

Facility Name & ID Number APERION CARE MOLINE

0052324 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	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	99		7,802	7,901	8
9	SNF/PED					9
10	ICF	15,466	899	4,854	21,219	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,565	899	12,656	29,120	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.48%

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 05/01/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/2013 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 1,249

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number APERION CARE MOLINE # 0052324 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	189,117	16,779	14,514	220,410		220,410	1,351	221,761		1
2	Food Purchase		169,473		169,473	0	169,473	37	169,510		2
3	Housekeeping	7,191	16,490	178,153	201,834		201,834	0	201,834		3
4	Laundry	2,184	7,147	118,769	128,100	0	128,100	0	128,100		4
5	Heat and Other Utilities			133,152	133,152		133,152	(10,831)	122,321		5
6	Maintenance	41,990	21,828	66,381	130,199		130,199	521	130,720		6
7	Other (specify):*	0	0	0	0		0	2,428	2,428		7
8	TOTAL General Services	240,482	231,717	510,969	983,168	0	983,168	(6,494)	976,674		8
	B. Health Care and Programs										
9	Medical Director	0	0	36,000	36,000		36,000	0	36,000		9
10	Nursing and Medical Records	1,760,966	84,535	68,832	1,914,333		1,914,333	(23,957)	1,890,376		10
10a	Therapy	77,933	226	0	78,159		78,159	0	78,159		10a
11	Activities	52,345	3,273	660	56,278		56,278	0	56,278		11
12	Social Services	106,950	0	14,702	121,652		121,652	0	121,652		12
13	CNA Training	0	0	0	0		0	0	0		13
14	Program Transportation	0	0	122	122		122	0	122		14
15	Other (specify):*	0	0	0	0		0	3,906	3,906		15
16	TOTAL Health Care and Programs	1,998,194	88,034	120,316	2,206,544	0	2,206,544	(20,051)	2,186,493		16
	C. General Administration										
17	Administrative	82,381	0	198,921	281,302		281,302	(78,223)	203,079		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			194,500	194,500	(21)	194,479	(50,445)	144,034		19
20	Dues, Fees, Subscriptions & Promotions			106,206	106,206		106,206	(76,044)	30,162		20
21	Clerical & General Office Expenses	93,476	0	216,058	309,534		309,534	(81,611)	227,923		21
22	Employee Benefits & Payroll Taxes			318,960	318,960	0	318,960	0	318,960		22
23	Inservice Training & Education			0	0		0	0	0		23
24	Travel and Seminar			5,298	5,298		5,298	1,286	6,584		24
25	Other Admin. Staff Transportation		0	1,881	1,881		1,881	4,802	6,683		25
26	Insurance-Prop.Liab.Malpractice			194,431	194,431		194,431	1,475	195,906		26
27	Other (specify):*	0	0	0	0		0	18,300	18,300		27
28	TOTAL General Administration	175,857	0	1,236,255	1,412,112	(21)	1,412,091	(260,461)	1,151,630		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,414,533	319,751	1,867,540	4,601,824	(21)	4,601,803	(287,005)	4,314,798		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			119,756	119,756		119,756	58,897	178,653			30
31	Amortization of Pre-Op. & Org.			18,442	18,442		18,442	(18,442)	0			31
32	Interest			45,587	45,587		45,587	200,007	245,594			32
33	Real Estate Taxes			66,660	66,660	21	66,681	1,014	67,695			33
34	Rent-Facility & Grounds			366,000	366,000		366,000	(366,000)	0			34
35	Rent-Equipment & Vehicles			19,568	19,568		19,568	2,603	22,171			35
36	Other (specify):*			0	0		0	0	0			36
37	TOTAL Ownership			636,013	636,013	21	636,034	(121,922)	514,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0		0	0	0			38
39	Ancillary Service Centers	0	63,178	280,224	343,402		343,402	(19,048)	324,354			39
40	Barber and Beauty Shops	0	0	0	0		0	0	0			40
41	Coffee and Gift Shops	0	0	0	0		0	0	0			41
42	Provider Participation Fee	0	0	234,365	234,365		234,365	0	234,365			42
43	Other (specify):*	0	0	19,006	19,006		19,006	(38,012)	(19,006)			43
44	TOTAL Special Cost Centers	0	63,178	533,595	596,773	0	596,773	(57,060)	539,713			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,414,533	382,929	3,037,148	5,834,610	0	5,834,610	(465,987)	5,368,623			45

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

APERION CARE MOLINE

ID# 0052324

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Theft and Damages Loss	\$ (229)	21	1
2	Amortization	(18,442)	31	2
3	PAC Dues	(12,312)	20	3
4	Building Co - Accounting	(7,983)	19	4
5	Building Co - Amortization	(20,461)	36	5
6	Building Co - License and Permits	(168)	20	6
7	Building Co - Bank Charges	(3,240)	21	7
8	Marketing - Foods	(8,240)	43	8
9	Advertising/ Marketing	(10,766)	43	9
10	Credit Card Processing	(175)	21	10
11	Bank Charges	(17,996)	21	11
12	Non-Allowable Expenses -Legal	(1,424)	19	12
13	Additional R & M	4,238	06	13
14	Capitalized R & M	(7,259)	06	14
15	Non-Allowable Seminar	(224)	24	15
16	Collections	(4,744)	19	16
17	Interbuild Adjustment	(290)	06	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		0		48
49	Total	(109,715)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APERION CARE MOLINE# 0052324

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	0	0	0	1,351	0	0	0	0	0	0	0	1,351	1
2	Food Purchase	(54)	0	91	0	0	0	0	0	0	0	0	37	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,585)	0	0	0	0	754	0	0	0	0	0	(10,831)	5
6	Maintenance	(3,311)	0	1,611	590	0	1,632	0	0	0	0	0	521	6
7	Other (specify):*	0	0	150	1,998	0	280	0	0	0	0	0	2,428	7
8	TOTAL General Services	(14,950)	0	1,852	3,939	0	2,665	0	0	0	0	0	(6,494)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	8,979	(32,935)	0	0	0	0	0	0	0	(23,957)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	913	2,993	0	0	0	0	0	0	0	3,906	15
16	TOTAL Health Care and Programs	0	0	9,892	(29,942)	0	0	0	0	0	0	0	(20,051)	16
	C. General Administration													
17	Administrative	0	0	(78,223)	0	0	0	0	0	0	0	0	(78,223)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,151)	7,983	2,156	1,732	(43,175)	485	0	(5,476)	0	0	0	(50,445)	19
20	Fees, Subscriptions & Promotions	(82,736)	168	4,594	913	1,009	8	0	0	0	0	0	(76,044)	20
21	Clerical & General Office Expenses	(200,098)	3,240	27,317	2,262	84,160	1,508	0	0	0	0	0	(81,611)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(224)	0	1,214	234	62	0	0	0	0	0	0	1,286	24
25	Other Admin. Staff Transportation	0	0	4,622	154	25	0	0	0	0	0	0	4,802	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,475	0	0	0	0	0	0	0	0	1,475	26
27	Other (specify):*	0	0	8,821	217	9,262	0	0	0	0	0	0	18,300	27
28	TOTAL General Administration	(297,209)	11,391	(28,023)	5,512	51,343	2,001	0	(5,476)	0	0	0	(260,461)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(312,159)	11,391	(16,280)	(20,491)	51,343	4,666	0	(5,476)	0	0	0	(287,005)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APERION CARE MOLINE# 0052324

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	(65,930)	113,723	1,184	213	217	9,490	0	0	0	0	0	58,897	30
31	Amortization of Pre-Op. & Org.	(18,442)	0	0	0	0	0	0	0	0	0	0	(18,442)	31
32	Interest	(13,766)	205,363	5,652	11	0	2,747	0	0	0	0	0	200,007	32
33	Real Estate Taxes	0	0	0	0	0	1,014	0	0	0	0	0	1,014	33
34	Rent-Facility & Grounds	0	(336,000)	0	0	0	(30,000)	0	0	0	0	0	(366,000)	34
35	Rent-Equipment & Vehicles	0	0	1,376	236	244	746	0	0	0	0	0	2,603	35
36	Other (specify):*	(20,461)	20,461	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(118,599)	3,547	8,212	460	461	(16,003)	0	0	0	0	0	(121,922)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	(19,048)	0	0	0	0	(19,048)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(38,012)	0	0	0	0	0	0	0	0	0	0	(38,012)	43
44	TOTAL Special Cost Centers	(38,012)	0	0	0	0	0	(19,048)	0	0	0	0	(57,060)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(468,770)	14,938	(8,067)	(20,031)	51,804	(11,337)	(19,048)	(5,476)	0	0	0	(465,987)	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	\$ 336,000	430 South 30th Avenue	100.00%	\$	\$ (336,000)	1
2	V	33 Real Estate Tax	68,400	430 South 30th Avenue	100.00%	68,400	0	2
3	V	32 Interest	12	430 South 30th Avenue	100.00%	205,375	205,363	3
4	V	19 Accounting		430 South 30th Avenue	100.00%	7,983	7,983	4
5	V	36 Amortization		430 South 30th Avenue	100.00%	20,461	20,461	5
6	V	30 Depreciation		430 South 30th Avenue	100.00%	113,723	113,723	6
7	V	20 Licenses and Permits		430 South 30th Avenue	100.00%	168	168	7
8	V	21 Bank Charges		430 South 30th Avenue	100.00%	3,240	3,240	8
9	V			430 South 30th Avenue	100.00%		0	9
10	V			430 South 30th Avenue	100.00%		0	10
11	V			430 South 30th Avenue	100.00%		0	11
12	V						0	12
13	V						0	13
14	Total		\$ 404,412			\$ 419,350	\$ * 14,938	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2	FOOD	\$	APERION CARE, INC.	\$	91	\$ 91	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.		1,473	1,473	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.		138	138	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.		150	150	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.		3	3	19
20	V	10	SALARY- NURSE		APERION CARE, INC.		8,976	8,976	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.		913	913	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.		43,191	43,191	22
23	V	17	MANAGEMENT FEES		APERION CARE, INC.		77,507	77,507	23
24	V	19	PROFESSIONAL FEES		APERION CARE, INC.		7,450	7,450	24
25	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.		4,594	4,594	25
26	V	21	CLERICAL SALARY		APERION CARE, INC.		25,928	25,928	26
27	V	21	CLERICAL & GENERAL		APERION CARE, INC.		1,389	1,389	27
28	V	24	SEMINARS		APERION CARE, INC.		1,214	1,214	28
29	V	25	AUTO AND TRAVEL		APERION CARE, INC.		4,622	4,622	29
30	V	26	INSURANCE		APERION CARE, INC.		1,475	1,475	30
31	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.		8,821	8,821	31
32	V	30	DEPRECIATION		APERION CARE, INC.		1,184	1,184	32
33	V	32	INTEREST		APERION CARE, INC.		5,652	5,652	33
34	V	35	AUTO LEASE		APERION CARE, INC.		1,376	1,376	34
35	V	17	MANAGEMENT FEE	198,921	APERION CARE, INC.			(198,921)	35
36	V	19	HOME OFFICE	5,294	APERION CARE, INC.			(5,294)	36
37	V							0	37
38	V							0	38
39	Total		\$ 204,214			\$	196,147	\$ * (8,067)	39

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

Facility Name & ID Number APERION CARE MOLINE# 0052324Report Period Beginning: 01/01/18Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	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>		\$ 11,061	\$ 11,061 15
16	V	<u>6</u> MAINTENANCY SALARY		<u>APERION CONSULTING, LLC</u>		7,048	7,048 16
17	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		<u>APERION CONSULTING, LLC</u>		1,998	1,998 17
18	V	<u>10</u> SALARY NURSE		<u>APERION CONSULTING, LLC</u>		26,750	26,750 18
19	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		2,993	2,993 19
20	V	<u>19</u> PROFESSIONAL FEES		<u>APERION CONSULTING, LLC</u>		1,732	1,732 20
21	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>APERION CONSULTING, LLC</u>		913	913 21
22	V	<u>21</u> CLERICAL & GENERAL		<u>APERION CONSULTING, LLC</u>		2,262	2,262 22
23	V	<u>24</u> SEMINARS		<u>APERION CONSULTING, LLC</u>		234	234 23
24	V	<u>25</u> AUTO AND TRAVEL		<u>APERION CONSULTING, LLC</u>		154	154 24
25	V	<u>27</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		217	217 25
26	V	<u>30</u> DEPRECIATION		<u>APERION CONSULTING, LLC</u>		213	213 26
27	V	<u>32</u> INTEREST		<u>APERION CONSULTING, LLC</u>		11	11 27
28	V	<u>35</u> AUTO LEASE		<u>APERION CONSULTING, LLC</u>		236	236 28
29	V						0 29
30	V						0 30
31	V						0 31
32	V	<u>10</u> RN CONSULTING	59,685	<u>APERION CONSULTING, LLC</u>			(59,685) 32
33	V	<u>01</u> DIETICIAN	9,710	<u>APERION CONSULTING, LLC</u>			(9,710) 33
34	V	<u>06</u> PROJECT MANAGER	6,458	<u>APERION CONSULTING, LLC</u>			(6,458) 34
35	V						0 35
36	V						0 36
37	V						0 37
38	V						0 38
39	Total		\$ 75,853			\$ 55,822	\$ * (20,031) 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		4,467	\$ 4,467 15
16	V	20	FEES, SUBSCRIPTIONS	APERION FINANCIAL, LLC		1,009	1,009 16
17	V	21	CLERICAL & GENERAL	APERION FINANCIAL, LLC		84,160	84,160 17
18	V	24	SEMINARS	APERION FINANCIAL, LLC		62	62 18
19	V	25	AUTO AND TRAVEL	APERION FINANCIAL, LLC		25	25 19
20	V	27	EMP. BEN.-GEN. ADMIN.	APERION FINANCIAL, LLC		9,262	9,262 20
21	V	30	DEPRECIATION	APERION FINANCIAL, LLC		217	217 21
22	V	35	EQUIPMENT RENTAL	APERION FINANCIAL, LLC		244	244 22
23	V	0				0	0 23
24	V	0				0	0 24
25	V	0				0	0 25
26	V	0				0	0 26
27	V	0				0	0 27
28	V	0				0	0 28
29	V	0				0	0 29
30	V	0				0	0 30
31	V	19	HOME OFFICE EXPENSE	APERION FINANCIAL, LLC			(47,642) 31
32	V						0 32
33	V						0 33
34	V						0 34
35	V						0 35
36	V						0 36
37	V						0 37
38	V						0 38
39	Total		\$ 47,642			\$ 99,446	\$ * 51,804 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		\$ 754	\$ 754 15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,632	1,632 16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		280	280 17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		485	485 18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		8	8 19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,508	1,508 20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		9,490	9,490 21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		2,747	2,747 22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,014	1,014 23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		746	746 24
25	V	34 RENTAL INCOME	30,000	CHASE OFFICE,LLC			(30,000) 25
26	V						0 26
27	V						0 27
28	V						0 28
29	V						0 29
30	V						0 30
31	V						0 31
32	V						0 32
33	V						0 33
34	V						0 34
35	V						0 35
36	V						0 36
37	V						0 37
38	V						0 38
39	Total		\$ 30,000			\$ 18,663	\$ * (11,337) 39

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

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 254,656	Renewal Rehab		\$ 235,608	\$ (19,048) 15
16	V						0 16
17	V						0 17
18	V						0 18
19	V						0 19
20	V						0 20
21	V						0 21
22	V						0 22
23	V						0 23
24	V						0 24
25	V						0 25
26	V						0 26
27	V						0 27
28	V						0 28
29	V						0 29
30	V						0 30
31	V						0 31
32	V						0 32
33	V						0 33
34	V						0 34
35	V						0 35
36	V						0 36
37	V						0 37
38	V						0 38
39	Total		\$ 254,656			\$ 235,608	\$ * (19,048) 39

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

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 20,918	ProPay HR		\$ 15,442	\$ (5,476)
16	V						0
17	V						0
18	V						0
19	V						0
20	V						0
21	V						0
22	V						0
23	V						0
24	V						0
25	V						0
26	V						0
27	V						0
28	V						0
29	V						0
30	V						0
31	V						0
32	V						0
33	V						0
34	V						0
35	V						0
36	V						0
37	V						0
38	V						0
39	Total		\$ 20,918			\$ 15,442	\$ * (5,476)

* 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	\$ 15,570	Aperion Incorporated Cell		\$ 15,570	\$ 0	15
16	V						0	16
17	V						0	17
18	V						0	18
19	V						0	19
20	V						0	20
21	V						0	21
22	V						0	22
23	V						0	23
24	V						0	24
25	V						0	25
26	V						0	26
27	V						0	27
28	V						0	28
29	V						0	29
30	V						0	30
31	V						0	31
32	V						0	32
33	V						0	33
34	V						0	34
35	V						0	35
36	V						0	36
37	V						0	37
38	V						0	38
39	Total		\$ 15,570			\$ 15,570	\$ *	0 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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$	\$	0 *	0 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		\$			\$	\$	0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total		\$ 0			\$ 0	\$ *	0	39

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

Facility Name & ID Number

APERION CARE MOLINE

0052324

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DECLARATION OF TRUST OF YOSEF MEYSTEL	32.34%	Aperion Care Angola	Angola, IN	430 South 30th Avenue		Building Co.	1
2	DECLARATION OF TRUST OF DAVID	32.33%	Aperion Care Bloomington	Bloomington	Interbuild Construction	Chicago	Bldg Improvements	2
3	MICHAEL ROSEN	35.33%	Aperion Care Bridgeport	Bridgeport	Chase Office, LLC	Lincolnwood	Home Office, Building Co.	3
4			Aperion Care Burbank	Burbank	Propay	Evanston	Payroll Services	4
5			Aperion Care Cairo	Cairo	Renewal Rehab	Lincolnwood	Therapy Services	5
6			Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, Inc.	Lincolnwood	Consulting Co.	7
8			Aperion Care Demotte	Demotte, IN	Aperion Financial, Inc.	Lincolnwood	Bookkeeping	8
9			Aperion Care Dolton	Dolton	Eco-Brite	Skokie	Laundry	9
10			Aperion Care Elgin	Elgin	Pointe Group Care, LLC	Boston, MA	Bookkeeping	10
11			Aperion Care Evanston	Evanston	Pointe Property, LLC	Boston, MA	Property Management	11
12			Aperion Care Fairfield	Fairfield	Aperion Estates Peru	Peru, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Demotte	Demotte, IN	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ALF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	15
16			Aperion Care Galesburg	Galesburg	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	16
17			Aperion Care Hidden Lake	St. Louis, MO	San Antonio Property, LLC	San Antonio, TX	Building Co.	17
18			Aperion Care 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 Morton Terrace	Morton				27
28			Aperion Care Morton Villa	Morton				28
29			Aperion Care Oak Lawn	Oak Lawn				29
30			Aperion Care Olney	Olney				30

Facility Name & ID Number APERION CARE MOLINE # 0052324 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	0.83	2.08%	Alloc. Salary	\$ 5,194	17-07	1
2	Jay Meystel	Relative	Clerical		See Attached	0.42	1.04%	Alloc. Salary	642	21-07	2
3	Elisheva Adest	Relative	Clerical		See Attached	0.32	1.38%	Alloc. Salary	257	21-07	3
4	Cynthia Meystel	Relative	Clerical		See Attached	0.11	2.76%	Alloc. Salary	365	21-07	4
5	David Berkowitz	Relative	Administrative		See Attached	0.83	2.08%	Alloc. Salary	5,194	17-07	5
6	Nosson Factor	Relative	Clerical		See Attached	0.38	2.76%	Alloc. Salary	174	21-07	6
7	Michael Rosen	Owner	Administrative	33.33%	See Attached	12.40	31.00%	Alloc. Fees	77,507	17-07	7
8											8
9											9
10									0		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	\$ 89,333		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 MOLINE

0052324

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					\$	\$		0	1
2								0	2
3								0	3
4								0	4
5								0	5
6								0	6
7								0	7
8								0	8
9								0	9
10								0	10
11								0	11
12								0	12
13								0	13
14								0	14
15								0	15
16								0	16
17								0	17
18								0	18
19								0	19
20								0	20
21								0	21
22								0	22
23								0	23
24								0	24
25	TOTALS				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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	\$ 29,120	\$ 91	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	29,120	1,473	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	29,120	138	3
4	7	EMP. BEN.-GEN. SERV. & DIE	ACTUAL CENSUS	1,401,635	55	5,656	29,120	150	4
5	10	NURSING & MEDICAL RECOR	ACTUAL CENSUS	1,401,635	55	128	29,120	3	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	29,120	8,976	6
7	15	PAYROLL TAXES/GROUP INS	ACTUAL CENSUS	1,401,635	55	42,957	29,120	913	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	29,120	43,191	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,401,635	55	250,000	29,120	77,507	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	29,120	7,450	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	29,120	4,594	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	29,120	25,928	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	29,120	1,389	13
14	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	29,120	1,214	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	29,120	4,622	15
16	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	29,120	1,475	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	29,120	8,821	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	29,120	1,184	18
19	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	29,120	5,652	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	29,120	1,376	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,968,302	\$ 3,836,913		\$ 196,147	25

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETITIAN SALARY	PATIENT DAYS	1,401,635	55	\$ 424,292	\$ 29,120	\$ 11,061	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	29,120	7,048	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,401,635	55	81,117	29,120	1,998	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	26,750	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437	29,120	2,993	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360	29,120	1,732	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964	29,120	913	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	2,262	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275	29,120	234	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427	29,120	154	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636	29,120	217	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275	29,120	213	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508	29,120	11	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374	29,120	236	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	\$ 55,822	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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	29,120	4,467	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	29,120	1,009	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	84,160	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	29,120	62	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	29,120	25	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	29,120	9,262	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	29,120	217	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	29,120	244	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		\$ 99,446	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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	\$ 29,120	\$ 754	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	29,120	1,632	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	29,120	280	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	29,120	485	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	29,120	8	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	29,120	1,508	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	29,120	9,490	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	29,120	2,747	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	29,120	1,014	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	29,120	746	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	\$ 0	\$ 18,663	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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		\$	\$		\$ 235,608	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				\$ 0	\$ 0		\$ 235,608	25

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

ProPay HR LLC

Street Address

2201 W. MAIN ST

City / State / Zip Code

EVANSTON , ILLINOIS 60202

Phone Number

(847) 905 3268

Fax Number

()

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

1	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		\$	\$		\$ 15,442	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				\$ 0	\$ 0		\$ 15,442	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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		\$	\$		15,570	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				\$ 0	\$ 0		15,570	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number APERION CARE MOLINE

0052324

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				\$ 0	\$ 0		\$ 0	25

Facility Name & ID Number

APERION CARE MOLINE

0052324

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			\$	7,058,804			\$	205,375	1							
2													2							
3													3							
4													4							
5	0						0	0				0	5							
Working Capital																				
6	First Midwest Bank		X	Line of Credit				686,250				44,265	6							
7	Interest - Insurance Policies		X									1,322	7							
8	See Supplemental Schedule						0	0				8,410	8							
9	TOTAL Facility Related						\$	0	\$	7,745,054		\$	259,372	9						
B. Non-Facility Related*																				
10	Interest Income		X									(13,766)	10							
11	Building Co - Interest Income		X									(12)	11							
12	0												12							
13	0				\$0.00		0	0				0	13							
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	(13,778)	14						
15	TOTALS (line 9+line14)						\$	0	\$	7,745,054		\$	245,594	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.	\$	68,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	67,674	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(726)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	68,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	21	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	67,695	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	59,275	8
	2014	88,734	9
	2015	62,426	10
	2016	64,330	11
	2017	66,660	12

2018 Accrual: \$66,660 x 1.03 = \$68,400 (Rounded)

Allocated from Chase Office LLC: \$1,014

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

NOTES:

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

2018 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APERION CARE MOLINE COUNTY Rock Island
 FACILITY IDPH LICENSE NUMBER 0052324
 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>17-02-20-40-22</u>	<u>Long Term Care Property</u>	\$ <u>66,660.00</u>	\$ <u>66,660.00</u>
2.	<u>10-27-307-027-0000</u>	<u>Home Office Allocation</u>	\$ <u>45,392.90</u>	\$ <u>943.07</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>112,052.90</u></u>	\$ <u><u>67,603.07</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.**

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,040 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>2015</u>	<u>\$ 373,200</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>1,290</u>	<u>2</u>
3	TOTALS			\$ 374,490	3

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	120		2015	1971	\$ 3,358,800	\$ 113,723	35	\$ 95,996	\$ (17,727)	\$ 423,976	4
5									0		5
6									0		6
7									0		7
8									0		8
	Improvement Type**										
9	Various		2013		385,130		20	19,639	19,639	102,270	9
10	Various		2014		187,997		20	9,400	9,400	45,125	10
11	0		0		0		0	0	0	0	11
12	0		0		0		0	0	0	0	12
13	0		0		0		0	0	0	0	13
14	0		0		0		0	0	0	0	14
15	0		0		0		0	0	0	0	15
16	0		0		0		0	0	0	0	16
17	0		0		0		0	0	0	0	17
18	0		0		0		0	0	0	0	18
19	0		0		0		0	0	0	0	19
20	0		0		0		0	0	0	0	20
21	0		0		0		0	0	0	0	21
22	0		0		0		0	0	0	0	22
23	0		0		0		0	0	0	0	23
24	0		0		0		0	0	0	0	24
25	0		0		0		0	0	0	0	25
26	0		0		0		0	0	0	0	26
27	0		0		0		0	0	0	0	27
28	0		0		0		0	0	0	0	28
29	0		0		0		0	0	0	0	29
30	0		0		0		0	0	0	0	30
31	0		0		0		0	0	0	0	31
32	0		0		0		0	0	0	0	32
33	0		0		0		0	0	0	0	33
34	0		0		0		0	0	0	0	34
35	0		0		0		0	0	0	0	35
36	0		0		0		0	0	0	0	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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	0	0	\$ 0	\$ 0		\$ 0	\$	\$ 0	37
38	0	0	0			0		0	38
39	0	0	0			0		0	39
40	0	0	0			0		0	40
41	0	0	0			0		0	41
42	0	0	0			0		0	42
43	0	0	0			0		0	43
44	0	0	0			0		0	44
45	0	0	0			0		0	45
46	0	0	0			0		0	46
47	0	0	0			0		0	47
48	0	0	0			0		0	48
49	0	0	0			0		0	49
50	0	0	0			0		0	50
51	0	0	0			0		0	51
52	0	0	0			0		0	52
53	0	0	0			0		0	53
54	0	0	0			0		0	54
55	0	0	0			0		0	55
56	0	0	0			0		0	56
57	0	0	0			0		0	57
58	0	0	0			0		0	58
59	0	0	0			0		0	59
60	0	0	0			0		0	60
61	0	0	0			0		0	61
62	0	0	0			0		0	62
63	0	0	0			0		0	63
64	0	0	0			0		0	64
65	0	0	0			0		0	65
66	0	0	0			0		0	66
67	Related Building Company (Pages 12F & 12G)		0	0		0	0	0	67
68	Related Party Allocations (Pages 12H & 12I)		74,062	4,917		3,420	(1,497)	8,420	68
69	Financial Statement Depreciation			119,756			(119,756)		69
70	TOTAL (lines 4 thru 69)		\$ 4,005,989	\$ 238,396		\$ 128,455	\$ (109,941)	\$ 579,791	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	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		\$ 4,005,989	\$ 238,396		\$ 128,455	\$ (109,941)	\$ 579,791	1
2	Therapy Room / Corridor - Cove Base, Vct, Activity Sign	2015	7,494		20	375	375	1,499	2
3	Installed Privacy Fence With Walk Gate	2016	6,654		20	333	333	887	3
4	New Bryant 1.5 Ton A/C	2017	2,984		20	149	149	236	4
5	New Ruud 3 Ton Rooftop Unit	2017	5,187		20	259	259	411	5
6	A/C Rooftop Unit	2017	5,943		20	297	297	471	6
7	Ruud 70000 Btu Furnace	2018	6,249		20	312	312	312	7
8	2 Doors With Glass	2018	2,625		20	109	109	109	8
9	Roof Top Hvac Unit	2018	7,574		20	260	260	260	9
10	Asphalt, Sealcoat & Paint Parking Lot	2018	5,520		20	115	115	115	10
11	Furnace	2018	3,150		20	39	39	39	11
12	Repairs Locks/Doors	2018	2,692		20	135	135	135	12
13	Repaired Doors	2018	4,567		20	228	228	228	13
14						0	0	0	14
15						0	0	0	15
16						0	0	0	16
17						0	0	0	17
18						0	0	0	18
19						0	0	0	19
20						0	0	0	20
21						0	0	0	21
22						0	0	0	22
23						0	0	0	23
24						0	0	0	24
25						0	0	0	25
26						0	0	0	26
27						0	0	0	27
28						0	0	0	28
29						0	0	0	29
30						0	0	0	30
31						0	0	0	31
32						0	0	0	32
33						0	0	0	33
34	TOTAL (lines 1 thru 33)		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	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		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	1
2						0	0	0	2
3						0	0	0	3
4						0	0	0	4
5						0	0	0	5
6						0	0	0	6
7						0	0	0	7
8						0	0	0	8
9						0	0	0	9
10						0	0	0	10
11						0	0	0	11
12						0	0	0	12
13						0	0	0	13
14						0	0	0	14
15						0	0	0	15
16						0	0	0	16
17						0	0	0	17
18						0	0	0	18
19						0	0	0	19
20						0	0	0	20
21						0	0	0	21
22						0	0	0	22
23						0	0	0	23
24						0	0	0	24
25						0	0	0	25
26						0	0	0	26
27						0	0	0	27
28						0	0	0	28
29						0	0	0	29
30						0	0	0	30
31						0	0	0	31
32						0	0	0	32
33						0	0	0	33
34	TOTAL (lines 1 thru 33)		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	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		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	1
2						0		0	2
3						0		0	3
4						0		0	4
5						0		0	5
6						0		0	6
7						0		0	7
8						0		0	8
9						0		0	9
10						0		0	10
11						0		0	11
12						0		0	12
13						0		0	13
14						0		0	14
15						0		0	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	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		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	1
2						0		0	2
3						0		0	3
4						0		0	4
5						0		0	5
6						0		0	6
7						0		0	7
8						0		0	8
9						0		0	9
10						0		0	10
11						0		0	11
12						0		0	12
13						0		0	13
14						0		0	14
15						0		0	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		\$ 4,066,629	\$ 238,396		\$ 131,066	\$ (107,330)	\$ 584,493	34

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

Facility Name & ID Number APERION CARE MOLINE

0052324

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							0		9
10							0		10
11							0		11
12							0		12
13							0		13
14							0		14
15							0		15
16							0		16
17							0		17
18							0		18
19							0		19
20							0		20
21							0		21
22							0		22
23							0		23
24							0		24
25							0		25
26							0		26
27							0		27
28							0		28
29							0		29
30							0		30
31							0		31
32							0		32
33							0		33
34	TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 0	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		\$ 0	\$ 0		\$ 0	\$ 0	\$ 0	1
2							0		2
3							0		3
4							0		4
5							0		5
6							0		6
7							0		7
8							0		8
9							0		9
10							0		10
11							0		11
12							0		12
13							0		13
14							0		14
15							0		15
16							0		16
17							0		17
18							0		18
19							0		19
20							0		20
21							0		21
22							0		22
23							0		23
24							0		24
25							0		25
26							0		26
27							0		27
28							0		28
29							0		29
30							0		30
31							0		31
32							0		32
33							0		33
34	TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 0	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	11,610	298	20	298		719	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	619	99	20	31	(69)	248	9
10	Allocated from Aperion Care	2012	175	14	20	9	(5)	53	10
11	Allocated from Aperion Care	2013	75	8	20	4	(5)	19	11
12									12
13	Allocated from Chase Office LLC	2018	53	0	20	3	3	3	13
14	Allocated from Chase Office LLC	2017	2,687	190	20	134	(56)	269	14
15	Allocated from Chase Office LLC	2016	58,843	4,308	20	2,942	(1,366)	7,110	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)		\$ 74,062	\$ 4,917		\$ 3,420	\$ (1,497)	\$ 8,420	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		\$ 74,062	\$ 4,917		\$ 3,420	\$ (1,497)	\$ 8,420	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)		\$ 74,062	\$ 4,917		\$ 3,420	\$ (1,497)	\$ 8,420	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	\$ 328,981	\$ 5,706	\$ 38,505	\$ 32,799	10	\$ 168,041	71
72	Current Year Purchases	23,635	293	2,146	1,853	10	2,146	72
73	Fully Depreciated Assets	0	0	0	0	0	0	73
74					0			74
75	TOTALS	\$ 352,616	\$ 5,999	\$ 40,651	\$ 34,652		\$ 170,187	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 GMC SAVANNA	2013	\$ 54,662	\$	\$ 6,696	\$ 6,696	5	\$ 44,619	76
77		Allocated from Aperion Care	2018	695	105	139	34	5	451	77
78		Allocated from Aperion Consultin	2018	507	84	101	18	5	406	78
79		0		0	0	0	0		0	79
80	TOTALS			\$ 55,864	\$ 189	\$ 6,936	\$ 6,747		\$ 45,476	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)	\$ 4,849,598	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 244,584	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,654	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (65,930)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 800,155	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		\$ 0	\$	\$	86
87		0			87
88		0			88
89		0			89
90		0			90
91	TOTALS	\$ 0	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 0			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.	<u> </u> /2019	\$ <u> </u>
13.	<u> </u> /2020	\$ <u> </u>
14.	<u> </u> /2021	\$ <u> </u>

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

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

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,769 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	Facility	BMW	\$ <u>830.00</u>	\$ <u>10,789</u>	17
18	Allocated from Aperion Care Inc.			<u>1,376</u>	18
19	Allocated from Aperion Consulting LLC			<u>236</u>	19
20					20
21	TOTAL		\$ 830.00	\$ 12,401	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 MOLINE # 0052324 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	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$ 0		\$ 85,159	\$ 0	0	\$ 85,159	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs	0		40,772	0	0	40,772	2	
3	Licensed Recreational Therapist	0	hrs	0		0	0	0	0	3	
4	Licensed Physical Therapist	39 - 03	hrs	0		128,638	0	0	128,638	4	
5	Physician Care	0	visits	0		0	0	0	0	5	
6	Dental Care	0	visits	0		0	0	0	0	6	
7	Work Related Program	0	hrs	0		0	0	0	0	7	
8	Habilitation	0	hrs	0		0	0	0	0	8	
9	Pharmacy	39 - 03	# of prescripts	0		10	48,359	0	48,369	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs	0		0	0	0	0	10	
11	Academic Education		hrs	0		0	0	0	0	11	
12	Other (specify):	0				0	0	0	0	12	
13	Other (specify):			0		25,645	14,819	0	40,464	13	
14	TOTAL			\$ 0		\$ 280,224	\$ 63,178	0	\$ 343,402	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 MOLINE

0052324

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	\$ 99,325	\$ 137,314	1
2	Cash-Patient Deposits	700	700	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,384,469	1,384,469	3
4	Supply Inventory (priced at)	0	0	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	85,041	85,041	6
7	Other Prepaid Expenses	0	0	7
8	Accounts Receivable (owners or related parties)	48,724	48,724	8
9	Other(specify): See Attached Schedule	534,497	716,294	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,152,756	\$ 2,372,542	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	0	373,200	13
14	Buildings, at Historical Cost	0	3,358,800	14
15	Leasehold Improvements, at Historical Cost	732,952	732,952	15
16	Equipment, at Historical Cost	157,039	295,039	16
17	Accumulated Depreciation (book methods)	(589,314)	(1,002,710)	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	0	0	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0	0	20
21	Restricted Funds	0	0	21
22	Other Long-Term Assets (specify):	0	0	22
23	Other(specify): See Attached Schedule	2,577,912	5,976,099	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,878,589	\$ 9,733,380	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,031,345	\$ 12,105,922	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 440,079	\$ 440,079	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	686,250	686,250	29
30	Accrued Salaries Payable	181,686	181,686	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,608	8,608	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	68,400	32
33	Accrued Interest Payable	3,474	22,525	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	262,130	253,796	36
37		0	0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,582,227	\$ 1,661,344	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	7,058,804	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	4,418,766	4,418,766	43
44		0	0	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,418,766	\$ 11,477,570	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,000,993	\$ 13,138,914	46
47	TOTAL EQUITY(page 18, line 24)	\$ (969,648)	\$ (1,032,992)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,031,345	\$ 12,105,922	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (256,533)	1
2	Restatements (describe):		2
3	Prior Year Bad Debts	(190,286)	3
4	Rounding	(1)	4
5		0	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (446,820)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(522,828)	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	0	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe)	0	15
16	Other (describe)	0	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (522,828)	17
B. Transfers (Itemize):			
18		0	18
19		0	19
20		0	20
21		0	21
22		0	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (969,648)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number APERION CARE MOLINE

0052324

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	\$ 5,484,720	1
2	Discounts and Allowances for all Levels	(299,767)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,184,953	3
B. Ancillary Revenue			
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	18,200	6
7	Oxygen	0	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 18,200	8
C. Other Operating Revenue			
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	81,163	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	5,422	19
20	Radiology and X-Ray	1,724	20
21	Other Medical Services	6,554	21
22	Laundry	0	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 94,863	23
D. Non-Operating Revenue			
24	Contributions	0	24
25	Interest and Other Investment Income***	13,766	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,766	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	0	0	28
28a	0	0	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,311,782	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	983,168	31
32	Health Care	2,206,544	32
33	General Administration	1,412,112	33
B. Capital Expense			
34	Ownership	636,013	34
C. Ancillary Expense			
35	Special Cost Centers	362,408	35
36	Provider Participation Fee	234,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,834,610	40
41	Income before Income Taxes (line 30 minus line 40)**	(522,828)	41
42	Income Taxes	0	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (522,828)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,526,031	44
45	Private Pay - Net Inpatient Revenue	168,035	45
46	Medicare - Net Inpatient Revenue	644,386	46
47	Other-(specify) <u>Insurance</u>	342,158	47
48	Other-(specify) <u>Manage care</u>	1,504,343	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,184,953	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 MOLINE

0052324

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	2,072	2,147	\$ 88,441	\$ 41.19	1
2	Assistant Director of Nursing	2,076	2,133	71,053	33.31	2
3	Registered Nurses	8,921	9,667	316,242	32.71	3
4	Licensed Practical Nurses	16,754	17,863	506,710	28.37	4
5	CNAs & Orderlies	56,641	60,982	778,520	12.77	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	2,734	2,734	77,933	28.51	8
9	Activity Director	1,280	1,315	20,034	15.23	9
10	Activity Assistants	3,478	3,772	32,311	8.57	10
11	Social Service Workers	5,396	5,675	82,091	14.47	11
12	Dietician			0		12
13	Food Service Supervisor	2,016	2,200	34,397	15.64	13
14	Head Cook	7,195	7,745	83,284	10.75	14
15	Cook Helpers/Assistants	7,968	8,443	71,436	8.46	15
16	Dishwashers			0		16
17	Maintenance Workers	2,044	2,080	41,990	20.19	17
18	Housekeepers	813	874	7,191	8.23	18
19	Laundry	248	268	2,184	8.15	19
20	Administrator	2,024	2,080	82,381	39.61	20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager	1,089	1,199	34,240	28.56	23
24	Clerical	6,299	6,704	59,236	8.84	24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified MR Prof. (QMRP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records			0		31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,863	2,056	24,859	12.09	33
34	TOTAL (lines 1 - 33)	130,911	139,937	\$ 2,414,533 *	\$ 17.25	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	264	\$ 14,514	01-03	35
36	Medical Director	144	36,000	09-03	36
37	Medical Records Consultant		0	0	37
38	Nurse Consultant	Monthly	59,685	10-03	38
39	Pharmacist Consultant	124	9,147	10-03	39
40	Physical Therapy Consultant		0	0	40
41	Occupational Therapy Consultant		0	0	41
42	Respiratory Therapy Consultant		0	0	42
43	Speech Therapy Consultant		0	0	43
44	Activity Consultant	16	660	11-03	44
45	Social Service Consultant	37	2,702	12-03	45
46	Other(specify)				46
47	<u>Psychiatric MD</u>	29	12,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	614	\$ 134,708		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	0	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)	0	\$ 0	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		
Tara Wassell	Administrator	0.00%	\$ 82,381	Workers' Compensation Insurance	\$ 97,876	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	27,215	Advertising: Employee Recruitment	535		
				FICA Taxes	180,023	Health Care Worker Background Check	1,909		
				Employee Health Insurance	(4,101)	(Indicate # of checks performed <u>191</u>)			
				Employee Meals	3,084	Patient Background Checks	146		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscription	17,069		
			0	Employee Physical	618	Licenses & Permits	674		
				Employee Benefits	14,245	Allocated from Aperion Care Inc.	4,594		
						Allocated from Aperion Consulting LLC	913		
						See Supplemental Schedule	1,017		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,381	TOTAL (agree to Schedule V, line 22, col.8)		\$ 30,162			
B. Administrative - Other									
Description			Amount						
Aperion Care Inc. - Management Fees			\$ 198,921						
			0						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 198,921						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attachment	Legal Fees		\$ 8,522				Out-of-State Travel	\$	
Marcum LLP	Accounting Services		23,690						
Creative Technology	IT Consulting		6,956						
COMS Interactive	Care Management Software		7,130				In-State Travel		
DGTell	Surveillance		1,090						
Ability	Data Processing		7,106						
Aperion Care	Data Processing		17,224						
PointClickCare Technologies	EMR / Billing Software		22,944				Seminar Expense	5,074	
Interbuild	Energy Procurement		907				Allocated from Aperion Care Inc.	1,214	
Consonus Pack	Data Analytics		3,762				Allocated from Aperion Consulting LLC	234	
GCHMO	Managed Care Consulting		10,200				See Supplemental Schedule	62	
See Supplemental Schedule			84,972				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 194,503	TOTAL		\$ 0	(agree to Sch. V, line 24, col. 8)		\$ 6,584

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APERION CARE MOLINE

0052324

Report Period Beginning:

01/01/18

Ending: 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. HealthCare Council of Illinois \$24,624
- (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. \$ 19,342 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? 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, Alloc: IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 234,365
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. \$ 3,084 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,240
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees