V	19	125,130	APERION FINANCIAL, LLC	100.00%		(125,130)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 125,130			\$ 95,887	\$ * (29,243)

* 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%	\$ 981	\$ 981	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,972	1,972	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		303	303	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		6,926	6,926	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		12	12	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,723	1,723	20
21	V	26 INSURANCE		CHASE OFFICE,LLC				21
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		13,715	13,715	22
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		3,496	3,496	23
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,279	1,279	24
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		801	801	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			\$ 31,208	\$ * 3,208	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	\$ 415,738	Renewal Rehab		\$ 398,984	\$ (16,754)
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		\$ 415,738			\$ 398,984	\$ * (16,754)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 18,563	ProPay HR LLC	24.00%	\$ 14,108	\$ (4,455)
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		\$ 18,563			\$ 14,108	\$ * (4,455)

* 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 (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	MICHAEL ROSEN TRUST	29.50%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	1
2	YOSEF MEYSEL TRUST	32.00%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	2
3	FREDRICK S. FRANKEL	1.00%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	3
4	DAVID BERKOWITZ TRUST	32.00%	Aperion Care Chicago Heights	Chicago Heights	Renewal Rehab	Skokie	Therapy Services	4
5	STEVEN TUROFSKY	1.00%	Aperion Care Demotte	Demotte,IN	Aperion Care, Inc.	Skokie	Corporate Manager	5
6	HOWARD BORENSTEIN	4.50%	Aperion Care Dolton	Dolton	Aperion Consulting, Inc.	Skokie	Consulting Co.	6
7			Aperion Care Elgin	Elgin	Aperion Financial, Inc.	Skokie	Bookkeeping	7
8			Aperion Care Evanston	Evanston	Eco-Brite	Skokie	Laundry	8
9			Aperion Care Forest Park	Forest Park	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Plum Grove	Palatine	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 GALESBURG

0052761

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	1.2	3.00%	Alloc. Salary	\$ 6,076	17-7	1	
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	878	17-7	2	
3	Joel Meystel	Relative	Clerical	0.00%	See Attached	0.6	3.00%	Alloc. Salary	222	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.098	2.93%	Alloc. Salary	828	21-7	4	
5	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	6,076	17-7	5	
6	Fredrick Frankel	Owner	Administrative	1.00%	See Attached	1.2	3.00%	Alloc. Salary	5,573	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.2	3.00%	Alloc. Salary	6,076	17-7	7	
8	Michael Rosen	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	6,076	17-7	8	
9	Nosson Factor	Relative	Clerical	0.00%	See Attached	1	3.00%	Alloc. Salary	2,085	21-7	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	\$ 33,890		13	

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APERION CARE GALESBURG

0052761

Report Period Beginning:

01/01/17

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 GALESBURG

0052761

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	\$ 33,626	\$ 66	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)	33,626	(11)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	26,901	817	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855	33,626	178	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359	33,626	41	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	248,007	7,535	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526	33,626	381	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	1,478,789	44,926	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000	33,626	6,076	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754	33,626	3,972	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435	33,626	5,026	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	1,137,341	34,553	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500	33,626	1,261	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097	33,626	1,218	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545	33,626	958	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232	33,626	1,799	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354	33,626	4,142	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899	33,626	1,303	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529	33,626	3,328	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699	33,626	2,512	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707	33,626	21	21
22									22
23									23
24									24
25	TOTALS					\$ 3,953,315	\$ 2,891,038	\$ 120,103	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

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	\$ 33,626	\$ 8,827	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	33,626	9,894	2
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162	33,626	5	3
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378	33,626	2,655	4
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	1,194,994	36,304	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233	33,626	4,108	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241	33,626	1,283	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820	33,626	1,908	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	200,283	6,825	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340	33,626	709	10
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550	33,626	1,353	11
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866	33,626	907	12
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685	33,626	233	13
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508	33,626	15	14
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204	33,626	371	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	\$ 75,398	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

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	\$ 33,626	\$ 3	1	
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	86,036	33,626	2,614	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233	33,626	33,626	1,192	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932	33,626	33,626	514	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	2,630,420	33,626	81,076	5
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567	33,626	33,626	139	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179	33,626	33,626	66	7
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931	33,626	33,626	10,054	8
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460	33,626	33,626	287	9
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)	33,626	33,626	(404)	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395	33,626	33,626	346	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	\$	95,887	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

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	\$ 33,626	\$ 981	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905	33,626	1,972	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989	33,626	303	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965	33,626	6,926	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387	33,626	12	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714	33,626	1,723	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47		33,626		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435	33,626	13,715	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060	33,626	3,496	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109	33,626	1,279	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374	33,626	801	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	\$	\$ 31,208	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

RENEWAL REHAB

Street Address

4655 W. CHASE

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	39	Therapy Services	Direct	43	\$	\$		\$ 398,984	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				\$	\$		\$ 398,984	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

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		\$	\$		\$ 14,108	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				\$	\$		\$ 14,108	25

Facility Name & ID Number APERION CARE GALESBURG

0052761

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 GALESBURG

0052761 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 GALESBURG

0052761

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 GALESBURG

0052761

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**					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			\$	\$ 3,337,500			\$	181,502					
2																	
3																	
4																	
5																	
Working Capital																	
6	First Midwest Bank		X	Line of Credit				1,025,639				48,618					
7	Insurance Policies		X									3,105					
8																	
9	TOTAL Facility Related						\$	\$ 4,363,139			\$	233,225					
B. Non-Facility Related*																	
10	Interest Income		X									(25,351)					
11	Interest Income - Bldg Co		X									(10)					
12																	
13	See Supplemental Schedule											6,435					
14	TOTAL Non-Facility Related						\$	\$			\$	(18,926)					
15	TOTALS (line 9+line14)						\$	\$ 4,363,139			\$	214,299					

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.		\$	26,345	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.)		\$	78,792	2
3. Under or (over) accrual (line 2 minus line 1).		\$	52,447	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	77,513	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	152	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.		\$	130,112	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	23,782	8
	2013	24,740	9
	2014	25,294	10
	2015	25,973	11
	2016	77,513	12

2017 Accrual = 2016 Tax

Allocated from Chase Office \$1279

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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 GALESBURG

0052761 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	Facility		2015	\$ 308,847	1
2	Allocated from Chase Office		2016	1,886	2
3	TOTALS			\$ 310,733	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	108		2015	1972	\$ 2,758,153	\$ 87,322	35	\$ 78,804	\$ (8,518)	\$ 217,142	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			108,224	7,170	4,996	(2,174)	7,374	68
69				98,882		(98,882)		69
70			\$ 2,866,377	\$ 193,374	\$ 83,800	\$ (109,574)	\$ 224,516	70

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

Facility Name & ID Number APERION CARE GALESBURG# 0052761

Report Period Beginning:

01/01/17

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		\$ 2,866,377	\$ 193,374		\$ 83,800	\$ (109,574)	\$ 224,516	1
2	New White Alucabond Face Panel Mounted Sign	2014	4,141		20	276	276	966	2
3	Entrance Sign & 2 Formed Pan Faces	2014	5,450		20	1,090	1,090	4,360	3
4	100 Gallon Natural Gas Water Heater	2014	8,740		20	1,748	1,748	6,118	4
5	Security Camera System Installation	2014	13,842		20	2,768	2,768	9,459	5
6	Drain, Remove & Replace Old 100 Gallon Gas Tank	2014	5,168		20	258	258	883	6
7	New Landscape Design	2014	9,494		20	633	633	2,215	7
8	Vestibuleneu Ceramic Tile & Walk Off Carpet Tile, Dumpster	2014	14,132		20	707	707	2,296	8
9	Lounge / Dining Roomnew Vinyl Plankwood Tile, Wallcovering	2014	35,072		20	1,754	1,754	5,699	9
10	Admissions Office / Activiry Roomnew Carpet Tile, Wallcovering	2014	4,620		20	231	231	751	10
11	Conference Roomnew Carpet Tile, Wallcovering	2014	4,498		20	225	225	731	11
12	Therapy Room Replace Carpet With Vinyl Tile, Wallcovering	2014	10,288		20	514	514	1,672	12
13	2 North Corridors New Vct & Pure Vinyl Tile	2014	10,864		20	543	543	1,765	13
14	2 South Corridors New Vct & Pure Vinyl Tile	2014	7,917		20	396	396	1,287	14
15	Corridors Wallcovering, Handrails, Bumper & Corner Guards	2014	34,495		20	1,725	1,725	5,605	15
16	Nurse Call System Annunciator Panet	2014	5,956		20	298	298	918	16
17	10 Windows Near Egress	2015	4,841		20	242	242	625	17
18	Bwing Corridor Install Wallcovering & Paint	2015	17,689		20	884	884	2,653	18
19	Guest Bathroomreplace Flr & Wall Tile,Toilet,Sink,Faucet,Fixtur	2015	4,260		20	213	213	639	19
20	Nurses Station2 Custom Nurse Stations With Sink & Faucet	2015	28,376		20	1,419	1,419	4,256	20
21	Vestibule & Diningwallcovering, New Divider Wall, Light Fixture	2015	21,725		20	1,086	1,086	3,259	21
22	Therapy Roomlaminat Workstation; Admissions Officeshades	2015	9,970		20	499	499	1,496	22
23	Paint Library, Activity Rm, Doorframes, Therapy Rm, Dining Rm	2015	28,018		20	1,401	1,401	4,203	23
24	2 N & 2 S Corridors Millwork Base, Signage, Lighting	2015	43,324		20	2,166	2,166	6,499	24
25	Guest Bathrm & Vestibule Tile,Mirror,Remove Windows	2015	2,561		20	128	128	373	25
26	Nurse Station Demo, Electrical Power To New Station	2015	4,243		20	212	212	619	26
27	Library/Group & Conference Rm Cove Base & Shades	2015	3,374		20	169	169	492	27
28	Lounge New Vinyl Tile, Light Fixtures	2015	8,402		20	420	420	1,225	28
29	Therapy Rm & Misc New Workstation, Dumpster	2015	5,563		20	278	278	811	29
30	Corridors Reroute Power & New Light Fixtures, 6 Outlets	2015	39,362		20	1,968	1,968	5,740	30
31	Fence	2015	4,340		20	217	217	597	31
32	Corridors Signage, Cornice Dining Room & Resident Rooms...	2016	16,578		20	829	829	1,658	32
33	Heat Pump	2016	4,150		20	208	208	311	33
34	TOTAL (lines 1 thru 33)		\$ 3,287,830	\$ 193,374		\$ 109,305	\$ (84,069)	\$ 304,697	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,287,830	\$ 193,374		\$ 109,305	\$ (84,069)	\$ 304,697	1
2	Installation Of Entrance Sign & Cabinet Faces	2016	4,722		20	236	236	295	2
3	Basio Plumbingheat Exchanger	2016	3,714		20	186	186	201	3
4	Guest Bath & Nursing Station	2017	5,082		20	254	254	254	4
5	Ao Smith 100 Gal Commercial Waterheater	2017	5,799		20	483	483	483	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,307,147	\$ 193,374		\$ 110,464	\$ (82,910)	\$ 305,930	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		\$ 3,307,147	\$ 193,374		\$ 110,464	\$ (82,910)	\$ 305,930	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,307,147	\$ 193,374		\$ 110,464	\$ (82,910)	\$ 305,930	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		\$ 3,307,147	\$ 193,374		\$ 110,464	\$ (82,910)	\$ 305,930	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		\$ 3,307,147	\$ 193,374		\$ 110,464	\$ (82,910)	\$ 305,930	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	16,977	435	39	435		617	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	905	145	20	45	(100)	362	9
10	Allocated from Aperion Care	2012	257	20	20	13	(7)	77	10
11	Allocated from Aperion Care	2013	109	12	20	5	(7)	27	11
12									12
13	Allocated from Chase Office	2017	3,930	258	20	196	(62)	196	13
14	Allocated from Chase Office	2016	86,046	6,300	20	4,302	(1,998)	6,095	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)		\$ 108,224	\$ 7,170		\$ 4,996	\$ (2,174)	\$ 7,374	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		\$ 108,224	\$ 7,170		\$ 4,996	\$ (2,174)	\$ 7,374	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)	\$ 108,224	\$ 7,170		\$ 4,996	\$ (2,174)	\$ 7,374	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 263,442	\$ 7,665	\$ 30,127	\$ 22,462	10	\$ 73,794	71
72	Current Year Purchases	\$ 50,660	433	6,331	5,898	10	6,331	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 314,102	\$ 8,098	\$ 36,458	\$ 28,360		\$ 80,125	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 GMC SAVANA	2013	\$ 54,662	\$	\$ 6,659	\$ 6,659	5	\$ 35,517	76
77		Allocated from Aperion Care		1,016	154	203	49	5	659	77
78		Allocated from Aperion Consulting		704	116	141	25	5	423	78
79										79
80	TOTALS			\$ 56,382	\$ 270	\$ 7,003	\$ 6,733		\$ 36,599	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)	\$ 3,988,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 201,742	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 153,926	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,816)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 422,655	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	Equipment Rental - Building				88			5
6								6
7	TOTAL				\$ 88			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: \$ 7,633 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		\$	2,512	17
18	Allocated from Aperion Consulting			371	18
19					19
20					20
21	TOTAL		\$	2,883	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				\$ 189,022				\$ 189,022	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				7,345				7,345	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				219,449				219,449	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 03	# of prescripts				74,073				74,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						18,956	70,088			89,044	13
14	TOTAL				\$		\$ 508,845	\$ 70,088			\$ 578,933	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	\$ 30,452	\$ 32,499	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,640,283	1,640,283	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,132	110,132	6
7	Other Prepaid Expenses	994	994	7
8	Accounts Receivable (owners or related parties)	600,000	600,000	8
9	Other(specify): <u>See Attached Schedule</u>	51,818	248,224	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,433,679	\$ 2,632,132	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		308,847	13
14	Buildings, at Historical Cost		2,758,153	14
15	Leasehold Improvements, at Historical Cost	346,600	346,600	15
16	Equipment, at Historical Cost	305,481	388,481	16
17	Accumulated Depreciation (book methods)	(275,284)	(497,919)	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>	1,186,920	1,241,877	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,563,717	\$ 4,546,039	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,997,396	\$ 7,178,171	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,540	\$ 376,539	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,025,639	1,025,639	29
30	Accrued Salaries Payable	175,007	175,007	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,811	6,811	31
32	Accrued Real Estate Taxes(Sch.IX-B)		77,513	32
33	Accrued Interest Payable	4,309	20,487	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	84,662	84,662	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,672,968	\$ 1,766,658	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,337,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,647,814	394,273	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,647,814	\$ 3,731,773	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,320,782	\$ 5,498,431	46
47	TOTAL EQUITY(page 18, line 24)	\$ 676,614	\$ 1,679,740	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,997,396	\$ 7,178,171	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 605,097	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 605,097	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	196,517	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	(125,000)	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)	\$ 71,517	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)	\$ 676,614	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number APERION CARE GALESBURG

0052761

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,619,753	1
2	Discounts and Allowances for all Levels	599,013	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,218,766	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,630	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 200,630	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	932	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30	19
20	Radiology and X-Ray	6	20
21	Other Medical Services	(1,253)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (285)	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	25,351	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,351	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,444,462	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	898,466	31
32	Health Care	2,234,715	32
33	General Administration	1,570,769	33
B. Capital Expense			
34	Ownership	684,759	34
C. Ancillary Expense			
35	Special Cost Centers	607,431	35
36	Provider Participation Fee	251,805	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,247,945	40
41	Income before Income Taxes (line 30 minus line 40)**	196,517	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 196,517	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,959,456	44
45	Private Pay - Net Inpatient Revenue	188,100	45
46	Medicare - Net Inpatient Revenue	1,163,523	46
47	Other-(specify) <u>Insurance</u>	217,308	47
48	Other-(specify) <u>Managed Care</u>	1,690,379	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,218,766	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 GALESBURG**

0052761

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	2,008	2,386	\$ 82,129	\$ 34.42	1
2	Assistant Director of Nursing	1,920	2,439	55,837	22.89	2
3	Registered Nurses	9,513	10,105	258,164	25.55	3
4	Licensed Practical Nurses	19,937	21,734	456,317	21.00	4
5	CNAs & Orderlies	54,047	57,651	685,183	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,195	9,182	195,328	21.27	8
9	Activity Director	2,064	2,085	38,031	18.24	9
10	Activity Assistants	4,054	4,451	49,275	11.07	10
11	Social Service Workers	6,088	6,401	159,655	24.94	11
12	Dietician					12
13	Food Service Supervisor	1,844	1,908	31,360	16.44	13
14	Head Cook	2,033	2,536	26,685	10.52	14
15	Cook Helpers/Assistants	10,835	12,011	111,538	9.29	15
16	Dishwashers					16
17	Maintenance Workers	5,014	5,297	79,982	15.10	17
18	Housekeepers	12,901	13,980	141,064	10.09	18
19	Laundry	4,983	5,353	54,811	10.24	19
20	Administrator	1,912	2,127	81,347	38.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	15	15	195	13.00	23
24	Clerical	4,811	5,240	79,014	15.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,010	1,105	15,706	14.21	31
32	Other Health Care(specify)					32
33	Other(specify)	1,174	1,198	12,313	10.28	33
34	TOTAL (lines 1 - 33)	154,358	167,204	\$ 2,613,934 *	\$ 15.63	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	372	\$ 23,700	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	436	36,450	10-03	38
39	Pharmacist Consultant	Monthly	10,206	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				44
45	Social Service Consultant	62	3,886	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	870	\$ 98,242		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 GALESBURG# 0052761

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 \$4320
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,365 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 251,805
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100 % Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? 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? N/A
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees