



Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,485	261	1,131	22,877	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,485	261	1,131	22,877	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.43%

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 09/01/2010

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 09/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided N/A

Medicare Intermediary N/A

**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 Springfield, Llc # 0051086 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
	<b>A. General Services</b>										
1	Dietary	141,566	13,663	8,280	163,509		163,509	6,006	169,515		1
2	Food Purchase		128,709		128,709		128,709	(8,645)	120,064		2
3	Housekeeping	94,425	12,701		107,126		107,126		107,126		3
4	Laundry	19,002	7,939		26,941		26,941		26,941		4
5	Heat and Other Utilities			73,063	73,063		73,063	(5,925)	67,138		5
6	Maintenance	41,690	21,928	43,076	106,694		106,694	(868)	105,826		6
7	Other (specify):*							2,040	2,040		7
8	<b>TOTAL General Services</b>	296,683	184,940	124,419	606,042		606,042	(7,393)	598,649		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	708,898	37,682	18,712	765,292		765,292	18,025	783,317		10
10a	Therapy			130	130		130		130		10a
11	Activities	47,518	3,537	2,087	53,142		53,142		53,142		11
12	Social Services	86,616			86,616		86,616		86,616		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,054	3,054		15
16	<b>TOTAL Health Care and Programs</b>	843,032	41,219	37,729	921,980		921,980	21,079	943,059		16
	<b>C. General Administration</b>										
17	Administrative	103,684		94,311	197,995		197,995	(57,834)	140,161		17
18	Directors Fees										18
19	Professional Services			183,062	183,062	(103)	182,959	(95,948)	87,011		19
20	Dues, Fees, Subscriptions & Promotions			82,762	82,762		82,762	(65,386)	17,376		20
21	Clerical & General Office Expenses	29,735		59,078	88,813		88,813	63,050	151,863		21
22	Employee Benefits & Payroll Taxes			188,205	188,205		188,205		188,205		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,283	6,283		6,283	779	7,062		24
25	Other Admin. Staff Transportation			9,795	9,795		9,795	1,618	11,413		25
26	Insurance-Prop.Liab.Malpractice			38,711	38,711		38,711	1,224	39,935		26
27	Other (specify):*							10,275	10,275		27
28	<b>TOTAL General Administration</b>	133,419		662,207	795,626	(103)	795,523	(142,221)	653,301		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,273,134	226,159	824,355	2,323,648	(103)	2,323,545	(128,535)	2,195,010		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 Springfield, Llc

#0051086

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	
	<b>D. Ownership</b>											
30	Depreciation			42,140	42,140		42,140	39,973	82,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,081	17,081		17,081	144,210	161,291			32
33	Real Estate Taxes			19,754	19,754	103	19,857	870	20,728			33
34	Rent-Facility & Grounds			292,000	292,000		292,000	(292,000)				34
35	Rent-Equipment & Vehicles			8,341	8,341		8,341	2,757	11,098			35
36	Other (specify):*			10,137	10,137		10,137	(10,137)				36
37	<b>TOTAL Ownership</b>			389,453	389,453	103	389,556	(114,327)	275,229			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,061		2,061		2,061		2,061			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,300	175,300		175,300		175,300			42
43	Other (specify):*			13,175	13,175		13,175	(13,175)				43
44	<b>TOTAL Special Cost Centers</b>		2,061	188,475	190,536		190,536	(13,175)	177,361			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,273,134	228,220	1,402,283	2,903,637		2,903,637	(256,037)	2,647,600			45

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



Aperion Care Springfield, Llc

ID# 0051086  
 Report Period Beginning: 01/01/17  
 Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Advertising/Marketing	\$ (11,900)	43	1
2	Bank Charges	(3,422)	21	2
3	Theft and Damage Loss	(1,163)	21	3
4	Amortization	(10,137)	36	4
5	Building Company - Home Office Expense	(14,140)	19	5
6	Building Company - Amortization	(19,567)	36	6
7	Building Company - Replacement Tax	(571)	21	7
8	Non Allowable Legal Fees	(719)	19	8
9	Non Allowable Seminar Expense	(626)	24	9
10	PAC Dues	(4,338)	20	10
11	Non Allowable Professional Fees	(2,326)	19	11
12	Capitalized R&M	(6,975)	06	12
13	Additional R&M	4,704	06	13
14	Sales/Use Tax	(397)	02	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	<b>Total</b>	(71,577)		49

Aperion Care Springfield, Llc

	<b>ID#</b>	<u>0051086</u>
<b>Report Period Beginning:</b>		<u>01/01/17</u>
<b>Ending:</b>		<u>12/31/17</u>

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086 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				6,006								6,006	1
2	Food Purchase	(412)		45	(8,280)	2							(8,645)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,585)		(8)			668						(5,925)	5
6	Maintenance	(2,271)		677	(616)		1,342						(868)	6
7	Other (specify):*			28	1,806		206						2,040	7
8	<b>TOTAL General Services</b>	<b>(9,268)</b>		<b>742</b>	<b>(1,084)</b>	<b>2</b>	<b>2,216</b>						<b>(7,393)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			5,126	12,899								18,025	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			259	2,795								3,054	15
16	<b>TOTAL Health Care and Programs</b>			<b>5,385</b>	<b>15,694</b>								<b>21,079</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(59,612)		1,778							(57,834)	17
18	Directors Fees													18
19	Professional Services	(17,185)	14,140	(32,166)	873	(63,945)	4,712	(2,376)					(95,948)	19
20	Fees, Subscriptions & Promotions	(70,461)		3,419	1,298	350	8						(65,386)	20
21	Clerical & General Office Expenses	(22,860)	571	24,365	4,643	55,159	1,172						63,050	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(626)		829	482	94							779	24
25	Other Admin. Staff Transportation			652	921	45							1,618	25
26	Insurance-Prop.Liab.Malpractice			1,224									1,224	26
27	Other (specify):*			2,818	617	6,840							10,275	27
28	<b>TOTAL General Administration</b>	<b>(111,132)</b>	<b>14,711</b>	<b>(58,471)</b>	<b>8,834</b>	<b>321</b>	<b>5,892</b>	<b>(2,376)</b>					<b>(142,221)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(120,400)</b>	<b>14,711</b>	<b>(52,344)</b>	<b>23,444</b>	<b>323</b>	<b>8,108</b>	<b>(2,376)</b>					<b>(128,535)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	18,171	11,229	887	159	196	9,331						39,973	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,994)	146,827	2,264	10	(275)	2,378						144,210	32
33	Real Estate Taxes						870						870	33
34	Rent-Facility & Grounds		(264,000)				(28,000)						(292,000)	34
35	Rent-Equipment & Vehicles			1,724	252	236	545						2,757	35
36	Other (specify):*	(29,704)	19,567										(10,137)	36
37	<b>TOTAL Ownership</b>	<b>(18,527)</b>	<b>(86,377)</b>	<b>4,875</b>	<b>421</b>	<b>157</b>	<b>(14,876)</b>						<b>(114,327)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(11,900)			(1,275)								(13,175)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(11,900)</b>			<b>(1,275)</b>								<b>(13,175)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(150,827)</b>	<b>(71,666)</b>	<b>(47,469)</b>	<b>22,591</b>	<b>479</b>	<b>(6,768)</b>	<b>(2,376)</b>					<b>(256,037)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 264,000	525 South MLK Drive, LLC	100.00%	\$	(264,000)	1
2	V	19 Home Office Expense		525 South MLK Drive, LLC	100.00%	14,140	14,140	2
3	V	36 Amortization		525 South MLK Drive, LLC	100.00%	19,567	19,567	3
4	V	30 Depreciation		525 South MLK Drive, LLC	100.00%	11,229	11,229	4
5	V	32 Interest Expense	6	525 South MLK Drive, LLC	100.00%	146,833	146,827	5
6	V	33 Real Estate Taxes	19,754	525 South MLK Drive, LLC	100.00%	19,754		6
7	V	21 Replacement Tax		525 South MLK Drive, LLC	100.00%	571	571	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 283,760			\$ 212,094	\$ * (71,666)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2	FOOD	APERION CARE, INC.	100.00%	\$ 45	\$ 45 15
16	V	5	UTILITIES	APERION CARE, INC.	100.00%	(8)	(8) 16
17	V	6	MAINTENANCE SALARY	APERION CARE, INC.	100.00%	556	556 17
18	V	6	REPAIRS & MAINTENANCE	APERION CARE, INC.	100.00%	121	121 18
19	V	7	EMP. BEN.-GEN. SERV. & DIETARY	APERION CARE, INC.	100.00%	28	28 19
20	V	10	SALARY- NURSE	APERION CARE, INC.	100.00%	5,126	5,126 20
21	V	15	PAYROLL TAXES/GROUP INSURANCE	APERION CARE, INC.	100.00%	259	259 21
22	V	17	ADMINISTRATIVE SALARIES	APERION CARE, INC.	100.00%	30,565	30,565 22
23	V	17	MANAGEMENT FEES	APERION CARE, INC.	100.00%	4,134	4,134 23
24	V	19	PROFESSIONAL FEES	APERION CARE, INC.	100.00%	2,703	2,703 24
25	V	20	FEES, SUBSCRIPTIONS	APERION CARE, INC.	100.00%	3,419	3,419 25
26	V	21	CLERICAL SALARY	APERION CARE, INC.	100.00%	23,507	23,507 26
27	V	21	CLERICAL & GENERAL	APERION CARE, INC.	100.00%	858	858 27
28	V	24	SEMINARS	APERION CARE, INC.	100.00%	829	829 28
29	V	25	AUTO AND TRAVEL	APERION CARE, INC.	100.00%	652	652 29
30	V	26	INSURANCE	APERION CARE, INC.	100.00%	1,224	1,224 30
31	V	27	EMP. BEN.-GEN. ADMIN.	APERION CARE, INC.	100.00%	2,818	2,818 31
32	V	30	DEPRECIATION	APERION CARE, INC.	100.00%	887	887 32
33	V	32	INTEREST	APERION CARE, INC.	100.00%	2,264	2,264 33
34	V	35	AUTO LEASE	APERION CARE, INC.	100.00%	1,709	1,709 34
35	V	35	EQUIPMENT RENTAL	APERION CARE, INC.	100.00%	15	15 35
36	V	17	MANAGEMENT FEE	APERION CARE, INC.	100.00%		(94,311) 36
37	V	19	HOME OFFICE	APERION CARE, INC.	100.00%		(34,869) 37
38	V						
39	Total		\$ 129,180			\$ 81,710	\$ * (47,469) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1		APERION CONSULTING, LLC	100.00%	\$ 6,006	\$ 6,006
16	V	6		APERION CONSULTING, LLC	100.00%	6,731	6,731
17	V	6		APERION CONSULTING, LLC	100.00%	3	3
18	V	7		APERION CONSULTING, LLC	100.00%	1,806	1,806
19	V	10		APERION CONSULTING, LLC	100.00%	24,699	24,699
20	V	15		APERION CONSULTING, LLC	100.00%	2,795	2,795
21	V	19		APERION CONSULTING, LLC	100.00%	873	873
22	V	20		APERION CONSULTING, LLC	100.00%	1,298	1,298
23	V	21		APERION CONSULTING, LLC	100.00%	4,643	4,643
24	V	24		APERION CONSULTING, LLC	100.00%	482	482
25	V	25		APERION CONSULTING, LLC	100.00%	921	921
26	V	27		APERION CONSULTING, LLC	100.00%	617	617
27	V	30		APERION CONSULTING, LLC	100.00%	159	159
28	V	32		APERION CONSULTING, LLC	100.00%	10	10
29	V	35		APERION CONSULTING, LLC	100.00%	252	252
30	V						
31	V						
32	V						
33	V						
34	V	10	11,800	APERION CONSULTING, LLC	100.00%		(11,800)
35	V	02	8,280	APERION CONSULTING, LLC	100.00%		(8,280)
36	V	06	7,350	APERION CONSULTING, LLC	100.00%		(7,350)
37	V	43	1,275	APERION CONSULTING, LLC	100.00%		(1,275)
38	V						
39	Total		\$ 28,705			\$ 51,296	\$ * 22,591

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	APERION FINANCIAL, LLC	100.00%	\$ 2	\$	2	15
16	V	17	ADMINISTRATIVE	APERION FINANCIAL, LLC	100.00%	1,778		1,778	16
17	V	19	PROFESSIONAL FEES	APERION FINANCIAL, LLC	100.00%	811		811	17
18	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC	100.00%	350		350	18
19	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC	100.00%	55,159		55,159	19
20	V	24	SEMINARS	APERION FINANCIAL, LLC	100.00%	94		94	20
21	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC	100.00%	45		45	21
22	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC	100.00%	6,840		6,840	22
23	V	30	DEPRECIATION	APERION FINANCIAL, LLC	100.00%	196		196	23
24	V	32	INTEREST	APERION FINANCIAL, LLC	100.00%	(275)		(275)	24
25	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC	100.00%	236		236	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	19	HOME OFFICE EXPENSE	APERION FINANCIAL, LLC	100.00%			(64,756)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 64,756			\$ 65,236	\$ *	479	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC	100.00%	\$ 668	\$ 668
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,342	1,342
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		206	206
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		4,712	4,712
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		8	8
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,172	1,172
21	V	26 INSURANCE		CHASE OFFICE,LLC			
22	V	30 DEPRECIATION		CHASE OFFICE,LLC		9,331	9,331
23	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,378	2,378
24	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		870	870
25	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		545	545
26	V	34 RENTAL INCOME	28,000	CHASE OFFICE,LLC			(28,000)
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		\$ 28,000			\$ 21,232	\$ * (6,768)

\* 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	\$ 9,901	ProPay HR LLC	24.00%	\$ 7,525	\$ (2,376)
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		\$ 9,901			\$ 7,525	\$ * (2,376)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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 Meyetel Trust	47.00%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	1
2	David Berkowitz	47.00%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	2
3	Jay Meystel Trust	4.00%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	3
4	Steve Turofsky	1.00%	Aperion Care Chicago Heights	Chicago Heights	Renewal Rehab	Skokie	Therapy Services	4
5	Fred Frankel	1.00%	Aperion Care Demotte	Demotte,IN	Aperion Care, Inc.	Skokie	Corporate Manager	5
6			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 Galesburg	Galesburg	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Hidden Lake	St. Louis, MO	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Highwood	Highwood	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care International	Chicago	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Jacksonville	Jacksonville	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Kokomo	Kokomo, IN	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Litchfield	Litchfield	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Midlothian	Midlothian				18
19			Aperion Care Moline	East Moline				19
20			Aperion Care Oak Lawn	Oak Lawn				20
21			Aperion Care Peru	Peru, IN				21
22			Aperion Care Spring Valley	Spring Valley				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 &amp; ID Number

Aperion Care Springfield, Llc

# 0051086

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%	See Attached	0.8	2.00%	Alloc Salary	\$ 4,134	17-7	1	
2	Jay Meystel	Relative	Administrative	0%	See Attached	0.4	1.00%	Alloc Salary	597	17-7	2	
3	Joel Meystel	Relative	Clerical	0%	See Attached	0.6	3.00%	Alloc Salary	217	21-7	3	
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.096	2.87%	Alloc Salary	809	21-7	4	
5	David Berkowitz	Owner	Administrative	47.00%	See Attached	0.8	2.00%	Alloc Salary	4,134	17-7	5	
6	Fred Frankel	Owner	Administrative	1.00%	See Attached	0.8	2.00%	Alloc Salary	3,791	17-7	6	
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.8	2.00%	Alloc Salary	4,134	17-7	7	
8	Nosson Factor	Relative	Clerical	0%	See Attached	0.7	2.13%	Alloc Salary	1,418	21-7	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 19,234		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 Springfield, Llc

# 0051086

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	\$ 22,877	\$ 45	1
2	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	(372)	22,877	(8)	2
3	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,106,839	47	26,901	22,877	556	3
4	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	5,855	22,877	121	4
5	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,106,839	47	1,359	22,877	28	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,106,839	47	248,007	22,877	5,126	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,106,839	47	12,526	22,877	259	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,106,839	47	1,478,789	22,877	30,565	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,106,839	47	200,000	22,877	4,134	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	130,754	22,877	2,703	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	165,435	22,877	3,419	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,106,839	47	1,137,341	22,877	23,507	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	41,500	22,877	858	13
14	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	40,097	22,877	829	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	31,545	22,877	652	15
16	26	INSURANCE	ACTUAL CENSUS	1,106,839	47	59,232	22,877	1,224	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	136,354	22,877	2,818	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	42,899	22,877	887	18
19	32	INTEREST	ACTUAL CENSUS	1,106,839	47	109,529	22,877	2,264	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,106,839	47	82,699	22,877	1,709	20
21	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	707	22,877	15	21
22									22
23									23
24									24
25	TOTALS					\$ 3,953,315	\$ 2,891,038	\$ 81,710	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

(

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	1	DIETITIAN SALARY	PATIENT DAYS	1,106,839	47	\$ 290,566	\$ 22,877	\$ 6,006	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,106,839	47	325,675	22,877	6,731	2
3	6	REPAIRS & MAINTENANCE	PATIENT DAYS	1,106,839	47	162	22,877	3	3
4	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,106,839	47	87,378	22,877	1,806	4
5	10	SALARY NURSE	PATIENT DAYS	1,106,839	47	1,194,994	22,877	24,699	5
6	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	135,233	22,877	2,795	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	1,106,839	47	42,241	22,877	873	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,106,839	47	62,820	22,877	1,298	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	1,106,839	47	224,648	22,877	4,643	9
10	24	SEMINARS	PATIENT DAYS	1,106,839	47	23,340	22,877	482	10
11	25	AUTO AND TRAVEL	PATIENT DAYS	1,106,839	47	44,550	22,877	921	11
12	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,106,839	47	29,866	22,877	617	12
13	30	DEPRECIATION	PATIENT DAYS	1,106,839	47	7,685	22,877	159	13
14	32	INTEREST	PATIENT DAYS	1,106,839	47	508	22,877	10	14
15	35	AUTO LEASE	PATIENT DAYS	1,106,839	47	12,204	22,877	252	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,481,871	\$ 2,011,519	\$ 51,296	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	\$ 22,877	\$ 2	1
2	17	ADMINISTRATIVE	ACTUAL CENSUS	1,106,839	47	86,036	22,877	1,778	2
3	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	39,233	22,877	811	3
4	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	16,932	22,877	350	4
5	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,106,839	47	2,668,725	22,877	55,159	5
6	24	SEMINARS	ACTUAL CENSUS	1,106,839	47	4,567	22,877	94	6
7	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,106,839	47	2,179	22,877	45	7
8	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,106,839	47	330,931	22,877	6,840	8
9	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	9,460	22,877	196	9
10	32	INTEREST	ACTUAL CENSUS	1,106,839	47	(13,300)	22,877	(275)	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	11,395	22,877	236	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,156,251	\$ 2,716,455	\$ 65,236	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

( 847) 262-3800

Fax Number

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,106,839	47	\$ 32,299	\$ 22,877	\$ 668	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,106,839	47	64,905	22,877	1,342	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,106,839	47	9,989	22,877	206	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,106,839	47	227,965	22,877	4,712	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,106,839	47	387	22,877	8	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,106,839	47	56,714	22,877	1,172	6
7	26	INSURANCE	ACTUAL CENSUS	1,106,839	47		22,877		7
8	30	DEPRECIATION	ACTUAL CENSUS	1,106,839	47	451,435	22,877	9,331	8
9	32	INTEREST EXPENSE	ACTUAL CENSUS	1,106,839	47	115,060	22,877	2,378	9
10	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,106,839	47	42,109	22,877	870	10
11	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,106,839	47	26,374	22,877	545	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,027,237	\$	\$ 21,232	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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, IL 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		\$	\$		\$ 7,525	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				\$	\$		\$ 7,525	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086 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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Aperion Care Springfield, Llc

# 0051086

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Midwest Bank		X	Mortgage			\$	2,700,000		\$	146,833	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Assurance		X	Insurance Financing							540	6								
7	First Midwest Bank		X	Line of Credit				250,454	07/21/2019	4.8790	16,541	7								
8	See Supplemental Schedule							44,130				8								
9	TOTAL Facility Related						\$	2,994,584			\$	163,914	9							
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(6,994)	10								
11	Bldg Co. Interest Income		X								(6)	11								
12	Allocated Aperion Care	X									2,264	12								
13	See Supplemental Schedule										2,113	13								
14	TOTAL Non-Facility Related						\$				\$	(2,623)	14							
15	TOTALS (line 9+line14)						\$	2,994,584			\$	161,291	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 Springfield, Llc

# 0051086

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.		\$	<u>19,770</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>19,874</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>104</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>20,520</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<u>103</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>20,728</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>16,907</u>	8
	2013	<u>17,236</u>	9
	2014	<u>17,630</u>	10
	2015	<u>18,109</u>	11
	2016	<u>19,004</u>	12

2017 Accrual = 19004\*1.05=20520 (rounded)

Allocated from Chase Office, LLC = \$870

Adjustment to beginning accrual

<b>FOR BHF USE ONLY</b>			
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 Springfield, LLC

# 0051086 Report Period Beginning:

01/01/17 Ending:

12/31/17

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>525 South MLK Drive, LLC</u>		<u>2011</u>	<u>\$ 183,518</u>	<u>1</u>
2	<u>Allocated from Chase Office, LLC</u>			<u>1,283</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 184,801</b>	<b>3</b>

**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	65	2011	1972	\$ 639,905	\$ 11,229	35	\$ 18,283	\$ 7,054	\$ 134,075	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		2011	19,082		20	1,300	1,300	14,640	9
10	Various		2012	161,607		20	14,749	14,749	104,446	10
11	Various		2013	7,628		20	381	381	1,707	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			73,629	4,878	3,401	(1,477)	5,018	68				
69				42,140		(42,140)		69				
70		\$	901,851	\$	58,247	\$	38,114	\$	(20,133)	\$	259,886	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 901,851	\$ 58,247		\$ 38,114	\$ (20,133)	\$ 259,886	1
2	American Backflow Prevention New Backflow Preventer With Shut	2014	7,200		20	360	360	1,260	2
3	Installed New Power Vent Hot Water Heater	2015	2,870		20	144	144	419	3
4	Installed Plumbing/Broke Concrete Floor,Replaced Floor Drain/K	2017	3,067		20	818	818	818	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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		\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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)	\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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		\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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)	\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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		\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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)	\$ 914,988	\$ 58,247		\$ 39,436	\$ (18,811)	\$ 262,383	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 <b>Building Company</b>		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 <b>Leasehold Improvements:</b>							
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 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$

\*\*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	<b>TOTAL (lines 1 thru 33)</b>	\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4	Allocated from Chase Office, LLC	2016	11,550	296	39	296		420	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	616	99	10	31	(68)	246	9
10	Allocated from Aperion Care	2012	175	13	15	9	(4)	52	10
11	Allocated from Aperion Care	2013	74	8	10	4	(4)	19	11
12									12
13									13
14	Allocated Chase Office, LLC	2016	58,540	4,286	20	2,927	(1,359)	4,147	14
15	Allocated Chase Office, LLC	2017	2,674	176	20	134	(42)	134	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)		\$ 73,629	\$ 4,878		\$ 3,401	\$ (1,477)	\$ 5,018	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		\$ 73,629	\$ 4,878		\$ 3,401	\$ (1,477)	\$ 5,018	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)	\$ 73,629	\$ 4,878		\$ 3,401	\$ (1,477)	\$ 5,018	34

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

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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	\$ 269,644	\$ 5,219	\$ 26,359	\$ 21,140	10	\$ 177,059	71
72	Current Year Purchases	12,306	294	2,042	1,748	10	2,042	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 281,950	\$ 5,513	\$ 28,401	\$ 22,888		\$ 179,101	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		2010 FORD E350 - Transfer from	2012	\$ 47,641	\$	\$ 5,836	\$ 5,836	5	\$ 38,888	76
77		2005 DODGE CARAVAN USED	2014	5,626		937	937	5	4,220	77
78		GMC Savana Passenger	2017	48,474		7,271	7,271	5	7,271	78
79		Aperion Care, Consulting	2017	1,170	184	234	50	5	737	79
80	TOTALS			\$ 102,911	\$ 184	\$ 14,278	\$ 14,094		\$ 51,116	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)	\$ 1,484,650	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,944	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 82,115	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,171	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 492,600	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.

Facility Name & ID Number Aperion Care Springfield, Llc

# 0051086

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: 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	<u>Allocated from 8131 N Monticello</u>		<u>65</u>					5
6								6
7	<b>TOTAL</b>		<b>65</b>		\$			<b>7</b>

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 9,138

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated Aperion Care</u>		\$	<u>1,709</u>	17
18	<u>Allocated Aperion Consulting</u>			<u>252</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$	<b>1,961</b>	<b>21</b>

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				1,844		1,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						217		217	13
14	<b>TOTAL</b>			\$		\$	2,061		\$ 2,061	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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 48,428	\$ 49,119	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	132,878	132,878	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,270	66,270	6
7	Other Prepaid Expenses		28,444	7
8	Accounts Receivable (owners or related parties)	200,000	1,342,966	8
9	Other(specify): <b>See Attached Schedule</b>	11,071	21,420	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 458,647	\$ 1,641,097	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,440	13
14	Buildings, at Historical Cost		350,849	14
15	Leasehold Improvements, at Historical Cost	92,053	115,665	15
16	Equipment, at Historical Cost	294,418	476,713	16
17	Accumulated Depreciation (book methods)	(278,857)	(543,005)	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): <b>See Attached Schedule</b>	1,714,196	2,329,027	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,821,810	\$ 2,914,689	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,280,457	\$ 4,555,786	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 147,692	\$ 147,692	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	294,584	294,584	29
30	Accrued Salaries Payable	92,798	92,798	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,920	2,920	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,520	32
33	Accrued Interest Payable	1,317	14,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 539,311	\$ 572,918	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,700,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>See Attached Schedule</b>	980,937	1,064,645	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 980,937	\$ 3,764,645	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,520,248	\$ 4,337,563	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 760,209	\$ 218,223	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,280,457	\$ 4,555,786	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>335,693</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<u>Rounding</u>	<b>13</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>335,706</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>424,503</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>424,503</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>760,209</b>	<b>24</b> *

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

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,175,313	1
2	Discounts and Allowances for all Levels	(854,252)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,321,061	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 85	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	6,994	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,994	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,328,140	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	606,042	31
32	Health Care	921,980	32
33	General Administration	795,626	33
<b>B. Capital Expense</b>			
34	Ownership	389,453	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	15,236	35
36	Provider Participation Fee	175,300	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,903,637	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	424,503	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 424,503	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,110,821	44
45	Private Pay - Net Inpatient Revenue	47,300	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <b>Insurance</b>	48,737	47
48	Other-(specify) <b>Manafged Care</b>	114,203	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,321,061	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 Springfield, Llc

# 0051086

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,944	2,203	\$ 91,664	\$ 41.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,723	5,172	124,322	24.04	3
4	Licensed Practical Nurses	7,442	8,264	174,010	21.06	4
5	CNAs & Orderlies	23,993	26,799	318,902	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,080	27,931	13.43	9
10	Activity Assistants	887	917	9,668	10.54	10
11	Social Service Workers	3,736	4,160	86,616	20.82	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	39,552	19.02	13
14	Head Cook	5,368	5,776			14
15	Cook Helpers/Assistants	3,498	4,073	102,014	25.05	15
16	Dishwashers					16
17	Maintenance Workers	2,962	3,098	41,690	13.46	17
18	Housekeepers	7,100	8,064	94,425	11.71	18
19	Laundry	1,735	1,910	19,002	9.95	19
20	Administrator	1,944	2,260	103,684	45.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,928	2,066	29,735	14.39	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	488	503	9,919	19.72	33
34	TOTAL (lines 1 - 33)	71,663	79,425	\$ 1,273,134 *	\$ 16.03	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	\$ 8,280	01-03	35
36	Medical Director	Monthly	16,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	11,800	10-03	38
39	Pharmacist Consultant	138	6,912	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	130	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,087	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	140	\$ 46,009		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jackie Liddell	Administrator	0	\$ 103,684	Workers' Compensation Insurance	\$ 14,493	IDPH License Fee	\$		
				Unemployment Compensation Insurance	13,298	Advertising: Employee Recruitment	1,666		
				FICA Taxes	95,391	Health Care Worker Background Check (Indicate # of checks performed <u>26</u> )	255		
				Employee Health Insurance	57,040	Patient Background Checks <u>21</u>	209		
				Employee Meals		Dues and Subscriptions	8,685		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	1,486		
				401K	488	Allocated from Aperion Care	3,419		
				Employee Physicals	160	Allocated from Aperion Consulting	1,298		
				Employee Meals	248	See Supplemental Schedule	358		
				Other Employee Benefits	7,087	Less: Public Relations Expense ( )			
						Non-allowable advertising ( )			
						Yellow page advertising ( )			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,684	TOTAL (agree to Schedule V, line 22, col.8)		\$ 188,205	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,376
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, Inc			\$ 94,311				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 94,311				Seminar Expense	5,657	
							Allocated from Aperion Care	829	
							Allocated from Aperion Consulting	482	
							See Supplemental Schedule	94	
							Entertainment Expense ( )		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 183,062	TOTAL		\$	TOTAL		\$ 7,062

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Aperion Care Springfield, Llc# 0051086

Report Period Beginning:

01/01/17

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$8,676
- (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. \$ 410 Line 10-02
- (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? N/A  
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. \$ 175,300  
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? 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