

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611 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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,907	322	10,480	12,709	8
9	SNF/PED					9
10	ICF	17,207	2,331		19,538	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,114	2,653	10,480	32,247	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.15%

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 05/01/15

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/15 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 4,757

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Spring Valley, Llc # 0053611 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	203,404	15,662	14,390	233,456		233,456	(2,141)	231,315		1
2	Food Purchase		177,896		177,896	(114)	177,782	(42)	177,740		2
3	Housekeeping	104,664	24,796		129,460		129,460		129,460		3
4	Laundry	67,990	13,068		81,058		81,058		81,058		4
5	Heat and Other Utilities			110,056	110,056		110,056	(12,081)	97,975		5
6	Maintenance	41,706	56,815	71,584	170,105		170,105	15,882	185,987		6
7	Other (specify):*							2,689	2,689		7
8	TOTAL General Services	417,764	288,237	196,030	902,031	(114)	901,917	4,306	906,223		8
	B. Health Care and Programs										
9	Medical Director			27,600	27,600		27,600		27,600		9
10	Nursing and Medical Records	1,861,118	137,278	59,067	2,057,463		2,057,463	(9,189)	2,048,274		10
10a	Therapy	23,152			23,152		23,152		23,152		10a
11	Activities	94,226	3,278	1,782	99,286		99,286		99,286		11
12	Social Services	122,584		2,574	125,158		125,158		125,158		12
13	CNA Training										13
14	Program Transportation			632	632		632		632		14
15	Other (specify):*							4,325	4,325		15
16	TOTAL Health Care and Programs	2,101,080	140,556	91,655	2,333,291		2,333,291	(4,863)	2,328,428		16
	C. General Administration										
17	Administrative	114,383		306,166	420,549		420,549	(172,507)	248,042		17
18	Directors Fees										18
19	Professional Services			291,882	291,882	(23)	291,859	(139,335)	152,524		19
20	Dues, Fees, Subscriptions & Promotions			70,632	70,632		70,632	(52,442)	18,190		20
21	Clerical & General Office Expenses	70,488		100,587	171,075		171,075	62,693	233,768		21
22	Employee Benefits & Payroll Taxes			384,119	384,119	114	384,233		384,233		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,687	4,687		4,687	1,499	6,186		24
25	Other Admin. Staff Transportation			2,014	2,014		2,014	5,317	7,331		25
26	Insurance-Prop.Liab.Malpractice			163,860	163,860		163,860	1,633	165,493		26
27	Other (specify):*							20,264	20,264		27
28	TOTAL General Administration	184,871		1,323,947	1,508,818	91	1,508,909	(272,878)	1,236,031		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,703,715	428,793	1,611,632	4,744,140	(23)	4,744,117	(273,436)	4,470,681		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 Spring Valley, Llc

#0053611

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			62,663	62,663		62,663	(7,999)	54,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,793	33,793		33,793	2,146	35,939			32
33	Real Estate Taxes			57,436	57,436	23	57,459	1,122	58,582			33
34	Rent-Facility & Grounds			472,654	472,654		472,654	(30,000)	442,654			34
35	Rent-Equipment & Vehicles			13,862	13,862		13,862	2,882	16,744			35
36	Other (specify):*			524	524		524	(524)				36
37	TOTAL Ownership			640,932	640,932	23	640,955	(32,372)	608,583			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,697	779,574	932,271		932,271	(54,574)	877,697			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,057	219,057		219,057		219,057			42
43	Other (specify):*			11,719	11,719		11,719	(11,719)				43
44	TOTAL Special Cost Centers		152,697	1,010,350	1,163,047		1,163,047	(66,293)	1,096,754			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,703,715	581,490	3,262,914	6,548,119	(0)	6,548,119	(372,101)	6,176,018			45

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

Aperion Care Spring Valley, Llc

ID# 0053611

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing	\$ (413)	21	1
2	Advertising/Marketing Expense	(9,515)	43	2
3	Promotional Products	(1,679)	43	3
4	Bank Charges	(3,290)	21	4
5	Amortization	(524)	36	5
6	Supplemental Insurance	(592)	21	6
7	Additional R&M	15,886	06	7
8	Capitalized R&M	(3,292)	06	8
9	PAC Dues	(3,185)	20	9
10	Chamber of Commerce	(1,188)	20	10
11	Non-Allowable Legal	(1,271)	19	11
12	Non-Allowable Professional	(2,767)	19	12
13	Non-Allowable Seminar	(174)	24	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,005)		49

Aperion Care Spring Valley, Llc

ID# 0053611
 Report Period Beginning: 01/01/18
 Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
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 Spring Valley, Llc# 0053611

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				(2,141)								(2,141)	1
2	Food Purchase	(143)		101									(42)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,916)					835						(12,081)	5
6	Maintenance	12,594		1,784	(303)		1,807						15,882	6
7	Other (specify):*			166	2,213		310						2,689	7
8	TOTAL General Services	(465)		2,051	(232)		2,951						4,306	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			9,943	(19,132)								(9,189)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,011	3,314								4,325	15
16	TOTAL Health Care and Programs			10,954	(15,817)								(4,863)	16
	C. General Administration													
17	Administrative			(172,507)									(172,507)	17
18	Directors Fees													18
19	Professional Services	(4,039)		(6,286)	1,918	(125,878)	537		(5,587)				(139,335)	19
20	Fees, Subscriptions & Promotions	(59,668)		5,088	1,011	1,118	9						(52,442)	20
21	Clerical & General Office Expenses	(64,929)		30,250	2,505	93,197	1,670						62,693	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(174)		1,345	259	69							1,499	24
25	Other Admin. Staff Transportation			5,119	171	28							5,317	25
26	Insurance-Prop.Liab.Malpractice			1,633									1,633	26
27	Other (specify):*			9,768	240	10,256							20,264	27
28	TOTAL General Administration	(128,810)		(125,591)	6,104	(21,211)	2,216		(5,587)				(272,878)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(129,275)		(112,586)	(9,945)	(21,211)	5,168		(5,587)				(273,436)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Spring Valley, Llc# 0053611

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	(20,296)		1,311	236	241	10,509						(7,999)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,167)		6,259	12		3,042						2,146	32
33	Real Estate Taxes						1,122						1,122	33
34	Rent-Facility & Grounds						(30,000)						(30,000)	34
35	Rent-Equipment & Vehicles			1,524	262	270	826						2,882	35
36	Other (specify):*	(524)											(524)	36
37	TOTAL Ownership	(27,987)		9,094	510	511	(14,500)						(32,372)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(54,574)					(54,574)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(11,194)			(525)								(11,719)	43
44	TOTAL Special Cost Centers	(11,194)			(525)			(54,574)					(66,293)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(168,456)		(103,492)	(9,961)	(20,700)	(9,333)	(54,574)	(5,587)				(372,101)	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
1	V		\$				\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$				\$	\$ *	14

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	\$	APERION CARE, INC.	\$ 101	\$ 101	15
16	V	6	MAINTENANCE SALARY		APERION CARE, INC.	1,631	1,631	16
17	V	6	REPAIRS & MAINTENANCE		APERION CARE, INC.	153	153	17
18	V	7	EMP. BEN.-GEN. SERV. & DIETARY		APERION CARE, INC.	166	166	18
19	V	10	NURSING & MEDICAL RECORDS		APERION CARE, INC.	3	3	19
20	V	10	SALARY- NURSE		APERION CARE, INC.	9,940	9,940	20
21	V	15	PAYROLL TAXES/GROUP INSURANCE		APERION CARE, INC.	1,011	1,011	21
22	V	17	ADMINISTRATIVE SALARIES		APERION CARE, INC.	47,829	47,829	22
23	V	17	MANAGEMENT FEES		APERION CARE, INC.	85,830	85,830	23
24	V	19	PROFESSIONAL FEES		APERION CARE, INC.	8,250	8,250	24
25	V	20	FEES, SUBSCRIPTIONS		APERION CARE, INC.	5,088	5,088	25
26	V	21	CLERICAL SALARY		APERION CARE, INC.	28,712	28,712	26
27	V	21	CLERICAL & GENERAL		APERION CARE, INC.	1,538	1,538	27
28	V	24	SEMINARS		APERION CARE, INC.	1,345	1,345	28
29	V	25	AUTO AND TRAVEL		APERION CARE, INC.	5,119	5,119	29
30	V	26	INSURANCE		APERION CARE, INC.	1,633	1,633	30
31	V	27	EMP. BEN.-GEN. ADMIN.		APERION CARE, INC.	9,768	9,768	31
32	V	30	DEPRECIATION		APERION CARE, INC.	1,311	1,311	32
33	V	32	INTEREST		APERION CARE, INC.	6,259	6,259	33
34	V	35	AUTO LEASE		APERION CARE, INC.	1,524	1,524	34
35	V	17	MANAGEMENT FEE	306,166	APERION CARE, INC.		(306,166)	35
36	V	19	HOME OFFICE	14,536	APERION CARE, INC.		(14,536)	36
37	V							37
38	V							38
39	Total		\$ 320,702			\$ 217,210	\$ * (103,492)	39

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	<u>1</u>		<u>APERION CONSULTING, LLC</u>		\$ 12,249	\$ 12,249 15
16	V	<u>6</u>		<u>APERION CONSULTING, LLC</u>		7,805	7,805 16
17	V	<u>7</u>		<u>APERION CONSULTING, LLC</u>		2,213	2,213 17
18	V	<u>10</u>		<u>APERION CONSULTING, LLC</u>		29,622	29,622 18
19	V	<u>15</u>		<u>APERION CONSULTING, LLC</u>		3,314	3,314 19
20	V	<u>19</u>		<u>APERION CONSULTING, LLC</u>		1,918	1,918 20
21	V	<u>20</u>		<u>APERION CONSULTING, LLC</u>		1,011	1,011 21
22	V	<u>21</u>		<u>APERION CONSULTING, LLC</u>		2,505	2,505 22
23	V	<u>24</u>		<u>APERION CONSULTING, LLC</u>		259	259 23
24	V	<u>25</u>		<u>APERION CONSULTING, LLC</u>		171	171 24
25	V	<u>27</u>		<u>APERION CONSULTING, LLC</u>		240	240 25
26	V	<u>30</u>		<u>APERION CONSULTING, LLC</u>		236	236 26
27	V	<u>32</u>		<u>APERION CONSULTING, LLC</u>		12	12 27
28	V	<u>35</u>		<u>APERION CONSULTING, LLC</u>		262	262 28
29	V						
30	V						
31	V						
32	V	<u>10</u>	48,754	<u>APERION CONSULTING, LLC</u>			(48,754) 32
33	V	<u>01</u>	14,390	<u>APERION CONSULTING, LLC</u>			(14,390) 33
34	V	<u>06</u>	8,108	<u>APERION CONSULTING, LLC</u>			(8,108) 34
35	V	<u>43</u>	525	<u>APERION CONSULTING, LLC</u>			(525) 35
36	V						
37	V						
38	V						
39	Total		\$ 71,777			\$ 61,817	\$ * (9,961) 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		4,946	\$	4,946	15
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		1,118		1,118	16
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		93,197		93,197	17
18	V	24 SEMINARS		APERION FINANCIAL, LLC		69		69	18
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		28		28	19
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		10,256		10,256	20
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		241		241	21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		270		270	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V	19 HOME OFFICE EXPENSE	130,824	APERION FINANCIAL, LLC				(130,824)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 130,824			\$ 110,125	\$ *	(20,700)	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		\$ 835	\$	835	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		1,807		1,807	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		310		310	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		537		537	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		9		9	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		1,670		1,670	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		10,509		10,509	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		3,042		3,042	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		1,122		1,122	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		826		826	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	34 RENTAL INCOME	30,000	CHASE OFFICE, LLC				(30,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 30,000			\$ 20,667	\$ *	(9,333)	39

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	\$ 729,591	Renewal Rehab		\$ 675,017	\$	(54,574)	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		\$ 729,591			\$ 675,017	\$ *	(54,574)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Payroll Services	\$ 21,342	ProPay HR LLC		\$ 15,755	\$ (5,587)	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		\$ 21,342			\$ 15,755	\$ * (5,587)	39

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	\$ 127,294	Aperion Incorporated Cell		\$ 127,294	\$	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		\$ 127,294			\$ 127,294	\$ *	39

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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: 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		
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 Spring Valley, Llc

0053611

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	Yosef Meystel Delta Trust	24.50%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	David Berkowitz Delta Trust	24.50%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	Michael Rosen	24.00%	Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	David J. Wirtenberg	4.75%	Aperion Care Burbank	Burbank	Renewal Rehab	LIncolnwood	Therapy Services	4
5	Steven Turofsky	1.00%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	Michelle Koder	1.00%	Aperion Care Capitol	Capitol	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7	Frederick Frankel	1.25%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8	Morris Esformes	4.75%	Aperion Care Demotte	Demotte, IN	Eco-Brite	Skokie	Laundry	8
9	Delecia Wirtenberg Revocable Trust	4.75%	Aperion Care Dolton	Dolton	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10	Sylvia Yolinsky Revocable Trust	4.75%	Aperion Care Elgin	Elgin	Pointe Property, LLC	Boston, MA	Property Management	10
11	Jack Yolinsky	4.75%	Aperion Care Evanston	Evanston	Aperion Estates Peru	Peru, IN	ALF	11
12			Aperion Care Fairfield	Fairfield	Aperion Care Demotte	Demotte, IN	ALF	12
13			Aperion Care Forest Park	Forest Park	Aperion Care Hidden Lake	St. Louis, MO	ALF	13
14			Aperion Care Fort Wayne	Fort Wayne, IN	Aperion Care Hidden Lake	St. Louis, MO	ILF	14
15			Aperion Care Frankfort	Frankfort, IN	Aperion Care Hidden Lake	St. Louis, MO	Memory Care	15
16			Aperion Care Galesburg	Galesburg	San Antonio Property, LLC	San Antonio, TX	Building Co.	16
17			Aperion Care Hidden Lake	St. Louis, MO	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	17
18			Aperion Care Highwood	Highwood	Aperion Incorporated Cell	Burlington, VT	Insurance	18
19			Aperion Care International	Chicago				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 Spring Valley, Llc # 0053611 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.92	2.30%	Alloc Salary	\$ 5,752	17-7	1	
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.46	1.15%	Alloc Salary	711	21-7	2	
3	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.13	3.06%	Alloc Salary	404	21-7	3	
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.92	2.30%	Alloc Salary	5,752	17-7	4	
5	Frederick Frankel	Owner	Administrative	1.25%	See Attached	0.92	2.30%	Alloc Salary	5,175	17-7	5	
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.92	2.30%	Alloc Salary	4,746	17-7	6	
7	Michael Rosen	Relative	Administrative	24.00%	See Attached	13.73	34.33%	Alloc Salary	85,830	17-7	7	
8	Michelle Koder	Owner	Nursing	1.00%	See Attached	0.92	2.30%	Alloc Salary	3,045	10-7	8	
9	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.35	1.53%	Alloc Salary	285	21-7	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	\$ 111,700		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 Spring Valley, Llc

0053611 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 Spring Valley, Llc

0053611

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	\$ 32,247	\$ 101	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	32,247	1,631	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	32,247	153	3
4	7	EMP. BEN.-GEN. SERV. & DIED	ACTUAL CENSUS	1,401,635	55	5,656	32,247	166	4
5	10	NURSING & MEDICAL RECORDS	ACTUAL CENSUS	1,401,635	55	128	32,247	3	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	422,414	9,940	6
7	15	PAYROLL TAXES/GROUP INSURANCE	ACTUAL CENSUS	1,401,635	55	42,957	32,247	1,011	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	2,112,862	47,829	8
9	17	MANAGEMENT FEES	ACTUAL CENSUS	1,401,635	55	250,000	32,247	85,830	9
10	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	32,247	8,250	10
11	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	32,247	5,088	11
12	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	1,246,022	28,712	12
13	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	32,247	1,538	13
14	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	32,247	1,345	14
15	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	32,247	5,119	15
16	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	32,247	1,633	16
17	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	32,247	9,768	17
18	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	32,247	1,311	18
19	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	32,247	6,259	19
20	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	32,247	1,524	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,968,302	\$ 3,836,913		\$ 217,210	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	\$ 424,292	32,247	\$ 12,249	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	32,247	7,805	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,401,635	55	81,117		32,247	2,213	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	32,247	29,622	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437		32,247	3,314	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		32,247	1,918	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		32,247	1,011	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	32,247	2,505	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		32,247	259	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		32,247	171	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636		32,247	240	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		32,247	236	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		32,247	12	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		32,247	262	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		\$ 61,817	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	32,247	4,946	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	32,247	1,118	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	93,197	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	32,247	69	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	32,247	28	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	32,247	10,256	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	32,247	241	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	32,247	270	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	\$ 110,125	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	\$ 32,247	\$ 835	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	32,247	1,807	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	32,247	310	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	32,247	537	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	32,247	9	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	32,247	1,670	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	32,247	10,509	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	32,247	3,042	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	32,247	1,122	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	32,247	826	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	\$	\$ 20,667	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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

()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	55	\$	\$		\$ 675,017	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				\$	\$		\$ 675,017	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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		\$	\$		\$ 15,755	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				\$	\$		\$ 15,755	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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.

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		\$	\$		\$ 127,294	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				\$	\$		\$ 127,294	25

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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 Spring Valley, Llc

0053611

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

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	GM Financial		X	Auto			\$	\$ 32,670		\$ 1,191	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	CIBC Bank		X	Line of Credit				708,140		32,397	6									
7											7									
8	See Supplemental Schedule									205	8									
9	TOTAL Facility Related						\$	\$ 740,810		\$ 33,793	9									
B. Non-Facility Related*																				
10	Interest Income		X							(7,167)	10									
11	Allocated from Aperion Care									6,259	11									
12	Allocated from Aperion Consulting									12	12									
13	Allocated from Chase Office LLC									3,042	13									
14	TOTAL Non-Facility Related						\$	\$		\$ 2,146	14									
15	TOTALS (line 9+line14)						\$	\$ 740,810		\$ 35,939	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.	\$	<u>58,742</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>59,212</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>470</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>58,089</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	<u>23</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. 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.	\$	<u>58,582</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>47,790</u>	8
	2014	<u>54,229</u>	9
	2015	<u>56,062</u>	10
	2016	<u>58,742</u>	11
	2017	<u>58,089</u>	12

2018 Accrual = 2017 Tax

Allocated from Chase Office - \$1,122

	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Spring Valley, Llc COUNTY Bureau
 FACILITY IDPH LICENSE NUMBER 0053611
 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>18-27-400-011</u>	<u>Long Term Care Property</u>	\$ <u>58,089.14</u>	\$ <u>58,089.14</u>
2.	<u>10-27-307-027-0001</u>	<u>Home Office Allocation</u>	\$ <u>45,392.90</u>	\$ <u>1,044.34</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>103,482.04</u>	\$ <u>59,133.48</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 Spring Valley, Llc COUNTY Bureau
 FACILITY IDPH LICENSE NUMBER 0053611
 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 Spring Valley, Llc

0053611

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,107 B. General Construction Type: Exterior Brick Frame _____ 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				\$	1
2	<u>Allocated from Chase Office LLC</u>			<u>1,429</u>	2
3	TOTALS			\$ 1,429	3

Facility Name & ID Number Aperion Care Spring Valley, LLC

0053611

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
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62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68			82,016	5,445		3,788	(1,658)	9,324				
69				62,663			(62,663)					
70		\$	82,016	\$	68,108	\$	3,788	\$	(64,321)	\$	9,324	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 82,016	\$ 68,108		\$ 3,788	\$ (64,321)	\$ 9,324	1
2	Data Cable Installation	2015	7,643		20	382	382	1,338	2
3	Data And Voice Cable Installation	2015	7,866		20	393	393	1,377	3
4	Install Outlets-Hall/Nurse Station/Dining/Laundry/Admin Office	2015	2,520		20	126	126	441	4
5	Compressor Replacement And Piping	2015	2,865		20	143	143	501	5
6	Signage For Road Sign / Glass Door / Awning	2015	5,837		20	292	292	1,022	6
7	Install Trane Packaged Rooftop Unit	2017	8,250		20	413	413	773	7
8	Intake Damper Blade For Hvac Unit	2017	2,800		20	140	140	251	8
9	Cable Installation & Programming For Phones	2017	5,574		20	279	279	430	9
10	Installation Of 6 Foot White Privacy Fence	2017	3,200		20	160	160	240	10
11	Dining Room/Lounge-New Floors, Ceiling, Lighting, Paint	2017	391,065		20	19,553	19,553	20,368	11
12	98 Dry Pendant Sprinkler Heads	2017	19,760		20	988	988	1,112	12
13	Replace Compressor On Walk-In Cooler	2017	2,620		20	131	131	197	13
14	Project Management - Dining Room, Activity Room (2148)	2018	1,628		20	81	81	81	14
15	Dining Room Light/Electric Fixture Replacement (4973)	2018	4,731		20	237	237	237	15
16	Activity Office - New Walls, Electrical Work, Doors, Flooring	2018	108,783		20	5,439	5,439	5,439	16
17	Dining Room- Vinyl Tile, Millwork Base, Wallcovering	2018			20				17
18	Project Management Of Activity Office & Dining Room Reno	2018	13,102		20	655	655	655	18
19	Roofing - Repair Leak Area By Double Doors	2018	3,292		20	165	165	165	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)		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	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		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	34

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	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)		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	34

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	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)		\$ 673,552	\$ 68,108		\$ 33,364	\$ (34,744)	\$ 43,949	34

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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.

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	12,857	330	20	330		797	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	685	110	20	34	(76)	274	9
10	Allocated from Aperion Care	2012	194	15	20	10	(5)	58	10
11	Allocated from Aperion Care	2013	83	9	20	4	(5)	21	11
12									12
13	Allocated from Chase Office LLC	2018	58		20	3	3	3	13
14	Allocated from Chase Office LLC	2017	2,976	211	20	149	(62)	298	14
15	Allocated from Chase Office LLC	2016	65,162	4,771	20	3,258	(1,513)	7,874	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)		\$ 82,016	\$ 5,445		\$ 3,788	\$ (1,658)	\$ 9,324	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		\$ 82,016	\$ 5,445		\$ 3,788	\$ (1,658)	\$ 9,324	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)		\$ 82,016	\$ 5,445		\$ 3,788	\$ (1,658)	\$ 9,324	34

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

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 56,566	\$ 6,319	\$ 6,677	\$ 358	10	\$ 15,784	71
72	Current Year Purchases	29,017	324	2,902	2,577	10	2,902	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 85,584	\$ 6,643	\$ 9,578	\$ 2,935		\$ 18,685	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		2016 GMC Savana	2016	\$ 57,278	\$	\$ 11,456	\$ 11,456	5	\$ 26,730	76
77		Allocated from Aperion Care	2018	769	117	154	37	5	499	77
78		Allocated from Aperion Consultin	2018	561	93	112	20	5	449	78
79										79
80	TOTALS			\$ 58,609	\$ 209	\$ 11,722	\$ 11,513		\$ 27,678	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)	\$ 819,174	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,961	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,665	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,296)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 90,313	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	Therapy Gym / Conference Rm	\$ 40,258	92
93			93
94			94
95		\$ 40,258	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: Spring Valley Real Estate

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:		98		\$ 442,654			3
4	Additions							4
5								5
6								6
7	TOTAL		98		\$ 442,654			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,957 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Aperion Care</u>		\$ _____	\$ 1,524	17
18	<u>Allocated from Aperion Consulting</u>		\$ _____	262	18
19					19
20					20
21	TOTAL		\$ _____	\$ 1,786	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 Spring Valley, Llc # 0053611 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	39 - 03	hrs	\$		\$ 223,757	\$		\$ 223,757	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			115,720			115,720	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			390,094			390,094	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				131,433		131,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					50,003	21,264		71,267	13
14	TOTAL			\$		\$ 779,574	\$ 152,697		\$ 932,271	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 Spring Valley, Llc**# **0053611**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	\$ 100	\$	1
2	Cash-Patient Deposits	380		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,369,557		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,112		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	104,196		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,554,345	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	589,321		15
16	Equipment, at Historical Cost	147,798		16
17	Accumulated Depreciation (book methods)	(99,581)		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>	656,008		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,293,546	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,847,891	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 653,170	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	740,810		29
30	Accrued Salaries Payable	140,185		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,969		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,089		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,758		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,598,981	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	10,676		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,676	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,609,657	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,238,234	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,847,891	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 820,601	1
2	Restatements (describe):		2
3	Bad Debts	(160,000)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 660,600	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	740,134	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	(162,500)	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)	\$ 577,634	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)	\$ 1,238,234	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Spring Valley, Llc

0053611

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	\$ 7,085,852	1
2	Discounts and Allowances for all Levels	(58,678)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,027,174	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	241,927	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 241,927	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	8,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	269	19
20	Radiology and X-Ray	90	20
21	Other Medical Services	2,767	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,985	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,167	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,167	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)	\$ 7,288,253	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	902,031	31
32	Health Care	2,333,291	32
33	General Administration	1,508,818	33
B. Capital Expense			
34	Ownership	640,932	34
C. Ancillary Expense			
35	Special Cost Centers	943,990	35
36	Provider Participation Fee	219,057	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,548,119	40
41	Income before Income Taxes (line 30 minus line 40)**	740,134	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 740,134	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,995,647	44
45	Private Pay - Net Inpatient Revenue	577,029	45
46	Medicare - Net Inpatient Revenue	2,394,286	46
47	Other-(specify) <u>Insurance/Managed Care</u>	1,060,212	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,027,174	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 Spring Valley, Llc

0053611

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,908	2,080	\$ 84,535	\$ 40.64	1
2	Assistant Director of Nursing	1,784	1,864	53,449	28.67	2
3	Registered Nurses	15,346	16,241	445,541	27.43	3
4	Licensed Practical Nurses	14,120	15,533	389,035	25.05	4
5	CNAs & Orderlies	62,039	65,642	888,558	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,333	1,439	23,152	16.09	8
9	Activity Director	1,429	1,666	32,064	19.25	9
10	Activity Assistants	5,490	5,728	62,162	10.85	10
11	Social Service Workers	4,511	4,832	122,584	25.37	11
12	Dietician					12
13	Food Service Supervisor	1,643	2,022	41,150	20.35	13
14	Head Cook	6,754	7,377	96,624	13.10	14
15	Cook Helpers/Assistants	6,799	7,169	65,630	9.15	15
16	Dishwashers					16
17	Maintenance Workers	1,841	2,080	41,706	20.05	17
18	Housekeepers	9,101	9,842	104,664	10.63	18
19	Laundry	6,579	7,112	67,990	9.56	19
20	Administrator	1,864	2,080	114,383	54.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,873	2,080	34,111	16.40	23
24	Clerical	2,031	2,184	36,377	16.66	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)					33
34	TOTAL (lines 1 - 33)	146,445	156,971	\$ 2,703,715 *	\$ 17.22	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	Monthly	\$ 14,390	01-03	35
36	Medical Director	58	27,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	48,754	10-03	38
39	Pharmacist Consultant	115	10,313	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	27	1,782	11-03	44
45	Social Service Consultant	39	2,574	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	\$ 105,413		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions						
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount					
Jennifer Diaz	Administrator	0	\$ 114,383	Workers' Compensation Insurance	\$ 61,527	IDPH License Fee	\$					
				Unemployment Compensation Insurance	38,351	Advertising: Employee Recruitment	459					
				FICA Taxes	200,259	Health Care Worker Background Check						
				Employee Health Insurance	71,271	(Indicate # of checks performed <u>36</u>)	363					
				Employee Meals	114	Patient Background Checks	2,104					
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	6,625					
				Employee Physicals	500	Licenses and Permits	1,413					
				Employee Meals	3,080	Allocated from Aperion Care	5,088					
				Employee Benefits - Other	9,131	Allocated from Aperion Consulting	1,011					
						See Supplemental Schedule	1,127					
						Less: Public Relations Expense	()					
						Non-allowable advertising	()					
						Yellow page advertising	()					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,383	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)						
				\$ 384,233		\$ 18,190						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**					
Description			Amount	Description			Line #	Amount	Description			Amount
Aperion Care - Management Fees			\$ 306,166						Out-of-State Travel			\$
									In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 306,166	TOTAL					Seminar Expense			4,511
									Allocated From Aperion Care			1,345
									Allocated from Aperion Consulting			259
									Allocated from Aperion Financial			69
									Entertainment Expense			()
									(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 291,883						TOTAL			\$ 6,184

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Spring Valley, Llc# 0053611

Report Period Beginning:

01/01/18Ending: 12/31/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$6,370
- (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. \$ 10,292 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. \$ 219,057
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. \$ 114 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees