

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	18,992		4,063	23,055
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	18,992		4,063	23,055

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.18%

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 N/A and days of care provided N/A

Medicare Intermediary N/A

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 Litchfield, Llc # 0051102 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	165,894	10,668	11,684	188,246		188,246	(533)	187,713		1
2	Food Purchase		128,683		128,683		128,683	72	128,755		2
3	Housekeeping	80,009	20,580		100,589		100,589		100,589		3
4	Laundry	32,889	8,301		41,190		41,190		41,190		4
5	Heat and Other Utilities			56,832	56,832		56,832	108	56,940		5
6	Maintenance	33,672	10,982	32,059	76,713		76,713	2,280	78,993		6
7	Other (specify):*							1,923	1,923		7
8	TOTAL General Services	312,464	179,214	100,575	592,253		592,253	3,850	596,103		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	800,554	33,399	61,761	895,714		895,714	(23,349)	872,365		10
10a	Therapy										10a
11	Activities	82,551	1,190	1,881	85,622		85,622		85,622		11
12	Social Services	101,369			101,369		101,369		101,369		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,093	3,093		15
16	TOTAL Health Care and Programs	984,474	34,589	69,642	1,088,705		1,088,705	(20,256)	1,068,449		16
	C. General Administration										
17	Administrative	86,488		120,083	206,571		206,571	(85,887)	120,684		17
18	Directors Fees										18
19	Professional Services			191,493	191,493	(17)	191,476	(94,338)	97,138		19
20	Dues, Fees, Subscriptions & Promotions			65,060	65,060		65,060	(46,151)	18,909		20
21	Clerical & General Office Expenses	29,583		68,557	98,140		98,140	52,339	150,479		21
22	Employee Benefits & Payroll Taxes			165,419	165,419		165,419		165,419		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,783	3,783		3,783	1,195	4,978		24
25	Other Admin. Staff Transportation			5,311	5,311		5,311	3,801	9,112		25
26	Insurance-Prop.Liab.Malpractice			106,785	106,785		106,785	(4,137)	102,648		26
27	Other (specify):*							14,489	14,489		27
28	TOTAL General Administration	116,071		726,491	842,562	(17)	842,545	(158,690)	683,855		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,413,009	213,803	896,708	2,523,520	(17)	2,523,503	(175,096)	2,348,407		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 Litchfield, Llc

#0051102

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			44,102	44,102		44,102	29,678	73,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,525	20,525		20,525	168,055	188,580			32
33	Real Estate Taxes			23,693	23,693	17	23,710	802	24,512			33
34	Rent-Facility & Grounds			246,611	246,611		246,611	(246,000)	611			34
35	Rent-Equipment & Vehicles			6,339	6,339		6,339	2,061	8,400			35
36	Other (specify):*			17,670	17,670		17,670	(17,670)				36
37	TOTAL Ownership			358,940	358,940	17	358,957	(63,075)	295,882			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,605	802	7,407		7,407		7,407			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,750	175,750		175,750		175,750			42
43	Other (specify):*			4,853	4,853		4,853	(4,853)				43
44	TOTAL Special Cost Centers		6,605	181,405	188,010		188,010	(4,853)	183,157			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,413,009	220,408	1,437,053	3,070,470		3,070,470	(243,024)	2,827,446			45

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

Aperion Care Litchfield, Llc

ID# 0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Professional Fees	\$ (3,110)	19	1
2	Advertising/Marketing	(4,705)	43	2
3	Bank Charges	(13,417)	21	3
4	Theft and Damage Loss	(69)	21	4
5	Amortization	(17,670)	36	5
6	Marketing Food	(148)	43	6
7	Additional R&M	3,142	06	7
8	Building Co - Other Professional Fees	(361)	19	8
9	Building Co - Bank Charges	(2,255)	21	9
10	Building Co - Accounting Fees	(7,983)	19	10
11	Building Co - Amortizaiton	(19,147)	36	11
12	Building Co - Professional Fees	(450)	19	12
13	Building Co - License and Fees	(168)	20	13
14	Non-Allowable Legal	(205)	19	14
15	PAC Dues	(5,151)	20	15
16	Credit Card Processing	(24)	21	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	(71,721)		49

Aperion Care Litchfield, Llc

Report Period Beginning: ID# 0051102
 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 Litchfield, Llc# 0051102

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(533)								(533)	1
2	Food Purchase			72									72	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(489)					597						108	5
6	Maintenance	3,142		1,275	(3,428)		1,292						2,280	6
7	Other (specify):*			119	1,582		221						1,923	7
8	TOTAL General Services	2,653		1,466	(2,379)		2,110						3,850	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			7,108	(30,457)								(23,349)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			723	2,370								3,093	15
16	TOTAL Health Care and Programs			7,831	(28,087)								(20,256)	16
	C. General Administration													
17	Administrative			(85,887)									(85,887)	17
18	Directors Fees													18
19	Professional Services	(12,109)	8,794	(4,000)	1,371	(85,543)	384	(3,236)					(94,338)	19
20	Fees, Subscriptions & Promotions	(51,485)	168	3,637	723	799	7						(46,151)	20
21	Clerical & General Office Expenses	(41,159)	2,255	21,627	1,791	66,631	1,194						52,339	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			961	185	49							1,195	24
25	Other Admin. Staff Transportation			3,660	122	20							3,801	25
26	Insurance-Prop.Liab.Malpractice		(5,304)	1,167									(4,137)	26
27	Other (specify):*			6,984	172	7,333							14,489	27
28	TOTAL General Administration	(104,753)	5,913	(51,851)	4,364	(10,711)	1,584	(3,236)					(158,690)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(102,100)	5,913	(42,554)	(26,102)	(10,711)	3,695	(3,236)					(175,096)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102

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	9,469	11,416	938	169	172	7,514						29,678	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(121)	161,518	4,475	8		2,175						168,055	32
33	Real Estate Taxes						802						802	33
34	Rent-Facility & Grounds		(216,000)				(30,000)						(246,000)	34
35	Rent-Equipment & Vehicles			1,090	187	193	591						2,061	35
36	Other (specify):*	(36,817)	19,147										(17,670)	36
37	TOTAL Ownership	(27,469)	(23,919)	6,503	364	365	(18,918)						(63,075)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(4,853)											(4,853)	43
44	TOTAL Special Cost Centers	(4,853)											(4,853)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(134,422)	(18,006)	(36,052)	(25,738)	(10,346)	(15,224)	(3,236)					(243,024)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 216,000	1024 East Tyler, LLC		\$	\$ (216,000)	1
2	V	32 Interest	13	1024 East Tyler, LLC		161,531	161,518	2
3	V	33 Rent Income - Real Estate	23,693	1024 East Tyler, LLC		23,693		3
4	V	19 Accounting		1024 East Tyler, LLC		7,983	7,983	4
5	V	36 Amortization		1024 East Tyler, LLC		19,147	19,147	5
6	V	19 Professional Fees		1024 East Tyler, LLC		450	450	6
7	V	30 Depreciation		1024 East Tyler, LLC		11,416	11,416	7
8	V	20 License and Fees		1024 East Tyler, LLC		168	168	8
9	V	19 Other Professional Fees		1024 East Tyler, LLC		361	361	9
10	V	21 Bank Charges		1024 East Tyler, LLC		2,255	2,255	10
11	V	26 Insurance		1024 East Tyler, LLC		(5,304)	(5,304)	11
12	V							12
13	V							13
14	Total		\$ 239,706			\$ 221,700	\$ * (18,006)	14

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	\$ 72	\$ 72	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.	1,166	1,166	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	109	109	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	119	119	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.	2	2	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	7,106	7,106	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	723	723	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	34,195	34,195	22
23	V	19	PROFESSIONAL FEES		APERION CARE, INC.	5,898	5,898	23
24	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	3,637	3,637	24
25	V	21	CLERICAL SALARY		APERION CARE, INC.	20,528	20,528	25
26	V	21	CLERICAL & GENERAL		APERION CARE, INC.	1,099	1,099	26
27	V	24	SEMINARS		APERION CARE, INC.	961	961	27
28	V	25	AUTO AND TRAVEL		APERION CARE, INC.	3,660	3,660	28
29	V	26	INSURANCE		APERION CARE, INC.	1,167	1,167	29
30	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	6,984	6,984	30
31	V	30	DEPRECIATION		APERION CARE, INC.	938	938	31
32	V	32	INTEREST		APERION CARE, INC.	4,475	4,475	32
33	V	35	AUTO LEASE		APERION CARE, INC.	1,090	1,090	33
34	V	17	MANAGEMENT FEE	120,083	APERION CARE, INC.		(120,083)	34
35	V	19	HOME OFFICE	9,898	APERION CARE, INC.		(9,898)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 129,980			\$ 93,929	\$ * (36,052)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1		APERION CONSULTING, LLC		\$ 8,757	\$ 8,757
16	V	6		APERION CONSULTING, LLC		5,580	5,580
17	V	7		APERION CONSULTING, LLC		1,582	1,582
18	V	10		APERION CONSULTING, LLC		21,178	21,178
19	V	15		APERION CONSULTING, LLC		2,370	2,370
20	V	19		APERION CONSULTING, LLC		1,371	1,371
21	V	20		APERION CONSULTING, LLC		723	723
22	V	21		APERION CONSULTING, LLC		1,791	1,791
23	V	24		APERION CONSULTING, LLC		185	185
24	V	25		APERION CONSULTING, LLC		122	122
25	V	27		APERION CONSULTING, LLC		172	172
26	V	30		APERION CONSULTING, LLC		169	169
27	V	32		APERION CONSULTING, LLC		8	8
28	V	35		APERION CONSULTING, LLC		187	187
29	V						
30	V						
31	V						
32	V	10	51,635	APERION CONSULTING, LLC			(51,635)
33	V	01	9,290	APERION CONSULTING, LLC			(9,290)
34	V	06	9,008	APERION CONSULTING, LLC			(9,008)
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 69,933			\$ 44,195	\$ * (25,738)

* 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		3,536	\$ 3,536
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		799	799
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		66,631	66,631
18	V	24 SEMINARS		APERION FINANCIAL, LLC		49	49
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		20	20
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		7,333	7,333
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		172	172
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		193	193
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V	19 HOME OFFICE EXPENSE	89,079	APERION FINANCIAL, LLC			(89,079)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 89,079			\$ 78,733	\$ * (10,346)

* 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		\$ 597	\$ 597
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,292	1,292
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		221	221
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		384	384
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		7	7
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,194	1,194
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		7,514	7,514
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,175	2,175
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		802	802
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		591	591
25	V	34 RENTAL INCOME	30,000	CHASE OFFICE,LLC			(30,000)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,000			\$ 14,776	\$ * (15,224)

* 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	\$ 12,361	ProPay HR LLC		\$ 9,125	\$ (3,236)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,361			\$ 9,125	\$ * (3,236)

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 84,430	Aperion Incorporated Cell		\$ 84,430	\$	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		\$ 84,430			\$ 84,430	\$ *	39

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Aperion Care Litchfield, Llc

0051102

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 REVOCABLE TRUST	47.00%	Aperion Care Angola	Angola, IN	1024 East Tyler, LLC		Building Co.	1
2	DECLARATION OF TRUST OF YOSEF MEYSTEEL	47.00%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	2
3	JAY MEYSTEEL TRUST	4.00%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	3
4	STEVEN TUROFSKY	1.00%	Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	4
5	FREDERICK S. FRANKEL	1.00%	Aperion Care Cairo	Cairo	Renewal Rehab	Lincolnwood	Therapy Services	5
6			Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	Lincolnwood	Consulting Co.	7
8			Aperion Care Demotte	Demotte, IN	Aperion Financial, Inc.	Lincolnwood	Bookkeeping	8
9			Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	9
10			Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	10
11			Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	11
12			Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	15
16			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	16
17			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	17
18			Aperion Care Highwood	Highwood	Benton Harbor Property, LLC	Benton Harbor, MI	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 Litchfield, Llc

#

0051102

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative		See Attached	0.66	1.64%	Alloc. Salary	\$ 4,112	17-07	1
2	Jay Meystel	Relative	Clerical		See Attached	0.33	0.82%	Alloc. Salary	508	21-07	2
3	Cynthia Meystel	Relative	Clerical		See Attached	0.09	2.18%	Alloc. Salary	289	21-07	3
4	David Berkowitz	Relative	Administrative		See Attached	0.66	1.64%	Alloc. Salary	4,112	17-07	4
5	Fred Frankel	Owner	Administrative	1.00%	See Attached	0.66	1.64%	Alloc. Salary	3,700	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.66	1.64%	Alloc. Salary	3,393	17-7	6
7	Elisheva Adest	Relative	Clerical		See Attached	0.25	1.09%	Alloc. Salary	203	21-7	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	\$ 16,317		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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	FOOD	ACTUAL CENSUS	55	\$ 4,383	\$	23,055	\$ 72	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	55	55,615	55,615	23,055	1,166	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	55	6,652		23,055	109	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	55	5,656		23,055	119	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	55	128		23,055	2	5
6	10	SALARY- NURSE	ACTUAL CENSUS	55	422,414	422,414	23,055	7,106	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	55	42,957		23,055	723	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	55	2,112,862	2,112,862	23,055	34,195	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	55	358,581		23,055	5,898	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	55	221,133		23,055	3,637	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	55	1,246,022	1,246,022	23,055	20,528	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	55	66,841		23,055	1,099	12
13	24	SEMINARS	ACTUAL CENSUS	55	58,453		23,055	961	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	55	222,488		23,055	3,660	14
15	26	INSURANCE	ACTUAL CENSUS	55	70,976		23,055	1,167	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	55	427,828		23,055	6,984	16
17	30	DEPRECIATION	ACTUAL CENSUS	55	57,000		23,055	938	17
18	32	INTEREST	ACTUAL CENSUS	55	272,060		23,055	4,475	18
19	35	AUTO LEASE	ACTUAL CENSUS	55	66,252		23,055	1,090	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,718,302	\$ 3,836,913		\$ 93,929	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	\$ 23,055	\$ 8,757	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	23,055	5,580	2
3	7	EMP. BEN.-GEN. SERV. & DIET	PATIENT DAYS	1,401,635	55	81,117	23,055	1,582	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	23,055	21,178	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437	23,055	2,370	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360	23,055	1,371	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964	23,055	723	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	23,055	1,791	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275	23,055	185	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427	23,055	122	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636	23,055	172	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275	23,055	169	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508	23,055	8	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374	23,055	187	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	\$ 44,195	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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

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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	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	215,001	23,055	3,536	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	23,055	799	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	66,631	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	23,055	49	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	23,055	20	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	23,055	7,333	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	23,055	172	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	23,055	193	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	\$	78,733	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

CHASE OFFICE, LLC

Street Address

4655 W. CHASE AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 262-3800

Fax Number

(

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	ACTUAL CENSUS	1,401,635	55	\$ 36,284	\$ 23,055	\$ 597	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	23,055	1,292	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	23,055	221	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	23,055	384	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	23,055	7	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	23,055	1,194	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	23,055	7,514	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	23,055	2,175	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	23,055	802	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	23,055	591	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	\$	\$ 14,776	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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 Main ST

City / State / Zip Code

Evanston, IL 60202

Phone Number

(847 905 3268

Fax Number

)

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 9,125	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				\$	\$		\$ 9,125	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Aperion Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		\$ 84,430	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				\$	\$		\$ 84,430	25

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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 Litchfield, Llc

0051102

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			\$	\$ 2,625,000		\$ 161,531	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	First Midwest Bank		X	Line of Credit				\$ 547,686		\$ 20,363	6									
7	Insurance Policies		X							\$ 162	7									
8	See Supplemental Schedule									\$ 6,658	8									
9	TOTAL Facility Related						\$	\$ 3,172,686		\$ 188,714	9									
B. Non-Facility Related*																				
10	Interest Income		X							\$ (121)	10									
11	Interest Income - Bldg Co		X							\$ (13)	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (134)	14									
15	TOTALS (line 9+line14)						\$	\$ 3,172,686		\$ 188,580	15									

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Litchfield, Llc COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0051102

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>15-04-282-012</u>	<u>Long Term Care Property</u>	\$ <u>24,106.74</u>	\$ <u>24,106.74</u>
2. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office, LLC</u>	\$ <u>23,055.00</u>	\$ <u>746.65</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>47,161.74</u></u>	\$ <u><u>24,853.39</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 Litchfield, Llc COUNTY Montgomery
 FACILITY IDPH LICENSE NUMBER 0051102
 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 Litchfield, Llc

0051102

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2010</u>	<u>\$ 8,241</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>1,021</u>	<u>2</u>
3	TOTALS			\$ 9,262	3

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	65	2010	1971	\$ 666,776	\$ 11,416	35	\$ 19,051	\$ 7,635	\$ 158,758	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2011	197,162		20	10,008	10,008	85,162	9
10	Various		2012	77,849		20	6,395	6,395	42,669	10
11	Various		2013	3,250		20	325	325	1,950	11
12	Various		2014	21,309		20	1,155	1,155	5,463	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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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	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
		\$	\$		\$	\$	\$	
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
		1,024,983	59,411		39,642	(19,769)	300,669	

**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 12A, Carried Forward		\$ 1,024,983	\$ 59,411		\$ 39,642	\$ (19,769)	\$ 300,669	1
2	Installed Phone System & Cabling	2015	4,650		20	930	930	3,720	2
3	Seal Work Completed Per Bid Proposal Dated 5/20/16	2016	2,641		20	132	132	341	3
4	Repair Broken Pipe In Laundry Room & Sewer In Kitchen	2017	5,273		20	264	264	286	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)		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	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		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	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)		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	34

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	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)		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	34

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	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)		\$ 1,037,547	\$ 59,411		\$ 40,968	\$ (18,444)	\$ 305,015	34

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

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
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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	9,192	236	20	236		570	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	490	79	20	25	(54)	196	9
10	Allocated from Aperion Care	2012	139	11	20	7	(4)	42	10
11	Allocated from Aperion Care	2013	59	7	20	3	(4)	15	11
12									12
13	Allocated from Chase Office LLC	2018	42		20	2	2	2	13
14	Allocated from Chase Office LLC	2017	2,128	151	20	106	(44)	213	14
15	Allocated from Chase Office LLC	2016	46,588	3,411	20	2,329	(1,081)	5,629	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)		\$ 58,637	\$ 3,893		\$ 2,708	\$ (1,185)	\$ 6,666	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		\$ 58,637	\$ 3,893		\$ 2,708	\$ (1,185)	\$ 6,666	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)		\$ 58,637	\$ 3,893		\$ 2,708	\$ (1,185)	\$ 6,666	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	\$ 267,629	\$ 4,518	\$ 29,725	\$ 25,207	10	\$ 173,538	71
72	Current Year Purchases	11,300	232	708	476	10	708	72
73	Fully Depreciated Assets	36,006				10	36,006	73
74								74
75	TOTALS	\$ 314,935	\$ 4,750	\$ 30,433	\$ 25,683		\$ 210,253	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		2007 Ford E350- Purchased New	2011	\$ 16,615	\$	\$ 1,018	\$ 1,018	5	\$ 16,615	76
77		2006 DODGE GRAND CARAVAN	2014	7,031		1,171	1,171	5	6,445	77
78		Allocated from Aperion Care	2018	550	83	110	27	5	357	78
79		See Attached		401	66	80	14		321	79
80	TOTALS			\$ 24,598	\$ 150	\$ 2,379	\$ 2,230		\$ 23,739	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,386,342	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,310	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,780	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,469	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 539,006	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	Off-site Storage				611			5
6								6
7	TOTAL				\$ 611			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,123 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 Inc.		\$	\$ 1,090	17
18	Allocated from Aperion Care Consulting LLC			187	18
19					19
20					20
21	TOTAL		\$	\$ 1,277	21

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

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

Facility Name & ID Number Aperion Care Litchfield, Llc # 0051102 Report Period Beginning: 01/01/18 Ending: 12/31/18
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				6,201		6,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					802	404		1,206	13
14	TOTAL			\$		\$ 802	\$ 6,605		\$ 7,407	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 Litchfield, Llc**# **0051102**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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 69,125	\$ 69,893	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	555,191	555,191	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,699	58,699	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		805,316	8
9	Other(specify): <u>See Attached Schedule</u>	1,610	67,544	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 684,625	\$ 1,556,643	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	282,689	312,104	15
16	Equipment, at Historical Cost	165,212	354,037	16
17	Accumulated Depreciation (book methods)	(314,995)	(598,602)	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>	2,062,581	2,109,215	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,195,487	\$ 2,690,188	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,880,112	\$ 4,246,831	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,784	\$ 112,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	547,686	547,686	29
30	Accrued Salaries Payable	85,849	85,849	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,504	3,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)		24,144	32
33	Accrued Interest Payable		14,984	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	44,213	44,213	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 794,036	\$ 833,164	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,625,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	803,248	15,355	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 803,248	\$ 2,640,355	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,597,284	\$ 3,473,519	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,282,828	\$ 773,312	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,880,112	\$ 4,246,831	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,063,458	1
2	Restatements (describe):		2
3	Bad Debt Expense	(9,802)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,053,656	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	229,172	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)	\$ 229,172	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,282,828	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperia Care Litchfield, Llc

0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,501,930	1
2	Discounts and Allowances for all Levels	(1,202,520)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,299,410	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	111	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	121	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 121	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)	\$ 3,299,642	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	592,253	31
32	Health Care	1,088,705	32
33	General Administration	842,562	33
B. Capital Expense			
34	Ownership	358,940	34
C. Ancillary Expense			
35	Special Cost Centers	12,260	35
36	Provider Participation Fee	175,750	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,070,470	40
41	Income before Income Taxes (line 30 minus line 40)**	229,172	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 229,172	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,715,574	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Managed Care</u>	583,836	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,299,410	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 Litchfield, Llc

0051102

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	2,000	2,080	\$ 82,453	\$ 39.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,628	5,031	141,818	28.19	3
4	Licensed Practical Nurses	7,367	7,941	181,660	22.88	4
5	CNAs & Orderlies	28,916	31,752	394,623	12.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,535	2,038	36,354	17.84	9
10	Activity Assistants	1,040	1,108	11,149	10.06	10
11	Social Service Workers	4,599	5,138	101,369	19.73	11
12	Dietician					12
13	Food Service Supervisor	1,593	1,816	28,477	15.68	13
14	Head Cook	1,861	2,174	28,240	12.99	14
15	Cook Helpers/Assistants	8,463	9,610	109,177	11.36	15
16	Dishwashers					16
17	Maintenance Workers	1,678	2,018	33,672	16.69	17
18	Housekeepers	6,228	7,128	80,009	11.22	18
19	Laundry	2,320	2,595	32,889	12.67	19
20	Administrator	2,032	2,080	86,488	41.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,000	2,080	29,583	14.22	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	2,171	2,319	35,048	15.11	33
34	TOTAL (lines 1 - 33)	78,431	86,908	\$ 1,413,009 *	\$ 16.26	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	52hrs/monthly	\$ 11,684	01-03	35
36	Medical Director	97	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	26hrs/monthly	51,635	10-03	38
39	Pharmacist Consultant	per chart	4,626	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	28	1,881	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	87	5,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	212	\$ 81,326		49

C. CONTRACT NURSES

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

Facility Name & ID Number Aperion Care Litchfield, Llc

0051102

Report Period Beginning: 01/01/18

Ending: 12/31/18

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>Andy Kindernay</u>	<u>Administator</u>	<u>0.00%</u>	\$ <u>86,488</u>	<u>Workers' Compensation Insurance</u>	\$ <u>41,401</u>	<u>IDPH License Fee</u>	\$ <u>3,980</u>	
				<u>Unemployment Compensation Insurance</u>	<u>13,415</u>	<u>Advertising: Employee Recruitment</u>	<u>120</u>	
				<u>FICA Taxes</u>	<u>104,076</u>	<u>Health Care Worker Background Check</u>	<u>139</u>	
				<u>Employee Health Insurance</u>	<u>(8,010)</u>	<u>(Indicate # of checks performed <u>14</u>)</u>		
				<u>Employee Meals</u>	<u>2,343</u>	<u>Patient Background Checks</u>	<u>200</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues</u>	<u>8,614</u>	
				<u>Employee Physicals</u>	<u>240</u>	<u>Subscriptions</u>		
				<u>Other Employee Benefits</u>	<u>11,954</u>	<u>License and Permits</u>	<u>689</u>	
						<u>Allocated from Aperion Care Inc.</u>	<u>3,637</u>	
						<u>See Supplemental Schedule</u>	<u>1,529</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)			\$ <u>86,488</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>165,419</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>18,908</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees - Aperion Care Inc.</u>			\$ <u>120,083</u>				<u>Out-of-State Travel</u>	\$ <u> </u>
							<u>In-State Travel</u>	<u> </u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>120,083</u>	TOTAL		\$ <u> </u>	<u>Seminar Expense</u>	<u>3,783</u>
(Attach a copy of any management service agreement)							<u>Allocated from Aperion Care Inc.</u>	<u>961</u>
							<u>Allocated from Aperion Consulting</u>	<u>185</u>
							<u>See Supplemental Schedule</u>	<u>49</u>
							<u>Entertainment Expense</u>	<u>()</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
C. Professional Services							TOTAL	\$ <u>4,978</u>
Vendor/Payee	Type		Amount					
<u>Pinnacle Financial Services</u>	<u>Financial Consulting</u>		\$ <u>3,067</u>					
<u>Personnel Planners Inc</u>	<u>Unemployment Tax Consult</u>		<u>1,050</u>					
<u>Interbuild</u>	<u>Energy Procurement</u>		<u>765</u>					
<u>MTS Consulting,, LLC</u>	<u>Tax Consulting</u>		<u>1,395</u>					
<u>GCHMO</u>	<u>Managed Care Consulting</u>		<u>8,200</u>					
<u>Marcum LLP</u>	<u>Accounting</u>		<u>18,411</u>					
<u>ProPay HR</u>	<u>Payroll Processing</u>		<u>12,361</u>					
<u>Aperion Care, Inc</u>	<u>Home Office Expense</u>		<u>9,898</u>					
<u>Aperion Financial LLC</u>	<u>Home Office Expense</u>		<u>89,079</u>					
<u>See Supplemental Schedule</u>			<u>47,267</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>191,493</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Litchfield, Llc# 0051102

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 \$10,301
- (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. \$ 1,431 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. \$ 175,750
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. \$ 2,343 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? No
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