

		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>I. IDPH License ID Number: <u>0051094</u></p> <p>Facility Name: <u>Aperion Care Jacksonville, Llc</u></p> <p>Address: <u>1021 North Church Street</u> <u>Jacksonville</u> <u>62650</u> Number City Zip Code</p> <p>County: <u>Morgan</u></p> <p>Telephone Number: <u>(217)245-4174</u> Fax # <u>(217)243-5901</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>9/1/2010</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) _____</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(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) _____ (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>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																	
	(Type or Print Name) _____																	
	(Title) _____																	
Paid Preparer	(Signed) _____ (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>																	

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094 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	113	Skilled (SNF)	113	41,245	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	113	TOTALS	113	41,245	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	19,396	332	9,069	28,797	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,396	332	9,069	28,797	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.82%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/2010

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 113 and days of care provided 1,856

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL 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.

Facility Name & ID Number Aperion Care Jacksonville, Llc # 0051094 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	216,666	14,326	8,077	239,069		239,069	10,578	249,647		1
2	Food Purchase		172,863		172,863		172,863	70	172,933		2
3	Housekeeping	126,721	19,989		146,710		146,710		146,710		3
4	Laundry	56,467	15,328		71,795		71,795		71,795		4
5	Heat and Other Utilities			114,259	114,259		114,259	(13,332)	100,927		5
6	Maintenance	33,802	25,288	70,279	129,369		129,369	23,010	152,379		6
7	Other (specify):*							2,401	2,401		7
8	TOTAL General Services	433,656	247,794	192,615	874,065		874,065	22,728	896,793		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,946,445	106,361	58,527	2,111,333		2,111,333	(14,011)	2,097,322		10
10a	Therapy	26,310	92		26,402		26,402		26,402		10a
11	Activities	75,735	2,150	7,422	85,307		85,307		85,307		11
12	Social Services	177,983		6,000	183,983		183,983		183,983		12
13	CNA Training										13
14	Program Transportation			10,175	10,175		10,175		10,175		14
15	Other (specify):*							3,863	3,863		15
16	TOTAL Health Care and Programs	2,226,473	108,603	106,124	2,441,200		2,441,200	(10,148)	2,431,052		16
	C. General Administration										
17	Administrative	110,462		172,103	282,565		282,565	(129,391)	153,174		17
18	Directors Fees										18
19	Professional Services			314,230	314,230	(21)	314,209	(150,393)	163,816		19
20	Dues, Fees, Subscriptions & Promotions			88,202	88,202		88,202	(48,668)	39,534		20
21	Clerical & General Office Expenses	85,475		112,836	198,311		198,311	38,879	237,190		21
22	Employee Benefits & Payroll Taxes			427,569	427,569		427,569		427,569		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,383	4,383		4,383	1,494	5,877		24
25	Other Admin. Staff Transportation			3,219	3,219		3,219	4,748	7,967		25
26	Insurance-Prop.Liab.Malpractice			174,795	174,795		174,795	1,458	176,253		26
27	Other (specify):*							18,096	18,096		27
28	TOTAL General Administration	195,937		1,297,337	1,493,274	(21)	1,493,253	(263,776)	1,229,477		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,856,066	356,397	1,596,076	4,808,539	(21)	4,808,518	(251,196)	4,557,322		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 Jacksonville, Llc

#0051094

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	
	D. Ownership											
30	Depreciation			249,847	249,847		249,847	(17,157)	232,690			30
31	Amortization of Pre-Op. & Org.			17,670	17,670		17,670	(17,670)				31
32	Interest			32,536	32,536		32,536	132,706	165,242			32
33	Real Estate Taxes			31,375	31,375	21	31,396	1,002	32,398			33
34	Rent-Facility & Grounds			270,822	270,822		270,822	(270,000)	822			34
35	Rent-Equipment & Vehicles			8,010	8,010		8,010	2,574	10,584			35
36	Other (specify):*											36
37	TOTAL Ownership			610,260	610,260	21	610,281	(168,545)	441,735			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,840	310,066	442,906		442,906	(21,947)	420,959			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			220,196	220,196		220,196		220,196			42
43	Other (specify):*			16,049	16,049		16,049	(16,049)				43
44	TOTAL Special Cost Centers		132,840	546,311	679,151		679,151	(37,996)	641,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,856,066	489,237	2,752,647	6,097,950		6,097,950	(457,738)	5,640,212			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 Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,077)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(47,406)	30		9
10	Interest and Other Investment Income	(204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(2,860)	21		18
19	Entertainment				19
20	Contributions	(46,166)	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	(52,522)	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	(78,237)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (241,492)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(216,246)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (216,246)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (457,738)		37

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

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

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

Aperion Care Jacksonville, Llc

ID# 0051094

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing	\$ (14)	21	1
2	Advertising/Marketing	(13,139)	43	2
3	Marketing - Food	(1,003)	43	3
4	Promotional Products	(1,907)	43	4
5	Bank Charges	(19,804)	21	5
6	Theft & Damage Loss	112	21	6
7	Amortization	(17,670)	31	7
8	Bldg Co - Amortization	(18,205)	36	8
9	Bldg Co - Accounting	(7,983)	19	9
10	Bldg Co - Licenses & Fees	(168)	20	10
11	Bldg Co - Bank Charges	(1,902)	21	11
12	Bldg Co - State Replacement Tax	(1,139)	21	12
13	Additional R&M	20,091	06	13
14	Non-allowable Legal	(4,179)	19	14
15	PAC Dues	(8,954)	20	15
16	Non-Allowable Professional Fees	(2,373)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(78,237)		49

Aperion Care Jacksonville, Llc

Report Period Beginning: ID# 0051094
 Ending: 01/01/18
 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
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Jacksonville, Llc# 0051094

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				10,578								10,578	1
2	Food Purchase	(20)		90									70	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,077)					745						(13,332)	5
6	Maintenance	20,091		1,594	(288)		1,614						23,010	6
7	Other (specify):*			148	1,976		277						2,401	7
8	TOTAL General Services	5,994		1,832	12,266		2,636						22,728	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			8,879	(22,889)								(14,011)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			903	2,960								3,863	15
16	TOTAL Health Care and Programs			9,782	(19,929)								(10,148)	16
	C. General Administration													
17	Administrative			(129,391)									(129,391)	17
18	Directors Fees													18
19	Professional Services	(14,535)	7,983	(7,929)	1,713	(133,245)	479		(4,861)				(150,393)	19
20	Fees, Subscriptions & Promotions	(55,288)	168	4,543	903	998	8						(48,668)	20
21	Clerical & General Office Expenses	(78,129)	3,041	27,013	2,237	83,226	1,491						38,879	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,201	232	61							1,494	24
25	Other Admin. Staff Transportation			4,571	153	25							4,748	25
26	Insurance-Prop.Liab.Malpractice			1,458									1,458	26
27	Other (specify):*			8,723	214	9,159							18,096	27
28	TOTAL General Administration	(147,952)	11,192	(89,811)	5,452	(39,776)	1,979		(4,861)				(263,776)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(141,958)	11,192	(78,197)	(2,212)	(39,776)	4,615		(4,861)				(251,196)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Jacksonville, Llc# 0051094

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(47,406)	19,267	1,171	211	215	9,385						(17,157)	30
31	Amortization of Pre-Op. & Org.	(17,670)											(17,670)	31
32	Interest	(204)	124,593	5,590	10		2,717						132,706	32
33	Real Estate Taxes						1,002						1,002	33
34	Rent-Facility & Grounds		(240,000)				(30,000)						(270,000)	34
35	Rent-Equipment & Vehicles			1,361	234	241	738						2,574	35
36	Other (specify):*	(18,205)	18,205											36
37	TOTAL Ownership	(83,485)	(77,935)	8,122	455	456	(16,159)						(168,545)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(21,947)					(21,947)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(16,049)											(16,049)	43
44	TOTAL Special Cost Centers	(16,049)						(21,947)					(37,996)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(241,492)	(66,743)	(70,075)	(1,757)	(39,320)	(11,544)	(21,947)	(4,861)				(457,738)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 240,000	1021 North Church Street, LLC		\$	(240,000)	1
2	V	33 Real Estate Taxes	31,980	1021 North Church Street, LLC		31,980		2
3	V	36 Amortization		1021 North Church Street, LLC		18,205	18,205	3
4	V	30 Depreciation Expense		1021 North Church Street, LLC		19,267	19,267	4
5	V	32 Interest	17	1021 North Church Street, LLC		124,610	124,593	5
6	V	19 Accounting		1021 North Church Street, LLC		7,983	7,983	6
7	V	21 State Replacement Tax		1021 North Church Street, LLC		1,139	1,139	7
8	V	20 Licenses & Fees		1021 North Church Street, LLC		168	168	8
9	V	21 Bank Charges		1021 North Church Street, LLC		1,902	1,902	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 271,997			\$ 205,254	\$ * (66,743)	14

* Total must agree with the amount recorded on line 34 of Schedule V1.

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.	1,457	1,457	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	137	137	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	148	148	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.	3	3	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	8,876	8,876	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	903	903	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	42,712	42,712	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.	7,367	7,367	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	4,543	4,543	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.	25,640	25,640	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.	1,373	1,373	26
27	V	24	SEMINARS		APERION CARE, INC.	1,201	1,201	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.	4,571	4,571	28
29	V	26	INSURANCE		APERION CARE, INC.	1,458	1,458	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	8,723	8,723	30
31	V	30	DEPRECIATION		APERION CARE, INC.	1,171	1,171	31
32	V	32	INTEREST		APERION CARE, INC.	5,590	5,590	32
33	V	35	AUTO LEASE		APERION CARE, INC.	1,361	1,361	33
34	V	17	MANAGEMENT FEE	172,103	APERION CARE, INC.		(172,103)	34
35	V	19	HOME OFFICE	15,296	APERION CARE, INC.		(15,296)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 187,398			\$ 117,323	\$ * (70,075)	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	<u>1</u> DIETITIAN SALARY	\$	<u>APERION CONSULTING, LLC</u>		\$ 10,938	\$ 10,938 15
16	V	<u>6</u> MAINTENANCY SALARY		<u>APERION CONSULTING, LLC</u>		6,970	6,970 16
17	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		<u>APERION CONSULTING, LLC</u>		1,976	1,976 17
18	V	<u>10</u> SALARY NURSE		<u>APERION CONSULTING, LLC</u>		26,453	26,453 18
19	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		2,960	2,960 19
20	V	<u>19</u> PROFESSIONAL FEES		<u>APERION CONSULTING, LLC</u>		1,713	1,713 20
21	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>APERION CONSULTING, LLC</u>		903	903 21
22	V	<u>21</u> CLERICAL & GENERAL		<u>APERION CONSULTING, LLC</u>		2,237	2,237 22
23	V	<u>24</u> SEMINARS		<u>APERION CONSULTING, LLC</u>		232	232 23
24	V	<u>25</u> AUTO AND TRAVEL		<u>APERION CONSULTING, LLC</u>		153	153 24
25	V	<u>27</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		214	214 25
26	V	<u>30</u> DEPRECIATION		<u>APERION CONSULTING, LLC</u>		211	211 26
27	V	<u>32</u> INTEREST		<u>APERION CONSULTING, LLC</u>		10	10 27
28	V	<u>35</u> AUTO LEASE		<u>APERION CONSULTING, LLC</u>		234	234 28
29	V						
30	V						
31	V						
32	V	<u>10</u> RN CONSULTING	49,342	<u>APERION CONSULTING, LLC</u>			(49,342) 32
33	V	<u>01</u> DIETICIAN	360	<u>APERION CONSULTING, LLC</u>			(360) 33
34	V	<u>06</u> PROJECT MANAGER	7,258	<u>APERION CONSULTING, LLC</u>			(7,258) 34
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 56,961			\$ 55,204	\$ * (1,757) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19	PROFESSIONAL FEES	APERION FINANCIAL, LLC		4,417	\$	4,417	15
16	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC		998		998	16
17	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC		83,226		83,226	17
18	V	24	SEMINARS	APERION FINANCIAL, LLC		61		61	18
19	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC		25		25	19
20	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC		9,159		9,159	20
21	V	30	DEPRECIATION	APERION FINANCIAL, LLC		215		215	21
22	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC		241		241	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	APERION FINANCIAL, LLC				(137,662)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 137,662			\$ 98,342	\$ *	(39,320)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	CHASE OFFICE,LLC		\$ 745	\$	745	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,614		1,614	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		277		277	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		479		479	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		8		8	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,491		1,491	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		9,385		9,385	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,717		2,717	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,002		1,002	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		738		738	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			\$ 18,456	\$ *	(11,544)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy Services	\$ 293,411	Renewal Rehab		\$ 271,464	\$ (21,947)	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		\$ 293,411			\$ 271,464	\$ * (21,947)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Payroll Services	\$ 18,567	ProPay HR LLC		\$ 13,706	\$ (4,861)	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		\$ 18,567			\$ 13,706	\$ * (4,861)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 146,778	Aperion Incorporated Cell		\$ 146,778	\$	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		\$ 146,778			\$ 146,778	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

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: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DAVID BERKOWITZ TRUST	47.00%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	YOSEF MEYSEL TRUST	47.00%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	2
3	JAY MEYSEL TRUST	4.00%	Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	STEVEN TUROFSKY	1.00%	Aperion Care Burbank	Burbank	Renewal Rehab	Lincolnwood	Therapy Services	4
5	FREDERICK S. FRANKEL	1.00%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	Lincolnwood	Corporate Manager	5
6			Aperion Care Capitol	Capitol	Aperion Consulting, Inc.	Lincolnwood	Consulting Co.	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, Inc.	Lincolnwood	Bookkeeping	7
8			Aperion Care Demotte	Demotte, IN	Eco-Brite	Skokie	Laundry	8
9			Aperion Care Dolton	Dolton	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10			Aperion Care Elgin	Elgin	Pointe Property, LLC	Boston, MA	Property Management	10
11			Aperion Care Evanston	Evanston	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Fairfield	Fairfield	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Galesburg	Galesburg	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Hidden Lake	St. Louis, MO	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Highwood	Highwood	1021 North Church Street LLC		Building Co.	18
19			Aperion Care International	Chicago	Aperion Incorporated Cell	Burlington, VT	Insurance	19
20			Aperion Care Jacksonville	Jacksonville				20
21			Aperion Care Kokomo	Kokomo, IN				21
22			Aperion Care Litchfield	Litchfield				22
23			Aperion Care Marion	Marion, IN				23
24			Aperion Care Marseilles	Marseilles				24
25			Aperion Care Mascoutah	Mascoutah				25
26			Aperion Care Midlothian	Midlothian				26
27			Aperion Care Moline	East Moline				27
28			Aperion Care Morton Terrace	Morton				28
29			Aperion Care Morton Villa	Morton				29
30			Aperion Care Oak Lawn	Oak Lawn				30

Facility Name & ID Number Aperion Care Jacksonville, Llc # 0051094 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	2.05%	Alloc. Salary	\$ 5,136	17-7	1
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.41	1.03%	Alloc. Salary	635	21-7	2
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.32	1.36%	Alloc. Salary	254	21-7	3
4	Cynthia Meystel	Relative	Clerical	0%	See Attached	0.11	2.73%	Alloc. Salary	361	21-7	4
5	David Berkowitz	Relative	Administrative	0%	See Attached	0.82	2.05%	Alloc. Salary	5,136	17-7	5
6	Fred Frankel	Owner	Administrative	1.00%	See Attached	0.82	2.05%	Alloc. Salary	4,621	17-7	6
7	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.82	2.05%	Alloc. Salary	4,239	17-7	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	\$ 20,382		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 Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	FOOD	ACTUAL CENSUS	1,401,635	55	\$ 4,383	\$ 28,797	\$ 90	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	28,797	1,457	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	28,797	137	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,401,635	55	5,656	28,797	148	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128	28,797	3	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	28,797	8,876	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957	28,797	903	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	28,797	42,712	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	28,797	7,367	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	28,797	4,543	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	28,797	25,640	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	28,797	1,373	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	28,797	1,201	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	28,797	4,571	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	28,797	1,458	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	28,797	8,723	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	28,797	1,171	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	28,797	5,590	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	28,797	1,361	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,718,302	\$ 3,836,913		\$ 117,323	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

APERION CONSULTING, LLC

Street Address

4655 W CHASE AVE

City / State / Zip Code

LINCOLNWOOD, ILLINOIS 60712

Phone Number

(847) 262-3800

Fax Number

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETITIAN SALARY	PATIENT DAYS	1,401,635	55	\$ 424,292	\$ 28,797	\$ 10,938	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	28,797	6,970	2
3	7	EMP. BEN.-GEN. SERV. & DIET	PATIENT DAYS	1,401,635	55	81,117	28,797	1,976	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	28,797	26,453	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437	28,797	2,960	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360	28,797	1,713	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964	28,797	903	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	28,797	2,237	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275	28,797	232	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427	28,797	153	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636	28,797	214	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275	28,797	211	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508	28,797	10	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374	28,797	234	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	\$ 55,204	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001	28,797	4,417	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	28,797	998	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	83,226	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	28,797	61	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	28,797	25	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	28,797	9,159	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	28,797	215	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	28,797	241	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	\$ 98,342	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 28,797	\$ 745	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	28,797	1,614	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	28,797	277	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	28,797	479	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	28,797	8	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	28,797	1,491	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	28,797	9,385	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	28,797	2,717	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	28,797	1,002	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	28,797	738	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	\$	\$ 18,456	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Renewal Rehab

Street Address

7358 N. Lincoln Ave., Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 938-8750

Fax Number

(847) 410-9720

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	43	\$	\$		\$ 271,464	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				\$	\$		\$ 271,464	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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

ProPay HR LLC

Street Address

2201 W. MAIN ST

City / State / Zip Code

EVANSTON , ILLINOIS 60202

Phone Number

(847) 905 3268

Fax Number

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 13,706	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				\$	\$		\$ 13,706	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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

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Fax Number

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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		\$	\$		\$ 146,778	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				\$	\$		\$ 146,778	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		146,778	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				\$	\$		146,778	25

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	First Midwest Bank		X	Mortgage			\$	\$ 2,025,000		\$ 124,610	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Assurance		X	Insurance Financing						277	6									
7	First Midwest Bank		X	Line of Credit				598,122		32,259	7									
8											8									
9	TOTAL Facility Related						\$	\$ 2,623,122		\$ 157,146	9									
B. Non-Facility Related*																				
10	Interest Income		X							(204)	10									
11	Interest Income - Bldg Co.		X							(17)	11									
12	Allocated from Aperion Care	X								5,590	12									
13	See Supplemental Schedule									2,727	13									
14	TOTAL Non-Facility Related						\$	\$		\$ 8,096	14									
15	TOTALS (line 9+line14)						\$	\$ 2,623,122		\$ 165,242	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Jacksonville, Llc COUNTY Morgan
 FACILITY IDPH LICENSE NUMBER 0051094
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>09-17-204-013</u>	<u>Long Term Care Property</u>	\$ <u>31,375.20</u>	\$ <u>31,375.20</u>
2.	<u>10-27-307-027-0000</u>	<u>Home Office Allocation</u>	\$ <u>45,392.90</u>	\$ <u>932.61</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>76,768.10</u></u>	\$ <u><u>32,307.81</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Jacksonville, Llc COUNTY Morgan
 FACILITY IDPH LICENSE NUMBER 0051094
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,500 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>1021 N Church Street, LLC</u>		<u>2010</u>	<u>\$ 48,177</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>1,276</u>	<u>2</u>
3	TOTALS			\$ 49,453	3

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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	113		2010	1977	\$ 1,056,272	\$ 19,267	35	\$ 30,179	\$ 10,912	\$ 251,490	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2011		133,861		20	11,180	11,180	95,960	9
10	Various		2012		2,500		20	250	250	1,750	10
11	Various		2013		75,130		20	4,455	4,455	27,795	11
12	Various		2014		1,480,460		20	92,691	92,691	384,430	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
		2,821,464	273,977		142,138	(131,839)	769,752	
67								67
68								68
69								69
70								70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,821,464	\$ 273,977		\$ 142,138	\$ (131,839)	\$ 769,752		1
2	2 Data Lines In Therapy Rm, Data Lines In Dining Rm Kiosks	2,800		20	560	560	2,240		2
3	New Doors And Hardware For Entire Facility	34,850		20	1,743	1,743	6,825		3
4	Plumbing And Install Boost Hot Water Heater	4,167		20	208	208	816		4
5	Installed 3 Stone Flower Beds, 9 Dwarf Bushes, 3 Trees	15,500		20	1,033	1,033	3,789		5
6	Remove And Replace 2 Doors And Hardware	6,691		20	335	335	1,199		6
7	Install 2 New Ptacs	4,650		20	233	233	814		7
8	Replaced Bay Assembly In Alarm	2,792		20	140	140	442		8
9	7 Locksets & 2 Closers	3,239		20	162	162	459		9
10	Roof Top Unit And Compressor (21,062)	20,820		20	221	221	221		10
11	5 Frigidare 7000 Ptac Hp 230Volt 20 Amp	4,172		20	70	70	70		11
12	Replace Natural Gas Water Heater	4,156		20	45	45	45		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672		34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,925,301	\$ 273,977		\$ 146,888	\$ (127,089)	\$ 786,672	34

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

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	11,481	294	20	294		711	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	612	98	20	31	(68)	245	9
10	Allocated from Aperion Care	2012	174	13	20	9	(5)	52	10
11	Allocated from Aperion Care	2013	74	8	20	4	(5)	18	11
12									12
13	Allocated from Chase Office LLC	2018	52		20	3	3	3	13
14	Allocated from Chase Office LLC	2017	2,658	188	20	133	(55)	266	14
15	Allocated from Chase Office LLC	2016	58,190	4,260	20	2,910	(1,351)	7,031	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 73,241	\$ 4,863		\$ 3,382	\$ (1,480)	\$ 8,326	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 73,241	\$ 4,863		\$ 3,382	\$ (1,480)	\$ 8,326	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 73,241	\$ 4,863		\$ 3,382	\$ (1,480)	\$ 8,326	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 658,578	\$ 5,643	\$ 82,994	\$ 77,352	10	\$ 486,023	71
72	Current Year Purchases	13,014	290	1,354	1,064	10	1,354	72
73	Fully Depreciated Assets	38,324				10	38,324	73
74								74
75	TOTALS	\$ 709,916	\$ 5,932	\$ 84,348	\$ 78,416		\$ 525,701	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		2008 DODGE GRAND CARAVAN	2014	\$ 7,297	\$	\$ 1,216	\$ 1,216	5	\$ 6,689	76
77		Allocated from Aperion Care	2018	687	104	137	33	5	446	77
78		Allocated from Aperion Consultin	2018	501	83	100	18	5	401	78
79										79
80	TOTALS			\$ 8,486	\$ 187	\$ 1,454	\$ 1,267		\$ 7,536	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)	\$ 3,693,155	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 280,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,690	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,406)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,319,909	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	Offsite Storage				822			5
6								6
7	TOTAL				\$ 822			7

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: \$ 8,989 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		\$	\$ 1,361	17
18	Allocated from Aperion Consulting			234	18
19					19
20					20
21	TOTAL		\$	\$ 1,595	21

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	\$ _____

* 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.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 122,840	\$		\$ 122,840	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			44,144			44,144	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			126,428			126,428	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				94,309		94,309	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					16,654	38,531		55,185	13
14	TOTAL			\$		\$ 310,066	\$ 132,840		\$ 442,906	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 Jacksonville, Llc**# **0051094**Report Period Beginning: **01/01/18**Ending: **12/31/18****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 93,714	\$ 94,337	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,505,153	1,505,153	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,405	86,405	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): <u>See Attached Schedule</u>	2,823	81,483	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,888,095	\$ 1,967,378	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		312,840	13
14	Buildings, at Historical Cost		510,132	14
15	Leasehold Improvements, at Historical Cost	1,809,989	1,871,858	15
16	Equipment, at Historical Cost	404,407	770,925	16
17	Accumulated Depreciation (book methods)	(1,166,854)	(1,693,387)	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>	822,480	1,070,097	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,870,022	\$ 2,842,465	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,758,117	\$ 4,809,843	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 452,736	\$ 452,736	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	598,122	598,122	29
30	Accrued Salaries Payable	170,608	170,608	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,429	10,429	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,980	32
33	Accrued Interest Payable	3,028	14,587	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	14,232	14,232	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,249,155	\$ 1,292,694	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,025,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	6,546,437	6,294,839	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,546,437	\$ 8,319,839	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,795,592	\$ 9,612,533	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,037,475)	\$ (4,802,690)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,758,117	\$ 4,809,843	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,913,572)	1
2	Restatements (describe):		2
3	<u>Bad Debt</u>	(128,041)	3
4	<u>Rounding</u>	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,041,616)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(995,859)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (995,859)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,037,475)	24 *

* This must agree with page 17, line 47.

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,613,190	1
2	Discounts and Allowances for all Levels	(632,764)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,980,426	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,125	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 119,125	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,967	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	192	19
20	Radiology and X-Ray	98	20
21	Other Medical Services	79	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,336	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	204	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 204	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,102,091	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	874,065	31
32	Health Care	2,441,200	32
33	General Administration	1,493,274	33
B. Capital Expense			
34	Ownership	610,260	34
C. Ancillary Expense			
35	Special Cost Centers	458,955	35
36	Provider Participation Fee	220,196	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,097,950	40
41	Income before Income Taxes (line 30 minus line 40)**	(995,859)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (995,859)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,915,036	44
45	Private Pay - Net Inpatient Revenue	65,060	45
46	Medicare - Net Inpatient Revenue	834,573	46
47	Other-(specify) <u>Insurance</u>	320,284	47
48	Other-(specify) <u>Managed Care</u>	845,473	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,980,426	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Aperion Care Jacksonville, Llc

0051094

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	2,032	2,080	\$ 102,673	\$ 49.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,076	13,695	491,861	35.92	3
4	Licensed Practical Nurses	16,611	17,433	508,833	29.19	4
5	CNAs & Orderlies	52,059	56,164	838,169	14.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,612	1,756	26,310	14.98	8
9	Activity Director	1,671	1,826	31,993	17.52	9
10	Activity Assistants	3,741	3,948	43,742	11.08	10
11	Social Service Workers	6,067	6,255	127,471	20.38	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,212	42,926	19.41	13
14	Head Cook	5,079	5,545	63,540	11.46	14
15	Cook Helpers/Assistants	8,960	9,542	110,200	11.55	15
16	Dishwashers					16
17	Maintenance Workers	2,015	2,238	33,802	15.10	17
18	Housekeepers	10,130	10,817	126,721	11.71	18
19	Laundry	4,446	4,914	56,467	11.49	19
20	Administrator	1,920	1,920	110,462	57.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,464	1,597	34,456	21.58	23
24	Clerical	2,955	3,332	51,019	15.31	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	336	336	4,909	14.61	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,075	3,491	50,512	14.47	33
34	TOTAL (lines 1 - 33)	139,321	149,101	\$ 2,856,066 *	\$ 19.16	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	145	\$ 8,077	01-03	35
36	Medical Director	131	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	49,342	10-03	38
39	Pharmacist Consultant	111	9,185	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	122	7,422	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	94	6,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	602	\$ 104,026		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>Peggy Turke</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 110,462</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 78,840</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>83,338</u>	<u>Advertising: Employee Recruitment</u>	<u>278</u>	
				<u>FICA Taxes</u>	<u>215,430</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>33,881</u>	<u>(Indicate # of checks performed)</u>		
				<u>Employee Meals</u>	<u>3,048</u>	<u>Patient Background Checks</u>	<u>135</u> <u>1,350</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues</u>	<u>26,479</u>	
				<u>Employee Physicals</u>	<u>480</u>	<u>Subscriptions</u>	<u>3,921</u>	
				<u>Employee Benefits - Other</u>	<u>12,552</u>	<u>Licenses and Permits</u>	<u>1,054</u>	
						<u>Allocated from Aperion Care</u>	<u>4,543</u>	
						<u>See Supplemental Schedule</u>	<u>1,909</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 110,462			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 39,534	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount		\$ 427,569			
<u>Management Fees - Aperion Care, Inc</u>			<u>\$ 172,103</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 172,103	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services								
Vendor/Payee	Type		Amount				G. Schedule of Travel and Seminar**	
<u>See Attached</u>	<u>Legal Fees</u>		<u>\$ 10,053</u>				Description	
<u>Creative Technology Solutions</u>	<u>IT Consulting</u>		<u>12,384</u>				Amount	
<u>APEX Global</u>	<u>Website Development (Adj)</u>		<u>2,373</u>				<u>Out-of-State Travel</u>	
<u>COMS Interactive</u>	<u>Care Management Software</u>		<u>7,326</u>				\$	
<u>PointClickCare</u>	<u>EMR / Billing Software</u>		<u>23,862</u>					
<u>Ability Network</u>	<u>Healthcare Software</u>		<u>6,073</u>				<u>In-State Travel</u>	
<u>Aperion Care</u>	<u>Data Processing</u>		<u>18,078</u>					
<u>Aperion Care</u>	<u>Home Office Expense</u>		<u>15,296</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>137,662</u>				<u>Seminar Expense</u>	
<u>Propay HR</u>	<u>Payroll Processing</u>		<u>18,567</u>				<u>4,383</u>	
<u>Marcum LLP</u>	<u>Accounting Fees</u>		<u>23,175</u>				<u>Allocated from Aperion Care</u>	
<u>See Supplemental</u>			<u>39,381</u>				<u>1,201</u>	
							<u>Allocated from Aperion Consulting</u>	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 314,230				<u>232</u>	
(For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	<u>See Supplemental Schedule</u>	
							<u>61</u>	
							<u>Entertainment Expense</u>	
							<u>()</u>	
							<u>(agree to Sch. V, line 24, col. 8)</u>	
							TOTAL	
							\$ 5,877	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Jacksonville, Llc# 0051094

Report 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 - 17908
- (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. \$ 11,092 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. \$ 220,196
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 3,048 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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees