

Facility Name & ID Number Aperion Care Capitol, Llc

0054783 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	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	31,842	723	10,233	42,798	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,842	723	10,233	42,798	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.72%

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 11/1/2017

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 251 and days of care provided 4,536

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: 12/31/2018 Fiscal Year: 12/31/2018

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

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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	384,811	30,800	20,626	436,237		436,237	2,586	438,823		1
2	Food Purchase		261,648		261,648		261,648	(4,555)	257,093		2
3	Housekeeping	14,462	12,085	222,666	249,213		249,213		249,213		3
4	Laundry	3,717	10,029	148,444	162,190		162,190		162,190		4
5	Heat and Other Utilities			276,016	276,016		276,016	(28,074)	247,942		5
6	Maintenance	74,154	11,363	107,314	192,831		192,831	5,506	198,337		6
7	Other (specify):*							3,568	3,568		7
8	TOTAL General Services	477,144	325,925	775,066	1,578,135		1,578,135	(20,969)	1,557,166		8
	B. Health Care and Programs										
9	Medical Director			31,200	31,200		31,200		31,200		9
10	Nursing and Medical Records	3,005,950	176,354	58,262	3,240,566		3,240,566	8,112	3,248,678		10
10a	Therapy	59,656			59,656		59,656		59,656		10a
11	Activities	141,770	5,194	4,242	151,206		151,206		151,206		11
12	Social Services	216,134			216,134		216,134		216,134		12
13	CNA Training										13
14	Program Transportation			11,244	11,244		11,244		11,244		14
15	Other (specify):*							5,741	5,741		15
16	TOTAL Health Care and Programs	3,423,510	181,548	104,948	3,710,006		3,710,006	13,853	3,723,859		16
	C. General Administration										
17	Administrative	78,623		327,190	405,813		405,813	(263,712)	142,101		17
18	Directors Fees										18
19	Professional Services			373,045	373,045	(31)	373,014	(193,650)	179,364		19
20	Dues, Fees, Subscriptions & Promotions			88,075	88,075		88,075	(32,024)	56,051		20
21	Clerical & General Office Expenses	157,898		213,158	371,056		371,056	15,369	386,425		21
22	Employee Benefits & Payroll Taxes			626,742	626,742		626,742		626,742		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,951	2,951		2,951	2,046	4,997		24
25	Other Admin. Staff Transportation			10,663	10,663		10,663	7,057	17,720		25
26	Insurance-Prop.Liab.Malpractice			349,147	349,147		349,147	2,167	351,314		26
27	Other (specify):*							26,894	26,894		27
28	TOTAL General Administration	236,521		1,990,971	2,227,492	(31)	2,227,461	(435,852)	1,791,609		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,137,175	507,473	2,870,985	7,515,633	(31)	7,515,602	(442,969)	7,072,633		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			15,234	15,234		15,234	3,524	18,758			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,585	36,585		36,585	12,203	48,788			32
33	Real Estate Taxes			102,888	102,888	31	102,919	1,490	104,409			33
34	Rent-Facility & Grounds			369,820	369,820		369,820	(12,000)	357,820			34
35	Rent-Equipment & Vehicles			17,349	17,349		17,349	3,825	21,174			35
36	Other (specify):*			12,321	12,321		12,321	(12,321)				36
37	TOTAL Ownership			554,197	554,197	31	554,228	(3,279)	550,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		292,354	680,051	972,405		972,405	(50,056)	922,349			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			361,625	361,625		361,625		361,625			42
43	Other (specify):*			16,917	16,917		16,917	(16,917)				43
44	TOTAL Special Cost Centers		292,354	1,058,593	1,350,947		1,350,947	(66,973)	1,283,974			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,137,175	799,827	4,483,775	9,420,777		9,420,777	(513,221)	8,907,556			45

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(29,182)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,797)	30		9
10	Interest and Other Investment Income	(156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(39,128)	21		18
19	Entertainment				19
20	Contributions	(21,295)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,516)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(66,966)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (274,084)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(239,137)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (239,137)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (513,221)		37

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

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

(See instructions.)

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

Aperion Care Capitol, Llc

ID# 0054783

Report Period Beginning: 01/01/18

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Credit Card Processing	\$ (891)	21	1
2	Marketing Expense	(15,867)	43	2
3	Bank Charges	(8,557)	21	3
4	Theft & Damage Loss	(918)	21	4
5	Amortization Expense	(12,321)	36	5
6	Vending Commissions	(4,645)	02	6
7	Non-Allowable Seminar - Marketing	(174)	24	7
8	Additional R&M	7,740	06	8
9	PAC Dues	(20,318)	20	9
10	Non-Allowable Legal	(9,465)	19	10
11	Non-Allowable Professional Fees	(1,550)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(66,966)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Capitol, Llc# 0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				2,586								2,586	1
2	Food Purchase	(4,689)		134									(4,555)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(29,182)					1,108						(28,074)	5
6	Maintenance	7,740		2,368	(7,000)		2,398						5,506	6
7	Other (specify):*			220	2,937		411						3,568	7
8	TOTAL General Services	(26,131)		2,722	(1,477)		3,917						(20,969)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			13,196	(5,084)								8,112	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,342	4,399								5,741	15
16	TOTAL Health Care and Programs			14,538	(685)								13,853	16
	C. General Administration													
17	Administrative			(263,712)									(263,712)	17
18	Directors Fees													18
19	Professional Services	(11,015)		(8,722)	2,545	(170,477)	713		(6,693)				(193,650)	19
20	Fees, Subscriptions & Promotions	(41,613)		6,752	1,342	1,483	12						(32,024)	20
21	Clerical & General Office Expenses	(154,010)		40,148	3,324	123,691	2,216						15,369	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(174)		1,785	344	91							2,046	24
25	Other Admin. Staff Transportation			6,794	227	37							7,057	25
26	Insurance-Prop.Liab.Malpractice			2,167									2,167	26
27	Other (specify):*			12,964	318	13,612							26,894	27
28	TOTAL General Administration	(206,812)		(201,825)	8,100	(31,564)	2,941		(6,693)				(435,852)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(232,943)		(184,565)	5,938	(31,564)	6,858		(6,693)				(442,969)	29

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Capitol, Llc# 0054783

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(12,797)		1,740	314	319	13,948						3,524	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(156)		8,307	15		4,037						12,203	32
33	Real Estate Taxes						1,490						1,490	33
34	Rent-Facility & Grounds						(12,000)						(12,000)	34
35	Rent-Equipment & Vehicles			2,023	347	358	1,096						3,825	35
36	Other (specify):*	(12,321)											(12,321)	36
37	TOTAL Ownership	(25,274)		12,070	676	677	8,571						(3,279)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(50,056)					(50,056)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(15,867)			(1,050)								(16,917)	43
44	TOTAL Special Cost Centers	(15,867)			(1,050)			(50,056)					(66,973)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(274,084)		(172,495)	5,564	(30,886)	15,429	(50,056)	(6,693)				(513,221)	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 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		
	V		\$			\$	\$	1
	V							2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	\$ 134	\$ 134	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.	2,165	2,165	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	203	203	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	220	220	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.	4	4	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	13,192	13,192	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	1,342	1,342	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	63,478	63,478	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.	10,949	10,949	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	6,752	6,752	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.	38,107	38,107	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.	2,041	2,041	26
27	V	24	SEMINARS		APERION CARE, INC.	1,785	1,785	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.	6,794	6,794	28
29	V	26	INSURANCE		APERION CARE, INC.	2,167	2,167	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	12,964	12,964	30
31	V	30	DEPRECIATION		APERION CARE, INC.	1,740	1,740	31
32	V	32	INTEREST		APERION CARE, INC.	8,307	8,307	32
33	V	35	AUTO LEASE		APERION CARE, INC.	2,023	2,023	33
34	V	17	MANAGEMENT FEE	327,190	APERION CARE, INC.		(327,190)	34
35	V	19	HOME OFFICE	19,671	APERION CARE, INC.		(19,671)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 346,861			\$ 174,366	\$ * (172,495)	39

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

Facility Name & ID Number

Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1		APERION CONSULTING, LLC		\$ 16,256	\$	16,256	15
16	V	6		APERION CONSULTING, LLC		10,358		10,358	16
17	V	7		APERION CONSULTING, LLC		2,937		2,937	17
18	V	10		APERION CONSULTING, LLC		39,314		39,314	18
19	V	15		APERION CONSULTING, LLC		4,399		4,399	19
20	V	19		APERION CONSULTING, LLC		2,545		2,545	20
21	V	20		APERION CONSULTING, LLC		1,342		1,342	21
22	V	21		APERION CONSULTING, LLC		3,324		3,324	22
23	V	24		APERION CONSULTING, LLC		344		344	23
24	V	25		APERION CONSULTING, LLC		227		227	24
25	V	27		APERION CONSULTING, LLC		318		318	25
26	V	30		APERION CONSULTING, LLC		314		314	26
27	V	32		APERION CONSULTING, LLC		15		15	27
28	V	35		APERION CONSULTING, LLC		347		347	28
29	V								29
30	V								30
31	V								31
32	V	10	44,398	APERION CONSULTING, LLC				(44,398)	32
33	V	06		APERION CONSULTING, LLC					33
34	V	01	13,670	APERION CONSULTING, LLC				(13,670)	34
35	V	06	17,358	APERION CONSULTING, LLC				(17,358)	35
36	V	43	1,050	APERION CONSULTING, LLC				(1,050)	36
37	V								37
38	V								38
39	Total		\$ 76,477			\$ 82,041	\$ *	5,564	39

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

Facility Name & ID Number

Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES		APERION FINANCIAL, LLC		6,565	\$	6,565	15
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		1,483		1,483	16
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		123,691		123,691	17
18	V	24 SEMINARS		APERION FINANCIAL, LLC		91		91	18
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		37		37	19
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		13,612		13,612	20
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		319		319	21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		358		358	22
23	V			APERION FINANCIAL, LLC					23
24	V			APERION FINANCIAL, LLC					24
25	V			APERION FINANCIAL, LLC					25
26	V			APERION FINANCIAL, LLC					26
27	V			APERION FINANCIAL, LLC					27
28	V			APERION FINANCIAL, LLC					28
29	V			APERION FINANCIAL, LLC					29
30	V			APERION FINANCIAL, LLC					30
31	V	19 HOME OFFICE EXPENSE	177,042	APERION FINANCIAL, LLC				(177,042)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 177,042			\$ 146,156	\$ *	(30,886)	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		\$ 1,108	\$	1,108	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		2,398		2,398	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		411		411	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		713		713	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		12		12	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		2,216		2,216	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		13,948		13,948	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		4,037		4,037	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,490		1,490	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		1,096		1,096	24
25	V	34 RENTAL INCOME	12,000	CHASE OFFICE,LLC				(12,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,000			\$ 27,429	\$ *	15,429	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	\$ 669,201	Renewal Rehab		\$ 619,145	\$	(50,056)	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		\$ 669,201			\$ 619,145	\$ *	(50,056)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Payroll Services	\$ 25,567	ProPay HR LLC		\$ 18,874	\$ (6,693)	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		\$ 25,567			\$ 18,874	\$ * (6,693)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 324,300	Aperion Incorporated Cell		\$ 324,300	\$	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		\$ 324,300			\$ 324,300	\$ *	39

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	David Berkowitz as Trustee of the Yosef		Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	Meystel Delta Trust	15.00%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	Frederick Frankel as Trustee of the David		Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	Berkowitz Delta Trust	15.00%	Aperion Care Burbank	Burbank	Renewal Rehab	LIncolnwood	Therapy Services	4
5	David Berkowitz Revocable Trust	30.00%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7	Steven Turofsky	1.50%	Aperion Care Demotte	Demotte, IN	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8	Frederick S. Frankel	1.50%	Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	8
9	Naftali Wilhelm	1.50%	Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10	Jennifer Spector	1.50%	Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	10
11	257 Limited Partnership	1.34%	Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	11
12	1219 Limited Partnership	1.33%	Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	12
13	42170 Limited Partnership	1.33%	Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Highwood	Highwood	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care International	Chicago	Aperion Incorporated Cell	Burlington, VT	Insurance	18
19			Aperion Care Jacksonville	Jacksonville				19
20			Aperion Care Kokomo	Kokomo, IN				20
21			Aperion Care Litchfield	Litchfield				21
22			Aperion Care Marion	Marion, IN				22
23			Aperion Care Marseilles	Marseilles				23
24			Aperion Care Mascoutah	Mascoutah				24
25			Aperion Care Midlothian	Midlothian				25
26			Aperion Care Moline	East Moline				26
27			Aperion Care Morton Terrace	Morton				27
28			Aperion Care Morton Villa	Morton				28
29			Aperion Care Oak Lawn	Oak Lawn				29
30			Aperion Care Olney	Olney				30

Facility Name & ID Number

Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative		See Attached	1.22	3.05%	Alloc Salary	\$ 7,634	17-7	1	
2	Jay Meysel	Relative	Clerical		See Attached	0.61	1.53%	Alloc Salary	943	21-7	2	
3	Cynthia Meystel	Relative	Clerical		See Attached	0.17	4.06%	Alloc Salary	537	21-7	3	
4	David Berkowitz	Relative	Administrative		See Attached	1.22	3.05%	Alloc Salary	7,634	17-7	4	
5	Fred Frankel	Owner	Administrative	1.50%	See Attached	1.22	3.05%	Alloc Salary	6,868	17-7	5	
6	Steve Turofsky	Owner	Administrative	1.50%	See Attached	1.22	3.05%	Alloc Salary	6,299	17-7	6	
7	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	1.2	3.05%	Alloc Salary	7,634	21-7	7	
8	Elisheva Adest	Relative	Clerical		See Attached	0.47	2.03%	Alloc Salary	378	21-7	8	
9	Jennifer Spector	Owner	Clerical	1.50%	See Attached	1.22	3.05%	Alloc Salary	3,491	21-7	9	
10	Dovid Spector	Relative	Clerical		See Attached	1.22	3.05%	Alloc Salary	1,709	21-7	10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 43,127		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 Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	1,401,635	55	\$ 4,383	\$ 42,798	\$ 134	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	42,798	2,165	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	42,798	203	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,401,635	55	5,656	42,798	220	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128	42,798	4	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	42,798	13,192	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957	42,798	1,342	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	42,798	63,478	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	42,798	10,949	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	42,798	6,752	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	42,798	38,107	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	42,798	2,041	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	42,798	1,785	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	42,798	6,794	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	42,798	2,167	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	42,798	12,964	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	42,798	1,740	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	42,798	8,307	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	42,798	2,023	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,718,302	\$ 3,836,913	\$ 174,366	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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	1,401,635	55	\$ 424,292	\$ 42,798	\$ 16,256	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	42,798	10,358	2
3	7	EMP. BEN.-GEN. SERV. & D	PATIENT DAYS	1,401,635	55	81,117	42,798	2,937	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	42,798	39,314	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437	42,798	4,399	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360	42,798	2,545	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964	42,798	1,342	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	42,798	3,324	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275	42,798	344	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427	42,798	227	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636	42,798	318	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275	42,798	314	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508	42,798	15	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374	42,798	347	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,920,744	\$ 2,458,073	\$ 82,041	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

APERION FINANCIAL, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001	42,798	6,565	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	42,798	1,483	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	123,691	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	42,798	91	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	42,798	37	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	42,798	13,612	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	42,798	319	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	42,798	358	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,817,960	\$ 4,033,980		\$ 146,156	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 262-3800

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 42,798	\$ 1,108	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	42,798	2,398	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	42,798	411	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	42,798	713	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	42,798	12	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	42,798	2,216	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	42,798	13,948	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	42,798	4,037	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	42,798	1,490	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	42,798	1,096	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 898,317	\$	\$ 27,429	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Renewal Rehab

Street Address

7358 N. Lincoln Ave., Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 938-8750

Fax Number

(847) 410-9720

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	55	\$	\$		\$ 619,145	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				\$	\$		\$ 619,145	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

ProPay HR LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847) 905-3268

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 18,874	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				\$	\$		\$ 18,874	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Aperion Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		\$ 324,300	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				\$	\$		\$ 324,300	25

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Congressional Bank		X	Line of Credit				911,343		36,585	6									
7										7										
8										8										
9	TOTAL Facility Related							\$ 911,343		\$ 36,585	9									
B. Non-Facility Related*																				
10	Interest Income		X							(156)	10									
11	Alloc. From Aperion Care Inc.									8,307	11									
12	Alloc. From Aperion Consulting LLC									15	12									
13	Alloc. From Chase Office LLC									4,037	13									
14	TOTAL Non-Facility Related							\$		\$ 12,203	14									
15	TOTALS (line 9+line14)							\$ 911,343		\$ 48,788	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Capitol, Llc COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0054783

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-28.0-401-006</u>	<u>Long Term Care Property</u>	\$ <u>4,318.38</u>	\$ <u>4,318.38</u>
2. <u>14-28.0-401-018</u>	<u>Long Term Care Property</u>	\$ <u>98,513.00</u>	\$ <u>98,513.00</u>
3. <u>10-27-307-027-0000</u>	<u>Alloc. From Chase Office LLC</u>	\$ <u>45,392.90</u>	\$ <u>1,386.04</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>148,224.28</u></u>	\$ <u><u>104,217.42</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Capitol, Llc COUNTY Sangamon
 FACILITY IDPH LICENSE NUMBER 0054783
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from Chase Office LLC</u>			\$ <u>1,896</u>	1
2					2
3	TOTALS			\$ <u>1,896</u>	3

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
		108,850	7,227		5,027	(2,200)	12,375	
			15,234			(15,234)		
		\$ 108,850	\$ 22,461		\$ 5,027	\$ (17,434)	\$ 12,375	

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 108,850	\$ 22,461		\$ 5,027	\$ (17,434)	\$ 12,375	1
2	Install New Phone Lines	2018	4,100		20	171	171	171	2
3	New Drain Intalled In Kitchen	2018	2,880		20	96	96	96	3
4	Painting 4Th Floor Ceiling, Hallways & Door Jams	2018	12,995		20	271	271	271	4
5	Security System	2018	10,788		20	899	899	899	5
6	Thru The Wall A/C	2018	2,863		20	191	191	191	6
7	Thru The Wall A/C	2018	4,321		20	252	252	252	7
8	Thru The Wall A/C	2018	3,859		20	135	135	135	8
9	Replacement Of Exhaust Fans (28,800)	2018	28,364		20	120	120	120	9
10	Hvac Cooler	2018	20,057		20	1,003	1,003	1,003	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)		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	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		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	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)		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	34

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	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)		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	34

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

Facility Name & ID Number Aperion Care Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	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)		\$ 199,078	\$ 22,461		\$ 8,165	\$ (14,296)	\$ 15,513	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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 LLC	2016	17,063	438	20	438		1,057	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	910	146	20	45	(101)	364	9
10	Allocated from Aperion Care	2012	258	20	20	13	(7)	77	10
11	Allocated from Aperion Care	2013	110	12	20	5	(7)	27	11
12									12
13	Allocated from Chase Office LLC	2018	77		20	4	4	4	13
14	Allocated from Chase Office LLC	2017	3,950	280	20	197	(82)	395	14
15	Allocated from Chase Office LLC	2016	86,483	6,332	20	4,324	(2,007)	10,450	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)		\$ 108,850	\$ 7,227		\$ 5,027	\$ (2,200)	\$ 12,375	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 108,850	\$ 7,227		\$ 5,027	\$ (2,200)	\$ 12,375	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 108,850	\$ 7,227		\$ 5,027	\$ (2,200)	\$ 12,375	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	\$ 53,115	\$ 8,386	\$ 5,428	\$ (2,958)	10	\$ 12,254	71
72	Current Year Purchases	32,848	431	2,741	2,311	10	2,741	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 85,963	\$ 8,817	\$ 8,169	\$ (648)		\$ 14,995	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 Ford E350 Gsohen Bus	2018	\$ 15,534	\$	\$ 2,071	\$ 2,071	5	\$ 2,071	76
77		Allocated from Aperion Care	1900	1,021	155	204	49	5	663	77
78		Allocated from Aperion Consultin	1900	745	123	149	26	5	596	78
79										79
80	TOTALS			\$ 17,301	\$ 278	\$ 2,425	\$ 2,147		\$ 3,330	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)	\$ 304,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,758	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,797)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 33,838	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1975</u>	<u>251</u>	<u>11/1/2017</u>	\$ <u>357,820</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		<u>251</u>		\$ <u>357,820</u>			7

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12. /2019 \$

13. /2020 \$

14. /2021 \$

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

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

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,003 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>Facility</u>	<u>2013 Ford E350 Bus</u>	\$ <u>1,200.00</u>	\$ <u>4,800</u>	17
18	<u>Allocated from Aperion Care Inc.</u>			<u>2,023</u>	18
19	<u>Allocated from Aperion Consulting LLC</u>			<u>347</u>	19
20					20
21	TOTAL		\$ <u>1,200.00</u>	\$ <u>7,170</u>	21

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

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

Facility Name & ID Number Aperion Care Capitol, Llc # 0054783 Report Period Beginning: 01/01/18 Ending: 12/31/18
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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		\$			\$	305,316	\$			\$		305,316	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					\$	87,721						87,721	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						276,163						276,163	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								216,233				216,233	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):								10,851		76,121				86,972	13
14	TOTAL				\$			\$	680,051	\$	292,354		\$		972,405	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Aperion Care Capitol, Llc**

0054783

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 63,535	\$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,192,787		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,902		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	103,186		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,447,410	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	50,543		15
16	Equipment, at Historical Cost	103,389		16
17	Accumulated Depreciation (book methods)	(15,379)		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>	66,919		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 205,472	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,652,882	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 761,676	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	911,343		29
30	Accrued Salaries Payable	267,798		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,261		31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,831		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,058,909	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	2,366,211		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,366,211	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,425,120	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,772,238)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,652,882	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (236,286)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (236,286)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,535,952)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,535,952)	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)	\$ (1,772,238)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,312,361	1
2	Discounts and Allowances for all Levels	(1,688,494)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,623,867	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,162	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 249,162	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	5,745	17
18	Sale of Supplies to Non-Patients	110	18
19	Laboratory	232	19
20	Radiology and X-Ray	371	20
21	Other Medical Services	537	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,995	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	156	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 156	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,645	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,645	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,884,825	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,578,135	31
32	Health Care	3,710,006	32
33	General Administration	2,227,492	33
B. Capital Expense			
34	Ownership	554,197	34
C. Ancillary Expense			
35	Special Cost Centers	989,322	35
36	Provider Participation Fee	361,625	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,420,777	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,535,952)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,535,952)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,381,443	44
45	Private Pay - Net Inpatient Revenue	163,307	45
46	Medicare - Net Inpatient Revenue	2,217,687	46
47	Other-(specify) <u>Insurance</u>	262,419	47
48	Other-(specify) <u>Managed Care</u>	599,011	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,623,867	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 Capitol, Llc

0054783

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,906	2,002	\$ 97,541	\$ 48.72	1
2	Assistant Director of Nursing	584	656	20,346	31.02	2
3	Registered Nurses	9,682	10,168	347,362	34.16	3
4	Licensed Practical Nurses	38,170	40,554	1,152,643	28.42	4
5	CNAs & Orderlies	84,519	88,772	1,354,405	15.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,768	1,900	59,656	31.40	8
9	Activity Director	1,778	1,854	30,514	16.46	9
10	Activity Assistants	8,703	9,312	111,256	11.95	10
11	Social Service Workers	10,493	11,147	216,134	19.39	11
12	Dietician					12
13	Food Service Supervisor	2,617	2,819	51,778	18.37	13
14	Head Cook	603	614	7,769	12.65	14
15	Cook Helpers/Assistants	19,866	21,161	325,264	15.37	15
16	Dishwashers					16
17	Maintenance Workers	4,453	4,738	74,154	15.65	17
18	Housekeepers	1,233	1,233	14,462	11.73	18
19	Laundry	248	248	3,717	14.99	19
20	Administrator	1,056	1,143	62,044	54.28	20
21	Assistant Administrator	504	600	16,579	27.63	21
22	Other Administrative					22
23	Office Manager	2,000	2,092	41,664	19.92	23
24	Clerical	6,781	7,230	116,234	16.08	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	2,042	2,242	33,653	15.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,006	210,485	\$ 4,137,175 *	\$ 19.66	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	189hr/monthly	\$ 20,626	01-03	35
36	Medical Director	206	31,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	44,398	10-03	38
39	Pharmacist Consultant	145	13,864	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	53	4,242	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	404	\$ 114,330		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	
Michael Barth (3/15/18-5/25/18)	Administrator	0	\$ 22,618	Workers' Compensation Insurance	\$ 130,386	IDPH License Fee	\$ 2,252	
David Glat (7/3/18-10/2/18)	Administrator	0	26,367	Unemployment Compensation Insurance	67,339	Advertising: Employee Recruitment	900	
Gary Coulter (11/19/18-12/31/18)	Administrator	0	13,060	FICA Taxes	306,753	Health Care Worker Background Check	85	
John Kleinlein (1/1/18-3/16/18)	Admin in Training	0	16,579	Employee Health Insurance	109,002	(Indicate # of checks performed <u>9</u>)		
				Employee Meals	4,016	Patient Background Checks	469 4,686	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	34,172	
				Employee Physicals	960	Licenses & Permits	4,364	
				Other Employee Benefits	8,286	Allocated from Aperion Care Inc.	6,752	
						Allocated from Aperion Consulting LLC	1,342	
						See Supplement Schedule	1,495	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 78,624					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 626,742	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 56,048	
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
Aperion Care Inc. - Management Fees			\$ 327,190				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 327,190				In-State Travel	
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount					
Marcum LLP	Accounting		\$ 8,369				Seminar Expense	2,777
Propay HR	Payroll Processing		25,567				Allocated from Aperion Care Inc.	1,785
See Attached	Legal		9,515				Allocated from Aperion Consulting LLC	344
Creative Technology Solutions	IT Consulting		10,049				Allocated from Aperion Financial LLC	91
Point Click Care	EMR/ Billing Software		51,312				Entertainment Expense	()
DGTELL	Surveillance		865					
Ability	Healthcare Software		364					
Aperion Care	Data Processing		35,342					
Aperion Financial	Home Office Expense		177,042					
Aperion Care	Home Office Expense		19,671					
2401 Incorporated	Architect		2,800					
See Supplemental Schedule			32,150					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 373,046				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,997

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Capitol, Llc# 0054783

Report Period Beginning:

01/01/18Ending: 12/31/18**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. HCCI \$40,637
- (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. \$ 14,806 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 361,625
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 4,016 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees