

		FOR BHF USE					

LL1

**2018**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2018)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0048330</u></p> <p><b>Facility Name:</b> <u>Aperion Care Highwood, Llc</u></p> <p><b>Address:</b> <u>50 Pleasant Avenue</u> <u>Highwood</u> <u>60040</u>  Number City Zip Code</p> <p><b>County:</b> <u>Lake</u></p> <p><b>Telephone Number:</b> <u>(847) 432-9142</u> Fax # <u>(847) 432-4740</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>9/9/2006</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 282-6300</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ * Subject to the attached Accountants' Consulting Report (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE  ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____ * Subject to the attached Accountants' Consulting Report (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
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Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330 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	104	Skilled (SNF)	104	37,960	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	104	TOTALS	104	37,960	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	1,091	629	4,784	6,504	8
9	SNF/PED					9
10	ICF	6,439	5,041	10,915	22,395	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,530	5,670	15,699	28,899	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.13%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 09/06/06

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 09/06/06 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 104 and days of care provided 3,502

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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	298,787	14,041	15,770	328,598		328,598	(4,793)	323,805		1
2	Food Purchase		197,870		197,870		197,870	(896)	196,974		2
3	Housekeeping	189,607	21,415		211,022		211,022		211,022		3
4	Laundry		520	101,033	101,553		101,553	(2,354)	99,199		4
5	Heat and Other Utilities			111,824	111,824		111,824	748	112,572		5
6	Maintenance	60,083	12,988	78,671	151,742		151,742	1,517	153,259		6
7	Other (specify):*							2,410	2,410		7
8	<b>TOTAL General Services</b>	548,477	246,834	307,298	1,102,609		1,102,609	(3,368)	1,099,241		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			59,500	59,500		59,500		59,500		9
10	Nursing and Medical Records	2,326,463	123,249	55,196	2,504,908		2,504,908	(16,140)	2,488,768		10
10a	Therapy	145,898	1,020		146,918		146,918		146,918		10a
11	Activities	107,867	4,316	2,564	114,747		114,747		114,747		11
12	Social Services	212,684		1,937	214,621		214,621		214,621		12
13	CNA Training										13
14	Program Transportation			16,111	16,111		16,111		16,111		14
15	Other (specify):*							3,876	3,876		15
16	<b>TOTAL Health Care and Programs</b>	2,792,912	128,585	135,308	3,056,805		3,056,805	(12,264)	3,044,541		16
	<b>C. General Administration</b>										
17	Administrative	107,023		269,921	376,944		376,944	(227,058)	149,886		17
18	Directors Fees										18
19	Professional Services			236,995	236,995	(21)	236,974	(84,237)	152,738		19
20	Dues, Fees, Subscriptions & Promotions			103,089	103,089		103,089	(61,047)	42,042		20
21	Clerical & General Office Expenses	63,187		150,265	213,452		213,452	26,760	240,212		21
22	Employee Benefits & Payroll Taxes			508,418	508,418		508,418		508,418		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,175	4,175		4,175	1,499	5,674		24
25	Other Admin. Staff Transportation			573	573		573	4,765	5,338		25
26	Insurance-Prop.Liab.Malpractice			184,153	184,153		184,153	1,463	185,616		26
27	Other (specify):*							18,160	18,160		27
28	<b>TOTAL General Administration</b>	170,210		1,457,589	1,627,799	(21)	1,627,778	(319,695)	1,308,083		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,511,599	375,419	1,900,195	5,787,213	(21)	5,787,192	(335,327)	5,451,865		29

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

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

Facility Name & ID Number Aperion Care Highwood, Llc

#0048330

Report Period Beginning:

01/01/18

Ending:

12/31/18

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			113,628	113,628		113,628	538,638	652,266			30
31	Amortization of Pre-Op. & Org.			17,301	17,301		17,301	(17,301)				31
32	Interest			52,746	52,746		52,746	380,783	433,529			32
33	Real Estate Taxes			135,911	135,911	21	135,932	1,006	136,938			33
34	Rent-Facility & Grounds			570,000	570,000		570,000	(570,000)				34
35	Rent-Equipment & Vehicles			8,834	8,834		8,834	2,583	11,417			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			898,420	898,420	21	898,441	335,709	1,234,150			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,004	537,326	683,330		683,330	(37,540)	645,790			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,182	208,182		208,182		208,182			42
43	Other (specify):*			27,523	27,523		27,523	(27,523)				43
44	<b>TOTAL Special Cost Centers</b>		146,004	773,031	919,035		919,035	(65,063)	853,972			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,511,599	521,423	3,571,646	7,604,668		7,604,668	(64,681)	7,539,987			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 Highwood, Llc

# 0048330

Report Period Beginning:

01/01/18

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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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(167,867)	30		9
10	Interest and Other Investment Income	(42,908)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	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	(568)	21		18
19	Entertainment				19
20	Contributions	(57,666)	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	(59,071)	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	(144,944)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (473,410)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	408,729		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 408,729		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (64,681)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**Aperion Care Highwood, Llc**

ID# 0048330  
 Report Period Beginning: 01/01/18  
 Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing	\$ (3,397)	21	1
2	Marketing	(20,459)	43	2
3	Promotial Products	(3,755)	43	3
4	Bank Charges	(16,646)	21	4
5	Theft & Damage Loss	(4,105)	21	5
6	Amortization	(17,301)	31	6
7	Vending Income	(600)	02	7
8	Bldg Co - Accounting/Bookkeeping Fees	(7,982)	19	8
9	Bldg Co - Licenses & Fees	(579)	20	9
10	Bldg Co - Amortization - Loan Fees	(26,223)	36	10
11	Additional R&M	4,325	06	11
12	PAC Dues	(9,456)	20	12
13	Non-Allowable Professional Fees	(8,088)	19	13
14	Non-Allowable Legal Expense	(246)	19	14
15	Non Allowable Professional Fees Collections	(1,763)	19	15
16	Non-Allowable Legal Expense	(1,669)	19	16
17	Capitalized R&M	(6,518)	06	17
18	Marketing - Food	(3,309)	43	18
19	Bldg Co - Bank Charges	(6,484)	19	19
20	Chamber of Commerce	(400)	20	20
21	Supplemental Insurance	(10,289)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(144,944)		49

Aperion Care Highwood, Llc

ID# 0048330  
 Report Period Beginning: 01/01/18  
 Ending: 12/31/18

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
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72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Highwood, Llc# 0048330

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 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)	
	<b>A. General Services</b>													
1	Dietary				(4,793)								(4,793)	1
2	Food Purchase	(986)		90									(896)	2
3	Housekeeping													3
4	Laundry									(2,354)			(2,354)	4
5	Heat and Other Utilities						748						748	5
6	Maintenance	(2,193)		1,599	492		1,619						1,517	6
7	Other (specify):*			149	1,983		278						2,410	7
8	<b>TOTAL General Services</b>	<b>(3,179)</b>		<b>1,838</b>	<b>(2,318)</b>		<b>2,645</b>			<b>(2,354)</b>			<b>(3,368)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			8,911	(25,051)								(16,140)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			906	2,970								3,876	15
16	<b>TOTAL Health Care and Programs</b>			<b>9,817</b>	<b>(22,081)</b>								<b>(12,264)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(227,058)									(227,058)	17
18	Directors Fees													18
19	Professional Services	(26,232)	7,982	(105)	1,719	(63,053)	481	(5,029)					(84,237)	19
20	Fees, Subscriptions & Promotions	(68,101)	579	4,559	906	1,002	8						(61,047)	20
21	Clerical & General Office Expenses	(94,076)	6,464	27,109	2,245	83,521	1,497						26,760	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,205	232	62							1,499	24
25	Other Admin. Staff Transportation			4,587	153	25							4,765	25
26	Insurance-Prop.Liab.Malpractice			1,463									1,463	26
27	Other (specify):*			8,754	215	9,191							18,160	27
28	<b>TOTAL General Administration</b>	<b>(188,409)</b>	<b>15,025</b>	<b>(179,487)</b>	<b>5,470</b>	<b>30,748</b>	<b>1,986</b>	<b>(5,029)</b>					<b>(319,695)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(191,588)</b>	<b>15,025</b>	<b>(167,832)</b>	<b>(18,928)</b>	<b>30,748</b>	<b>4,631</b>	<b>(5,029)</b>		<b>(2,354)</b>			<b>(335,327)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Highwood, Llc# 0048330

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(167,867)	695,484	1,175	212	216	9,418						538,638	30
31	Amortization of Pre-Op. & Org.	(17,301)											(17,301)	31
32	Interest	(42,908)	415,346	5,609	10		2,726						380,783	32
33	Real Estate Taxes						1,006						1,006	33
34	Rent-Facility & Grounds		(540,000)				(30,000)						(570,000)	34
35	Rent-Equipment & Vehicles			1,366	235	242	740						2,583	35
36	Other (specify):*	(26,223)	26,223											36
37	<b>TOTAL Ownership</b>	<b>(254,299)</b>	<b>597,053</b>	<b>8,150</b>	<b>457</b>	<b>458</b>	<b>(16,109)</b>						<b>335,709</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(37,540)				(37,540)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(27,523)											(27,523)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(27,523)</b>							<b>(37,540)</b>				<b>(65,063)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(473,410)</b>	<b>612,078</b>	<b>(159,682)</b>	<b>(18,472)</b>	<b>31,206</b>	<b>(11,478)</b>	<b>(5,029)</b>	<b>(37,540)</b>	<b>(2,354)</b>			<b>(64,681)</b>	<b>45</b>

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

Report Period Beginning: 01/01/18

Ending: 12/31/18

**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
<a href="#">See Page 6-Supplemental</a>		<a href="#">See Page 6-Supplemental</a>		<a href="#">See Page 6-Supplemental</a>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 540,000	<a href="#">Highland Park NRC Realty</a>		\$	\$ (540,000)	1
2	V	32 Interest	20	<a href="#">Highland Park NRC Realty</a>		415,366	415,346	2
3	V	33 Rent Income - RE Taxes	135,911	<a href="#">Highland Park NRC Realty</a>		135,911		3
4	V	36 Amortization - Loan Fees		<a href="#">Highland Park NRC Realty</a>		26,223	26,223	4
5	V	30 Depreciation		<a href="#">Highland Park NRC Realty</a>		695,484	695,484	5
6	V	19 Accounting Fees		<a href="#">Highland Park NRC Realty</a>		7,982	7,982	6
7	V	20 Licenses & Fees		<a href="#">Highland Park NRC Realty</a>		579	579	7
8	V	21 Bank Charges		<a href="#">Highland Park NRC Realty</a>		6,464	6,464	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 675,931			\$ 1,288,009	\$ * 612,078	14

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

Facility Name & ID Number Aperion Care Highwood, Llc# 0048330Report Period Beginning 01/01/18Ending: 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	2	FOOD	\$	APERION CARE, INC.	\$	90	\$	90	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.		1,462		1,462	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.		137		137	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.		149		149	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.		3		3	19
20	V	10	SALARY- NURSE		APERION CARE, INC.		8,908		8,908	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.		906		906	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.		42,863		42,863	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.		7,393		7,393	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.		4,559		4,559	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.		25,731		25,731	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.		1,378		1,378	26
27	V	24	SEMINARS		APERION CARE, INC.		1,205		1,205	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.		4,587		4,587	28
29	V	26	INSURANCE		APERION CARE, INC.		1,463		1,463	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.		8,754		8,754	30
31	V	30	DEPRECIATION		APERION CARE, INC.		1,175		1,175	31
32	V	32	INTEREST		APERION CARE, INC.		5,609		5,609	32
33	V	35	AUTO LEASE		APERION CARE, INC.		1,366		1,366	33
34	V	17	MANAGEMENT FEE	269,921	APERION CARE, INC.				(269,921)	34
35	V	19	HOME OFFICE	7,498	APERION CARE, INC.				(7,498)	35
36	V									36
37	V									37
38	V									38
39	Total		\$ 277,420			\$	117,738	\$ *	(159,682)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 DIETITIAN SALARY	\$	APERION CONSULTING, LLC		\$ 10,977	\$ 10,977	15
16	V	6 MAINTENANCY SALARY		APERION CONSULTING, LLC		6,994	6,994	16
17	V	7 EMP. BEN.-GEN. SERV. & DIETARY		APERION CONSULTING, LLC		1,983	1,983	17
18	V	10 SALARY NURSE		APERION CONSULTING, LLC		26,547	26,547	18
19	V	15 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		2,970	2,970	19
20	V	19 PROFESSIONAL FEES		APERION CONSULTING, LLC		1,719	1,719	20
21	V	20 FEES, SUBSCRIPTIONS		APERION CONSULTING, LLC		906	906	21
22	V	21 CLERICAL & GENERAL		APERION CONSULTING, LLC		2,245	2,245	22
23	V	24 SEMINARS		APERION CONSULTING, LLC		232	232	23
24	V	25 AUTO AND TRAVEL		APERION CONSULTING, LLC		153	153	24
25	V	27 PAYROLL TAXES/GROUP INSURANCE		APERION CONSULTING, LLC		215	215	25
26	V	30 DEPRECIATION		APERION CONSULTING, LLC		212	212	26
27	V	32 INTEREST		APERION CONSULTING, LLC		10	10	27
28	V	35 AUTO LEASE		APERION CONSULTING, LLC		235	235	28
29	V							29
30	V							30
31	V							31
32	V	10 RN CONSULTING	51,597	APERION CONSULTING, LLC			(51,597)	32
33	V	01 DIETICIAN	15,770	APERION CONSULTING, LLC			(15,770)	33
34	V	06 PROJECT MANAGER	6,502	APERION CONSULTING, LLC			(6,502)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 73,870			\$ 55,398	\$ * (18,472)	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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		4,433	\$	4,433	15
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		1,002		1,002	16
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		83,521		83,521	17
18	V	24 SEMINARS		APERION FINANCIAL, LLC		62		62	18
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		25		25	19
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		9,191		9,191	20
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		216		216	21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		242		242	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	19 HOME OFFICE EXPENSE	67,486	APERION FINANCIAL, LLC				(67,486)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 67,486			\$ 98,692	\$ *	31,206	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	5 UTILITIES	\$	CHASE OFFICE,LLC		\$ 748	\$ 748	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,619	1,619	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		278	278	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		481	481	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		8	8	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,497	1,497	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		9,418	9,418	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,726	2,726	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,006	1,006	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		740	740	24
25	V	34 RENTAL INCOME	30,000	CHASE OFFICE,LLC			(30,000)	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		\$ 30,000			\$ 18,522	\$ * (11,478)	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	Payroll Services	19,208	ProPay HR LLC		14,179	\$	(5,029)	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			\$ 19,208			\$ 14,179	\$ *	(5,029)	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	39	Therapy Services	501,868	Renewal Rehab		464,328	\$	(37,540)	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			\$ 501,868			\$ 464,328	\$ *	(37,540)	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	04 Laundry Services	101,033	EcoBrite Linen		98,679	\$	(2,354)	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		\$ 101,033			\$ 98,679	\$ *	(2,354)	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	26	Insurance	\$ 135,087	Aperion Incorporated Cell		\$ 135,087	\$	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			\$ 135,087			\$ 135,087	\$ *	39

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	<b>Total</b>			\$			\$	\$ *	39

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

Facility Name & ID Number

Aperion Care Highwood, Llc

# 0048330

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	DECLARATION TRUST OF YOSEF MEYSEL	0.10%	Aperion Care Angola	Angola, IN	Highland Park NRC Realty		Building Co.	1
2	NRC INVESTMENT GROUP	99.90%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	2
3			Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	3
4			Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	4
5			Aperion Care Cairo	Cairo	Renewal Rehab	Lincolnwood	Therapy Services	5
6			Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	Lincolnwood	Consulting Co.	7
8			Aperion Care Demotte	Demotte, IN	Aperion Financial, Inc.	Lincolnwood	Bookkeeping	8
9			Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	9
10			Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	10
11			Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	11
12			Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	15
16			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	16
17			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	17
18			Aperion Care International	Chicago	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	18
19			Aperion Care Jacksonville	Jacksonville	Aperion Incorporated Cell	Burlington, VT	Insurance	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 Highwood, Llc

# 0048330

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			Aperion Care Peoria Heights	Peoria Heights				1
2			Aperion Care Peru	Peru, IN				2
3			Aperion Care Plum Grove	Palatine				3
4			Aperion Care Princeton	Princeton				4
5			Aperion Care Spencer	Spencer, IN				5
6			Aperion Care Spring Valley	Spring Valley				6
7			Aperion Care Springfield	Springfield				7
8			Aperion Care St. Elmo	St. Elmo				8
9			Aperion Care Tolleston Park	Gary, IN				9
10			Aperion Care Toluca	Toluca				10
11			Aperion Care University Park	Fort Wayne, IN				11
12			Aperion Care Valparaiso	Valparaiso, IN				12
13			Aperion Care Waldron	Wilmington				13
14			Aperion Care West Chicago	Springfield				14
15			Aperion Care Wilmington	Wilmington				15
16			Glennon Place (MO)	Bolivar, MO				16
17			Huntington Nursing & Rehab	Huntington, IN				17
18			Legend Healthcare (KS)	Tonganoxie, KS				18
19			The Arbors at Michigan City	Michigan City, IN				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Aperion Care Highwood, Llc

#

0048330

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	0	See Attached	0.82	2.06%	Alloc Salary	\$ 5,155	17-07	1	
2	Jay Meystel	Relative	Clerical	0	See Attached	0.41	1.03%	Alloc Salary	637	21-07	2	
3	Cynthia Meystel	Relative	Clerical	0	See Attached	0.11	2.74%	Alloc Salary	362	21-07	3	
4	Elisheva Adest	Relative	Clerical	0	See Attached	0.32	1.37%	Alloc Salary	255	21-07	4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 6,409		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 Highwood, Llc

# 0048330

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

# 0048330

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,401,635	55	\$ 4,383	\$ 28,899	\$ 90	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	28,899	1,462	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	28,899	137	3
4	7	EMP. BEN.-GEN. SERV. & DIS	ACTUAL CENSUS	1,401,635	55	5,656	28,899	149	4
5	10	NURSING & MEDICAL RECO	ACTUAL CENSUS	1,401,635	55	128	28,899	3	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	28,899	8,908	6
7	15	PAYROLL TAXES/GROUP IN	ACTUAL CENSUS	1,401,635	55	42,957	28,899	906	7
8	17	ADMINISTRATIVE SALARIE	ACTUAL CENSUS	1,401,635	55	2,112,862	28,899	42,863	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	28,899	7,393	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	28,899	4,559	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	28,899	25,731	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	28,899	1,378	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	28,899	1,205	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	28,899	4,587	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	28,899	1,463	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	28,899	8,754	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	28,899	1,175	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	28,899	5,609	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	28,899	1,366	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,718,302	\$ 3,836,913		\$ 117,738	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	1	DIETITIAN SALARY	PATIENT DAYS	1,401,635	55	\$ 424,292	\$ 424,292	28,899	\$ 10,977	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	28,899	6,994	2
3	7	EMP. BEN.-GEN. SERV. & DIS	PATIENT DAYS	1,401,635	55	81,117		28,899	1,983	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	28,899	26,547	4
5	15	PAYROLL TAXES/GROUP IN	PATIENT DAYS	1,401,635	55	183,437		28,899	2,970	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		28,899	1,719	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		28,899	906	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	28,899	2,245	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		28,899	232	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		28,899	153	10
11	27	PAYROLL TAXES/GROUP IN	PATIENT DAYS	1,401,635	55	9,636		28,899	215	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		28,899	212	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		28,899	10	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		28,899	235	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		\$ 55,398	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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 FINANCIAL, LLC  
 Street Address 4655 W CHASE AVE  
 City / State / Zip Code LINCOLNWOOD, ILLINOIS 60712  
 Phone Number ( 847) 262-3800  
 Fax Number ( )

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001	28,899	4,433	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	28,899	1,002	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	83,521	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	28,899	62	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	28,899	25	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	28,899	9,191	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	28,899	216	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	28,899	242	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	\$ 98,692	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 28,899	\$ 748	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	28,899	1,619	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	28,899	278	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	28,899	481	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	28,899	8	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	28,899	1,497	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	28,899	9,418	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	28,899	2,726	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	28,899	1,006	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	28,899	740	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	\$	\$ 18,522	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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 W. MAIN ST  
 City / State / Zip Code EVANSTON , ILLINOIS 60202  
 Phone Number ( 847) 905-3268  
 Fax Number ( )

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 14,179	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 14,179	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		\$	\$		\$ 464,328	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				\$	\$		\$ 464,328	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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 EcoBrite Linen  
 Street Address 3712 Jarvis Avenue  
 City / State / Zip Code Skokie, IL 60076  
 Phone Number (847) 582-4000  
 Fax Number ( )

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct		\$	\$		\$ 98,679	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				\$	\$		\$ 98,679	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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		\$	\$		\$ 135,087	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				\$	\$		\$ 135,087	25

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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

# 0048330

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2017 report.	\$	<u>120,153</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>125,915</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>5,762</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>131,155</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<u>21</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>136,938</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>113,851</u>	8
	2014	<u>116,400</u>	9
	2015	<u>117,602</u>	10
	2016	<u>120,153</u>	11
	2017	<u>124,909</u>	12

**2018 Accrual = 2017 Tax + 5% (124,909 \* 1.05 = 131,155)**

**Allocated from Chase Office LLC - \$1,073**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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





Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

Report Period Beginning:

01/01/18

Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,802 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2006</u>	<u>\$ 627,000</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>1,280</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 628,280</b>	<b>3</b>

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	104		2007	1961	\$ 3,407,107	\$ 695,485	35	\$ 97,346	\$ (598,139)	\$ 1,173,696	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2007		104,937		20	303	303	102,464	9
10	Various		2008		26,277		20	138	138	25,858	10
11	Various		2009		22,285		20	1,381	1,381	17,826	11
12	Various		2010		258,593		20	13,362	13,362	173,956	12
13	Various		2011		213,375		20	10,669	10,669	83,012	13
14	Various		2012		22,557		20	1,233	1,233	16,768	14
15	Various		2013		38,611		20	1,875	1,875	17,752	15
16	Various		2014		6,434		20	322	322	1,609	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	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	Related Building Company (Pages 12F & 12G)		9,501,814			475,091	475,091	3,851,894	67
68	Related Party Allocations (Pages 12H & 12I)		73,500	4,880		3,394	(1,486)	8,356	68
69	Financial Statement Depreciation			113,628			(113,628)		69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 13,675,490	\$ 813,993		\$ 605,114	\$ (208,879)	\$ 5,473,191	70

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 13,675,490	\$ 813,993		\$ 605,114	\$ (208,879)	\$ 5,473,191	1
2	Installed Seatwall, Columns For Signage, Signage & Plants	2015	18,614		20	931	931	3,568	2
3	Constructed Custom Two Tiered Pergola	2015	39,981		20	1,999	1,999	7,663	3
4	Installed Drain Tile Along Entire Location	2015	19,850		20	993	993	3,308	4
5	Installed 2 More Stone Columns & Drainage Pipes	2015	9,489		20	474	474	1,621	5
6	Nurse Station	2015	3,968		20	198	198	612	6
7	Installation Of Cat5E Cable On 1St Floor	2015	4,400		20	220	220	807	7
8	Installed Floor Tile & Ceramic Wall Tile Over Durock In Hall & B	2015	8,250		20	413	413	1,616	8
9	Installation Of Fire Rated 88 Device	2016	2,503		20	125	125	375	9
10	South Patio Project	2016	3,156		20	210	210	631	10
11	Electric Work - Steam Table	2016	38,898		20	1,945	1,945	4,700	11
12	Custom Signage Board W/Logo	2017	2,693		20	135	135	224	12
13	Fixture Replacement Sconces	2017	3,729		20	186	186	280	13
14	Replace Flue Pipe In Boiler Room	2018	2,518		20	126	126	126	14
15	Skylights Repair	2018	4,000		20	200	200	200	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	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
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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)		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	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
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17									17
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 13,837,539	\$ 813,993		\$ 613,269	\$ (200,724)	\$ 5,498,922	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Chandalier, Wallcovering, Flooring, Tile, Handrails</b>	2010	190,983		20	9,549	9,549	85,942	9
10	<b>Walls, Repair Cracks, Floor Prep</b>	2010	5,634		20	282	282	2,536	10
11	<b>Flooring, Chandalier, Cove Base</b>	2010	90,707		20	4,535	4,535	40,817	11
12	<b>Blinds, Ramp, Flooring, Cornice, Painting</b>	2010	113,000		20	5,650	5,650	50,850	12
13	<b>VCT &amp; Cove Base, Flooring, Cabinetry, Painting</b>	2010	270,481		20	13,524	13,524	121,717	13
14	<b>Elevator Floor, Granite Wall Caps, Floor Prep, Window Treatment</b>	2010	20,443		20	1,022	1,022	9,199	14
15	<b>Porcelain Tile, Wallcovering, Custom Reception Desk</b>	2010	18,851		20	943	943	8,484	15
16	<b>Sink Cabinet, Flooring</b>	2010	7,862		20	393	393	3,538	16
17	<b>Flooring, Wallcovering, Cove Base, Handrails, Room Signage</b>	2010	101,919		20	5,096	5,096	45,864	17
18	<b>Handrails, VCT, Flooring, Cubicle Tracks/Curtains, Painting</b>	2010	203,450		20	10,173	10,173	91,554	18
19	<b>Vinyl Cove Base, Corner Guards</b>	2011	1,850		20	92	92	739	19
20	<b>Corner Guards, VCT, Flooring, Signage</b>	2011	44,933		20	2,247	2,247	17,974	20
21	<b>Flooring, Bathroom Mirrors, Window Treatments, Cubicle Track</b>	2011	53,302		20	2,665	2,665	21,321	21
22	<b>Wall Sconces</b>	2011	2,391		20	120	120	957	22
23	<b>Additional Construction Costs</b>	2011	81,620		20	4,081	4,081	32,648	23
24	<b>General Construction on Building</b>	2011	7,849,388		20	392,469	392,469	3,139,754	24
25	<b>SAS Architect Fees</b>	2011	445,000		20	22,250	22,250	178,000	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 3,851,894	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 3,851,894	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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 9,501,814	\$		\$ 475,091	\$	\$ 3,851,894	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>Allocated from Chase Office LLC</b>	2016	11,522	295	20	295		714	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Allocated from Aperion Care</b>	2010	614	99	20	31	(68)	246	9
10	<b>Allocated from Aperion Care</b>	2012	174	13	20	9	(5)	52	10
11	<b>Allocated from Aperion Care</b>	2013	74	8	20	4	(5)	19	11
12									12
13	<b>Allocated from Chase Office LLC</b>	2018	52		20	3	3	3	13
14	<b>Allocated from Chase Office LLC</b>	2017	2,667	189	20	133	(55)	267	14
15	<b>Allocated from Chase Office LLC</b>	2016	58,397	4,275	20	2,920	(1,355)	7,056	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 73,500	\$ 4,880		\$ 3,394	\$ (1,486)	\$ 8,356	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 73,500	\$ 4,880		\$ 3,394	\$ (1,486)	\$ 8,356	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 73,500	\$ 4,880		\$ 3,394	\$ (1,486)	\$ 8,356	34

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

Facility Name & ID Number Aperion Care Highwood, Llc

# 0048330

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	\$ 289,283	\$ 5,663	\$ 37,452	\$ 31,790	10	\$ 317,428	71
72	Current Year Purchases	11,767	291	1,307	1,017	10	1,307	72
73	Fully Depreciated Assets	373,668				10	373,668	73
74								74
75	TOTALS	\$ 674,718	\$ 5,953	\$ 38,760	\$ 32,806		\$ 692,403	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		2009 GMC Savana	2009	\$ 46,762	\$	\$	\$	5	\$ 46,762	76
77		Allocated from Aperion Care	1900	690	105	138	33	5	448	77
78		Allocated from Aperion Consult	1900	503	83	101	18	5	403	78
79										79
80	TOTALS			\$ 47,955	\$ 188	\$ 239	\$ 51		\$ 47,612	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 15,188,492	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 820,134	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 652,267	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (167,867)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,238,937	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 9,816 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Aperion Care</u>		\$	\$ <u>1,366</u>	17
18	<u>Allocated from Aperion Consulting</u>			<u>235</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>1,600</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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		4	5		6	7	8				
			Staff Units of Service	3 Cost		Outside Practitioner (other than consultant)						Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
						Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 179,423	\$		\$	179,423	1			
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,722				60,722	2			
3	Licensed Recreational Therapist		hrs								3			
4	Licensed Physical Therapist	39 - 03	hrs			260,145				260,145	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					123,253		123,253	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10			
11	Academic Education		hrs								11			
12	Other (specify): _____										12			
13	Other (specify): _____					37,036		22,751		59,787	13			
14	TOTAL			\$		\$ 537,326	\$	146,004	\$	683,330	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 Highwood, Llc# 0048330Report 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 222,993	\$ 223,424	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,010,692	1,074,955	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,797	125,797	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	84,912	84,912	8
9	Other(specify): <u>See Attached Schedule</u>	1,966	123,092	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,446,360	\$ 1,632,180	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,407,107	14
15	Leasehold Improvements, at Historical Cost	941,518	9,240,012	15
16	Equipment, at Historical Cost	606,232	2,654,855	16
17	Accumulated Depreciation (book methods)	(1,224,356)	(7,194,756)	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>	6,809,470	2,561,085	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,132,864	\$ 11,295,303	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,579,224	\$ 12,927,483	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 984,134	\$ 984,134	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,174,113	1,174,113	29
30	Accrued Salaries Payable	326,470	326,470	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,989	7,989	31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,155	32
33	Accrued Interest Payable	5,944	44,475	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	77,551	77,551	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,576,201	\$ 2,745,887	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		6,750,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>	4,799,804	4,820,618	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,799,804	\$ 11,570,618	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,376,005	\$ 14,316,505	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,203,219	\$ (1,389,022)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,579,224	\$ 12,927,483	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,436,007	1
2	Restatements (describe):		2
3	<u>Bad Debt</u>	(175,632)	3
4	<u>Rounding</u>	(1)	4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,260,374	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(57,155)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (57,155)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,203,219	24 *

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

Facility Name &amp; ID Number Aperion Care Highwood, Llc

# 0048330

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,200,765	1
2	Discounts and Allowances for all Levels	(905,499)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,295,266	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	196,332	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 196,332	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,471	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	132	19
20	Radiology and X-Ray	198	20
21	Other Medical Services	7,606	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 12,407	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	42,908	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 42,908	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	600	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 600	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,547,513	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,102,609	31
32	Health Care	3,056,805	32
33	General Administration	1,627,799	33
<b>B. Capital Expense</b>			
34	Ownership	898,420	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	710,853	35
36	Provider Participation Fee	208,182	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,604,668	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(57,155)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (57,155)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,372,312	44
45	Private Pay - Net Inpatient Revenue	1,643,260	45
46	Medicare - Net Inpatient Revenue	2,011,137	46
47	Other-(specify) <u>Insurance</u>	264,739	47
48	Other-(specify) <u>Managed Care</u>	2,003,818	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 7,295,266	49

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not completed 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 Highwood, Llc**

# **0048330**

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	2,104	2,196	\$ 137,751	\$ 62.74	1
2	Assistant Director of Nursing	10	10	378	37.80	2
3	Registered Nurses	19,578	21,652	803,379	37.10	3
4	Licensed Practical Nurses	12,704	13,383	428,610	32.03	4
5	CNAs & Orderlies	50,015	53,600	922,676	17.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,946	6,629	145,898	22.01	8
9	Activity Director	2,037	2,163	44,375	20.52	9
10	Activity Assistants	5,464	5,880	63,492	10.80	10
11	Social Service Workers	7,718	8,119	212,684	26.20	11
12	Dietician					12
13	Food Service Supervisor	2,002	2,132	47,387	22.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,415	19,294	251,400	13.03	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,167	60,083	27.72	17
18	Housekeepers	13,867	15,625	189,607	12.14	18
19	Laundry					19
20	Administrator	2,135	2,186	107,023	48.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,119	4,460	63,187	14.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,889	2,092	33,669	16.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,005	161,586	\$ 3,511,599 *	\$ 21.73	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	287	\$ 15,770	01-03	35
36	Medical Director	252	59,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	727	51,597	10-03	38
39	Pharmacist Consultant	862	3,599	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	48	2,564	11-03	44
45	Social Service Consultant	31	1,937	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,206	\$ 134,967		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Katherine Geigel</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 107,023</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 101,266</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>32,140</u>	<u>Advertising: Employee Recruitment</u>	<u>254</u>	
				<u>FICA Taxes</u>	<u>262,763</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>77,576</u>	<u>(Indicate # of checks performed <u>3</u>)</u>	<u>33</u>	
				<u>Employee Meals</u>	<u>2,076</u>	<u>Patient Background Checks <u>187</u></u>	<u>1,874</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues and Subscriptions</u>	<u>31,564</u>	
				<u>Union Pension Fund</u>	<u>22,342</u>	<u>Licenses and Permits</u>	<u>1,842</u>	
				<u>401K Expense</u>	<u>551</u>	<u>Allocated from Aperion Care</u>	<u>4,559</u>	
				<u>Employee Physicals</u>	<u>240</u>	<u>Allocated from Aperion Consulting</u>	<u>906</u>	
				<u>Employee Benefits - Other</u>	<u>9,464</u>	<u>See Supplemental Schedule</u>	<u>1,010</u>	
						<u>Less: Public Relations Expense</u>	<u>( )</u>	
						<u>Non-allowable advertising</u>	<u>( )</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 107,023</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 508,418</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 42,042</b>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees - Aperion Care</u>			<u>\$ 269,921</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 269,921</b>	<b>TOTAL</b>		<b>\$</b>	<u>Seminar Expense</u>	<u>4,175</u>
<b>(Attach a copy of any management service agreement)</b>							<u>Allocated from Aperion Care</u>	<u>1,205</u>
							<u>Allocated from Aperion Consulting</u>	<u>232</u>
							<u>See Supplemental Schedule</u>	<u>62</u>
							<u>Entertainment Expense</u>	<u>( )</u>
							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	<b>\$ 5,674</b>
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>GCMHO</u>	<u>Managed Care Consulting</u>		<u>\$ 14,200</u>					
<u>Achieve Accreditation</u>	<u>Accreditation Consulting</u>		<u>14,695</u>					
<u>Aperion Interbuild</u>	<u>Energy Procurement</u>		<u>1,604</u>					
<u>Cononus Pact</u>	<u>Data Analytics</u>		<u>3,763</u>					
<u>Pinnacle Quality Insight</u>	<u>Customer Satisfaction Measure</u>		<u>1,607</u>					
<u>Pinnacle Financial Services</u>	<u>Financial Services</u>		<u>2,928</u>					
<u>Personnel Planners</u>	<u>Unemployment Consulting</u>		<u>597</u>					
<u>MTS Consulting</u>	<u>Tax Consulting</u>		<u>938</u>					
<u>Auditing Dept</u>	<u>Collections (Adj on p5A)</u>		<u>1,763</u>					
<u>Cassell Plan Audits</u>	<u>401K Audit</u>		<u>421</u>					
<u>See Attached</u>	<u>Legal Fees</u>		<u>6,634</u>					
<u>See Supplemental Schedule</u>			<u>187,846</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 236,995</b>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Aperion Care Highwood, Llc# 0048330Report Period Beginning: 01/01/18Ending: 12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. HCCI - \$18,912
- (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. \$ 21,892 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 208,182  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,076 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? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**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.