

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817 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	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,745</u>	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	<u>213</u>	TOTALS	<u>213</u>	<u>77,745</u>	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	<u>14,609</u>	<u>1,654</u>	<u>57,627</u>	<u>73,890</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,609</u>	<u>1,654</u>	<u>57,627</u>	<u>73,890</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.04%

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)

N/A

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 _____

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 213 and days of care provided 1,719

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Aperion Care West Chicago, Llc # 0054817 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	313,647	44,762	4,434	362,843		362,843	26,026	388,869		1
2	Food Purchase		434,616		434,616		434,616	(417)	434,199		2
3	Housekeeping	329,710	67,778		397,488		397,488		397,488		3
4	Laundry		25,416	24,430	49,846		49,846	(569)	49,277		4
5	Heat and Other Utilities			204,701	204,701		204,701	(10,531)	194,170		5
6	Maintenance	91,074	29,982	170,217	291,273		291,273	21,223	312,496		6
7	Other (specify):*							6,160	6,160		7
8	TOTAL General Services	734,431	602,554	403,782	1,740,767		1,740,767	41,893	1,782,660		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	2,903,897	106,720	49,690	3,060,307		3,060,307	63,020	3,123,327		10
10a	Therapy	67,652			67,652		67,652		67,652		10a
11	Activities	159,525	9,377	1,700	170,602		170,602		170,602		11
12	Social Services	341,027		4,109	345,136		345,136		345,136		12
13	CNA Training										13
14	Program Transportation			566	566		566		566		14
15	Other (specify):*							9,910	9,910		15
16	TOTAL Health Care and Programs	3,472,101	116,097	66,065	3,654,263		3,654,263	72,930	3,727,193		16
	C. General Administration										
17	Administrative	168,009		494,540	662,549		662,549	(384,947)	277,602		17
18	Directors Fees										18
19	Professional Services			450,958	450,958	(53)	450,905	(249,248)	201,657		19
20	Dues, Fees, Subscriptions & Promotions			72,916	72,916		72,916	(22,085)	50,831		20
21	Clerical & General Office Expenses	208,532		175,836	384,368		384,368	197,353	581,721		21
22	Employee Benefits & Payroll Taxes			633,079	633,079		633,079		633,079		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,656	6,656		6,656	3,832	10,488		24
25	Other Admin. Staff Transportation			4,664	4,664		4,664	12,184	16,848		25
26	Insurance-Prop.Liab.Malpractice			350,017	350,017		350,017	3,742	353,759		26
27	Other (specify):*							46,433	46,433		27
28	TOTAL General Administration	376,541		2,188,666	2,565,207	(53)	2,565,154	(392,736)	2,172,418		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,583,073	718,651	2,658,513	7,960,237	(53)	7,960,184	(277,914)	7,682,270		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 West Chicago, Llc

#0054817

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			13,662	13,662		13,662	9,770	23,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,137	18,137		18,137	16,901	35,038			32
33	Real Estate Taxes			337,726	337,726	53	337,779	2,572	340,351			33
34	Rent-Facility & Grounds			348,869	348,869		348,869	(12,000)	336,869			34
35	Rent-Equipment & Vehicles			12,566	12,566		12,566	6,604	19,170			35
36	Other (specify):*			12,321	12,321		12,321	(12,321)				36
37	TOTAL Ownership			743,281	743,281	53	743,334	11,526	754,860			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,790	415,753	539,543		539,543	(30,560)	508,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			556,268	556,268		556,268		556,268			42
43	Other (specify):*			14,534	14,534		14,534	(14,534)				43
44	TOTAL Special Cost Centers		123,790	986,555	1,110,345		1,110,345	(45,094)	1,065,251			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,583,073	842,441	4,388,349	9,813,863		9,813,863	(311,482)	9,502,381			45

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

Aperion Care West Chicago, Llc

ID# 0054817

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Processing	\$ (5,950)	21	1
2	Advertising/Marketing	(8,025)	43	2
3	Bank Charges	(8,631)	21	3
4	Theft & Damage Loss	(97)	21	4
5	Amortization	(12,321)	36	5
6	Marketing Food	(878)	43	6
7	Website	(48)	21	7
8	PAC Dues	(17,347)	20	8
9	Aditonal R&M	21,501	06	9
10	Promotional Products	(1,956)	43	10
11	Non Alllowable Legal	(2,826)	19	11
12	Non Alllowable Professional Fees	(1,900)	19	12
13	Capitalized R&M	(2,850)	06	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	(41,328)		49

Aperion Care West Chicago, Llc

Report Period Beginning: ID# 0054817
 Ending: 01/01/18
12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care West Chicago, Llc# 0054817

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				26,026								26,026	1
2	Food Purchase	(648)		231									(417)	2
3	Housekeeping													3
4	Laundry								(569)				(569)	4
5	Heat and Other Utilities	(12,444)					1,913						(10,531)	5
6	Maintenance	18,651		4,088	(5,656)		4,140						21,223	6
7	Other (specify):*			380	5,071		710						6,160	7
8	TOTAL General Services	5,559		4,699	25,441		6,763		(569)				41,893	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			22,782	40,238								63,020	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,316	7,594								9,910	15
16	TOTAL Health Care and Programs			25,098	47,832								72,930	16
	C. General Administration													
17	Administrative			(384,947)									(384,947)	17
18	Directors Fees													18
19	Professional Services	(4,726)		(8,547)	4,395	(235,712)	1,230			(5,889)			(249,248)	19
20	Fees, Subscriptions & Promotions	(38,642)		11,657	2,318	2,561	21						(22,085)	20
21	Clerical & General Office Expenses	(95,077)		69,314	5,739	213,550	3,827						197,353	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			3,081	594	157							3,832	24
25	Other Admin. Staff Transportation			11,729	392	63							12,184	25
26	Insurance-Prop.Liab.Malpractice			3,742									3,742	26
27	Other (specify):*			22,382	550	23,501							46,433	27
28	TOTAL General Administration	(138,445)		(271,588)	13,987	4,120	5,078			(5,889)			(392,736)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(132,886)		(241,791)	87,261	4,120	11,841		(569)	(5,889)			(277,914)	29

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care West Chicago, Llc# 0054817

Report Period Beginning:

01/01/18

Ending:

Summary B

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	(18,410)		3,005	542	552	24,081						9,770	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,438)		14,342	27		6,970						16,901	32
33	Real Estate Taxes						2,572						2,572	33
34	Rent-Facility & Grounds						(12,000)						(12,000)	34
35	Rent-Equipment & Vehicles			3,493	600	619	1,893						6,604	35
36	Other (specify):*	(12,321)											(12,321)	36
37	TOTAL Ownership	(35,169)		20,840	1,169	1,171	23,516						11,526	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(30,560)					(30,560)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(10,859)			(3,675)								(14,534)	43
44	TOTAL Special Cost Centers	(10,859)			(3,675)			(30,560)					(45,094)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(178,914)		(220,952)	84,754	5,291	35,357	(30,560)	(569)	(5,889)			(311,482)	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 Attached Supplemental		See Attached Supplemental		See Attached Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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 West Chicago, Llc# 0054817Report Period Beginning: 01/01/18Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>2</u> <u>FOOD</u>	\$	<u>APERION CARE, INC.</u>		\$ 231	\$	231	15
16	V	<u>6</u> <u>MAINTENANCE SALARY</u>		<u>APERION CARE, INC.</u>		3,737		3,737	16
17	V	<u>6</u> <u>REPAIRS & MAINTENANCE</u>		<u>APERION CARE, INC.</u>		351		351	17
18	V	<u>7</u> <u>EMP. BEN.-GEN. SERV. & DIETARY</u>		<u>APERION CARE, INC.</u>		380		380	18
19	V	<u>10</u> <u>NURSING & MEDICAL RECORDS</u>		<u>APERION CARE, INC.</u>		7		7	19
20	V	<u>10</u> <u>SALARY- NURSE</u>		<u>APERION CARE, INC.</u>		22,775		22,775	20
21	V	<u>15</u> <u>PAYROLL TAXES/GROUP INSURANCE</u>		<u>APERION CARE, INC.</u>		2,316		2,316	21
22	V	<u>17</u> <u>ADMINISTRATIVE SALARIES</u>		<u>APERION CARE, INC.</u>		109,593		109,593	22
23	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>APERION CARE, INC.</u>		18,903		18,903	23
24	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>APERION CARE, INC.</u>		11,657		11,657	24
25	V	<u>21</u> <u>CLERICAL SALARY</u>		<u>APERION CARE, INC.</u>		65,790		65,790	25
26	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>APERION CARE, INC.</u>		3,524		3,524	26
27	V	<u>24</u> <u>SEMINARS</u>		<u>APERION CARE, INC.</u>		3,081		3,081	27
28	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>APERION CARE, INC.</u>		11,729		11,729	28
29	V	<u>26</u> <u>INSURANCE</u>		<u>APERION CARE, INC.</u>		3,742		3,742	29
30	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>APERION CARE, INC.</u>		22,382		22,382	30
31	V	<u>30</u> <u>DEPRECIATION</u>		<u>APERION CARE, INC.</u>		3,005		3,005	31
32	V	<u>32</u> <u>INTEREST</u>		<u>APERION CARE, INC.</u>		14,342		14,342	32
33	V	<u>35</u> <u>AUTO LEASE</u>		<u>APERION CARE, INC.</u>		3,493		3,493	33
34	V	<u>17</u> <u>MANAGEMENT FEE</u>	494,540	<u>APERION CARE, INC.</u>				(494,540)	34
35	V	<u>19</u> <u>HOME OFFICE</u>	27,450	<u>APERION CARE, INC.</u>				(27,450)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 521,989			\$ 301,038	\$ *	(220,952)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> DIETITIAN SALARY	\$	<u>APERION CONSULTING, LLC</u>		\$ 28,066	\$ 28,066
16	V	<u>6</u> MAINTENANCY SALARY		<u>APERION CONSULTING, LLC</u>		17,884	17,884
17	V	<u>7</u> EMP. BEN.-GEN. SERV. & DIETARY		<u>APERION CONSULTING, LLC</u>		5,071	5,071
18	V	<u>10</u> SALARY NURSE		<u>APERION CONSULTING, LLC</u>		67,875	67,875
19	V	<u>15</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		7,594	7,594
20	V	<u>19</u> PROFESSIONAL FEES		<u>APERION CONSULTING, LLC</u>		4,395	4,395
21	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>APERION CONSULTING, LLC</u>		2,318	2,318
22	V	<u>21</u> CLERICAL & GENERAL		<u>APERION CONSULTING, LLC</u>		5,739	5,739
23	V	<u>24</u> SEMINARS		<u>APERION CONSULTING, LLC</u>		594	594
24	V	<u>25</u> AUTO AND TRAVEL		<u>APERION CONSULTING, LLC</u>		392	392
25	V	<u>27</u> PAYROLL TAXES/GROUP INSURANCE		<u>APERION CONSULTING, LLC</u>		550	550
26	V	<u>30</u> DEPRECIATION		<u>APERION CONSULTING, LLC</u>		542	542
27	V	<u>32</u> INTEREST		<u>APERION CONSULTING, LLC</u>		27	27
28	V	<u>35</u> AUTO LEASE		<u>APERION CONSULTING, LLC</u>		600	600
29	V						
30	V						
31	V						
32	V	<u>10</u> RN CONSULTING	27,638	<u>APERION CONSULTING, LLC</u>			(27,638)
33	V	<u>01</u> DIETICIAN	2,040	<u>APERION CONSULTING, LLC</u>			(2,040)
34	V	<u>06</u> PROJECT MANAGER	23,540	<u>APERION CONSULTING, LLC</u>			(23,540)
35	V	<u>43</u> MARKETING	3,675	<u>APERION CONSULTING, LLC</u>			(3,675)
36	V						
37	V						
38	V						
39	Total		\$ 56,893			\$ 141,647	\$ * 84,754

* 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		11,334	\$	11,334	15
16	V	20 FEES, SUBSCRIPTIONS		APERION FINANCIAL, LLC		2,561		2,561	16
17	V	21 CLERICAL & GENERAL		APERION FINANCIAL, LLC		213,550		213,550	17
18	V	24 SEMINARS		APERION FINANCIAL, LLC		157		157	18
19	V	25 AUTO AND TRAVEL		APERION FINANCIAL, LLC		63		63	19
20	V	27 EMP. BEN.-GEN. ADMIN.		APERION FINANCIAL, LLC		23,501		23,501	20
21	V	30 DEPRECIATION		APERION FINANCIAL, LLC		552		552	21
22	V	35 EQUIPMENT RENTAL		APERION FINANCIAL, LLC		619		619	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	247,046	APERION FINANCIAL, LLC				(247,046)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 247,046			\$ 252,337	\$ *	5,291	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		\$ 1,913	\$	1,913	15
16	V	6 REPAIRS & MAINTENANCE		CHASE OFFICE,LLC		4,140		4,140	16
17	V	7 HOUSEKEEPING		CHASE OFFICE,LLC		710		710	17
18	V	19 PROFESSIONAL FEES		CHASE OFFICE,LLC		1,230		1,230	18
19	V	20 DUES & SUBSCRIPTIONS		CHASE OFFICE,LLC		21		21	19
20	V	21 OFFICE EXPENSE		CHASE OFFICE,LLC		3,827		3,827	20
21	V	30 DEPRECIATION		CHASE OFFICE,LLC		24,081		24,081	21
22	V	32 INTEREST EXPENSE		CHASE OFFICE,LLC		6,970		6,970	22
23	V	33 REAL ESTATE TAXES		CHASE OFFICE,LLC		2,572		2,572	23
24	V	35 EQUIPMENT RENTAL		CHASE OFFICE,LLC		1,893		1,893	24
25	V	34 RENTAL INCOME	12,000	CHASE OFFICE,LLC				(12,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,000			\$ 47,357	\$ *	35,357	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy Services	\$ 408,551	Renewal Rehab		\$ 377,991	\$ (30,560)	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		\$ 408,551			\$ 377,991	\$ * (30,560)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	04 Laundry Services	\$ 24,430	Ecobrite Linen		\$ 23,861	\$ (569)	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		\$ 24,430			\$ 23,861	\$ *	(569)	39

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

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

Report Period Beginning: 01/01/18

Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Payroll Services	\$ 22,494	ProPay HR LLC		\$ 16,605	\$ (5,889)	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		\$ 22,494			\$ 16,605	\$ * (5,889)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 276,669	Aperion Incorporated Cell		\$ 276,669	\$	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		\$ 276,669			\$ 276,669	\$ *	39

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

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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 West Chicago, Llc

0054817

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DAVID BERKOWITZ	15.00%	Aperion Care Angola	Angola, IN	Interbuild Construction	Chicago	Bldg Improvements	1
2	FREDERICK S. FRANKEL	15.00%	Aperion Care Bloomington	Bloomington	Chase Office, LLC	LIncolnwood	Home Office, Building Co.	2
3	DAVID A. BERKOWITZ REVOCABLE TRUST	30.00%	Aperion Care Bridgeport	Bridgeport	Propay	Evanston	Payroll Services	3
4	DECLARATION OF TRUST OF YOSEF MEYSTEI	30.00%	Aperion Care Burbank	Burbank	Renewal Rehab	LIncolnwood	Therapy Services	4
5	STEVEN TUROSKY	1.50%	Aperion Care Cairo	Cairo	Aperion Care, Inc.	LIncolnwood	Corporate Manager	5
6	FREDERICK S. FRANKEL	1.50%	Aperion Care Capitol	Capitol	Aperion Consulting, Inc.	LIncolnwood	Consulting Co.	6
7	NAFTALL WILHELM	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, Inc.	LIncolnwood	Bookkeeping	7
8	JENNIFER SPECTOR	1.50%	Aperion Care Demotte	Demotte, IN	Eco-Brite	Skokie	Laundry	8
9	257 LIMITED PARTNERSHIP	1.34%	Aperion Care Dolton	Dolton	Pointe Group Care, LLC	Boston, MA	Bookkeeping	9
10	1219 LIMITED PARTNERSHIP	1.33%	Aperion Care Elgin	Elgin	Pointe Property, LLC	Boston, MA	Property Management	10
11	42170 LIMITED PARTNERSHIP	1.33%	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 West Chicago, Llc # 0054817 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0	See Attached	2.11	5.27%	Alloc. Salary	\$ 13,179	17-07	1	
2	Jay Meystel	Relative	Clerical	0	See Attached	1.05	2.64%	Alloc. Salary	1,629	21-07	2	
3	Cynthia Meystel	Relative	Clerical	0	See Attached	0.29	7.00%	Alloc. Salary	926	21-07	3	
4	David Berkowitz	Relative	Administrative	0	See Attached	2.11	5.27%	Alloc. Salary	13,179	17-07	4	
5	Fred Frankel	Owner	Administrative	1.50%	See Attached	2.11	5.27%	Alloc. Salary	11,857	17-7	5	
6	Steve Turofsky	Owner	Administrative	1.50%	See Attached	2.11	5.27%	Alloc. Salary	10,876	17-7	6	
7	Elisheva Adest	Relative	Clerical	0	See Attached	0.81	3.50%	Alloc. Salary	652	21-7	7	
8	Jennifer Spector	Owner	Clerical	1.50%	See Attached	2.11	5.27%	Alloc. Salary	6,028	21-7	8	
9	Dovid Spector	Relative	Clerical	0	See Attached	2.11	5.27%	Alloc. Salary	2,951	21-7	9	
10	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	2.1	5.27%	Alloc. Salary	13,179	21-7	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	\$ 74,456		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 West Chicago, Llc

0054817

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 West Chicago, Llc

0054817

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	\$ 73,890	\$ 231	1
2	6	MAINTENANCE SALARY	ACTUAL CENSUS	1,401,635	55	55,615	73,890	3,737	2
3	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	6,652	73,890	351	3
4	7	EMP. BEN.-GEN. SERV. & DIED	ACTUAL CENSUS	1,401,635	55	5,656	73,890	380	4
5	10	NURSING & MEDICAL RECORDS	ACTUAL CENSUS	1,401,635	55	128	73,890	7	5
6	10	SALARY- NURSE	ACTUAL CENSUS	1,401,635	55	422,414	73,890	22,775	6
7	15	PAYROLL TAXES/GROUP INSURANCE	ACTUAL CENSUS	1,401,635	55	42,957	73,890	2,316	7
8	17	ADMINISTRATIVE SALARIES	ACTUAL CENSUS	1,401,635	55	2,112,862	73,890	109,593	8
9	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	358,581	73,890	18,903	9
10	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	221,133	73,890	11,657	10
11	21	CLERICAL SALARY	ACTUAL CENSUS	1,401,635	55	1,246,022	73,890	65,790	11
12	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	66,841	73,890	3,524	12
13	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	58,453	73,890	3,081	13
14	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	222,488	73,890	11,729	14
15	26	INSURANCE	ACTUAL CENSUS	1,401,635	55	70,976	73,890	3,742	15
16	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	427,828	73,890	22,382	16
17	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	57,000	73,890	3,005	17
18	32	INTEREST	ACTUAL CENSUS	1,401,635	55	272,060	73,890	14,342	18
19	35	AUTO LEASE	ACTUAL CENSUS	1,401,635	55	66,252	73,890	3,493	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,718,302	\$ 3,836,913	\$ 301,038	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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	73,890	\$ 28,066	1
2	6	MAINTENANCY SALARY	PATIENT DAYS	1,401,635	55	311,197	311,197	73,890	17,884	2
3	7	EMP. BEN.-GEN. SERV. & DIE	PATIENT DAYS	1,401,635	55	81,117		73,890	5,071	3
4	10	SALARY NURSE	PATIENT DAYS	1,401,635	55	1,640,760	1,640,760	73,890	67,875	4
5	15	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	183,437		73,890	7,594	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	1,401,635	55	83,360		73,890	4,395	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	1,401,635	55	43,964		73,890	2,318	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	1,401,635	55	102,122	81,823	73,890	5,739	8
9	24	SEMINARS	PATIENT DAYS	1,401,635	55	11,275		73,890	594	9
10	25	AUTO AND TRAVEL	PATIENT DAYS	1,401,635	55	7,427		73,890	392	10
11	27	PAYROLL TAXES/GROUP INS	PATIENT DAYS	1,401,635	55	9,636		73,890	550	11
12	30	DEPRECIATION	PATIENT DAYS	1,401,635	55	10,275		73,890	542	12
13	32	INTEREST	PATIENT DAYS	1,401,635	55	508		73,890	27	13
14	35	AUTO LEASE	PATIENT DAYS	1,401,635	55	11,374		73,890	600	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		\$ 141,647	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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	73,890	11,334	1
2	20	FEES, SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	48,576	73,890	2,561	2
3	21	CLERICAL & GENERAL	ACTUAL CENSUS	1,401,635	55	4,078,193	4,033,980	213,550	3
4	24	SEMINARS	ACTUAL CENSUS	1,401,635	55	2,987	73,890	157	4
5	25	AUTO AND TRAVEL	ACTUAL CENSUS	1,401,635	55	1,197	73,890	63	5
6	27	EMP. BEN.-GEN. ADMIN.	ACTUAL CENSUS	1,401,635	55	449,805	73,890	23,501	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	10,463	73,890	552	7
8	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	11,738	73,890	619	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	\$ 252,337	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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	\$ 73,890	\$ 1,913	1
2	6	REPAIRS & MAINTENANCE	ACTUAL CENSUS	1,401,635	55	78,537	73,890	4,140	2
3	7	HOUSEKEEPING	ACTUAL CENSUS	1,401,635	55	13,463	73,890	710	3
4	19	PROFESSIONAL FEES	ACTUAL CENSUS	1,401,635	55	23,338	73,890	1,230	4
5	20	DUES & SUBSCRIPTIONS	ACTUAL CENSUS	1,401,635	55	402	73,890	21	5
6	21	OFFICE EXPENSE	ACTUAL CENSUS	1,401,635	55	72,586	73,890	3,827	6
7	30	DEPRECIATION	ACTUAL CENSUS	1,401,635	55	456,791	73,890	24,081	7
8	32	INTEREST EXPENSE	ACTUAL CENSUS	1,401,635	55	132,223	73,890	6,970	8
9	33	REAL ESTATE TAXES	ACTUAL CENSUS	1,401,635	55	48,786	73,890	2,572	9
10	35	EQUIPMENT RENTAL	ACTUAL CENSUS	1,401,635	55	35,907	73,890	1,893	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	\$	\$ 47,357	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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

Renewl Rehab

Street Address

7358 N. Lincoln Ave, Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847 938-8750

Fax Number

(847 410-9720

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	55	\$	\$		\$ 377,991	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				\$	\$		\$ 377,991	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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

EcoBrite Linen

Street Address

3712 Jarvis Avenue

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847 582-4000)

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	4	Laundry Services	Direct		\$	\$		\$ 23,861	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				\$	\$		\$ 23,861	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

ProPay HR LLC

Street Address

2201 W.Main ST

City / State / Zip Code

EVENSTON, IL 60202

Phone Number

(847 905 3268

Fax Number

)

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 16,605	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				\$	\$		\$ 16,605	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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 Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

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	26	Insurance	Direct Allocation		\$	\$		\$ 276,669	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				\$	\$		\$ 276,669	25

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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 West Chicago, Llc

0054817

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10	Reporting Period Interest Expense										
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
													YES	NO				Original	Balance		
A. Directly Facility Related																					
Long-Term																					
1						\$	\$			\$	1										
2											2										
3											3										
4											4										
5											5										
Working Capital																					
6	Congressional Bank		X	Line of Credit							18,137	6									
7												7									
8	See Supplemental Schedule										21,339	8									
9	TOTAL Facility Related					\$	\$			\$	39,476	9									
B. Non-Facility Related*																					
10	Interest Income		X								(4,438)	10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related					\$	\$			\$	(4,438)	14									
15	TOTALS (line 9+line14)					\$	\$			\$	35,038	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>68,128</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>60,551</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(7,577)</u>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>347,875</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>53</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>340,351</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	<u>345,123</u>	8			
	2014	<u>345,927</u>	9			
	2015	<u>350,763</u>	10	13	FROM R. E. TAX STATEMENT FOR 2017	\$ 13
	2016	<u>348,103</u>	11	14	PLUS APPEAL COST FROM LINE 5	\$ 14
	2017	<u>347,875</u>	12	15	LESS REFUND FROM LINE 6	\$ 15
2018 Accrual = 2017 Real Estate Tax				16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16
Allocated from Chase Office LLC: \$2,572						
The real estate tax expense on line 2 represents 2/12 of the 2017 tax bill, since current owner began operations on 11/1/2017.						

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.

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 West Chicago, Llc COUNTY Dupage
 FACILITY IDPH LICENSE NUMBER 0054817
 CONTACT PERSON REGARDING THIS REPORT Ryan Hill
 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.**

X. BUILDING AND GENERAL INFORMATION:

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

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>3,273</u>	2
3	TOTALS			\$ 3,273	3

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68			187,928	12,477		8,679	(3,798)	21,365				
69				13,662			(13,662)					
70		\$	187,928	\$	26,139	\$	8,679	\$	(17,460)	\$	21,365	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 187,928	\$ 26,139		\$ 8,679	\$ (17,460)	\$ 21,365	1
2	Cable And Voice Data	2018	3,995		20	183	183	183	2
3	Lower Front Canopy	2018	7,600		20	158	158	158	3
4	Exhaust Motor	2018	4,897		20	102	102	102	4
5	Door Board And Motor	2018	9,478		20	474	474	474	5
6	Tranco Pump/ Proj Mgmt	2018	18,688		20	250	250	250	6
7	Main Hallway - Interior Drywall	2018	54,648		20	458	458	458	7
8	Replace Outdoor Arc Lighting	2018	12,925		20	108	108	108	8
9	Installation Wireless Radio	2018	6,036		20	111	111	111	9
10	Repaired Electrical Circuit In Undergroup Piping	2018	2,850		20	143	143	143	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)		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	34

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

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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 12B, Carried Forward		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	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)		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	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)		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	34

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

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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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)		\$ 309,045	\$ 26,139		\$ 10,665	\$ (15,474)	\$ 23,351	34

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

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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	29,460	755	20	755		1,825	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	1,570	252	20	79	(174)	628	9
10	Allocated from Aperion Care	2012	445	34	20	22	(12)	134	10
11	Allocated from Aperion Care	2013	189	21	20	9	(12)	47	11
12									12
13	Allocated from Chase Office LLC	2018	134		20	7	7	7	13
14	Allocated from Chase Office LLC	2017	6,819	483	20	341	(142)	682	14
15	Allocated from Chase Office LLC	2016	149,311	10,931	20	7,466	(3,466)	18,042	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)		\$ 187,928	\$ 12,477		\$ 8,679	\$ (3,798)	\$ 21,365	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		\$ 187,928	\$ 12,477		\$ 8,679	\$ (3,798)	\$ 21,365	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 187,928	\$ 12,477		\$ 8,679	\$ (3,798)	\$ 21,365	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 86,223	\$ 14,479	\$ 8,823	\$ (5,656)	10	\$ 20,562	71
72	Current Year Purchases	46,918	743	3,332	2,589	10	3,332	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 133,141	\$ 15,222	\$ 12,155	\$ (3,067)		\$ 23,895	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		Allocated from Aperion Care	2018	\$ 1,763	\$ 267	\$ 353	\$ 85	5	\$ 1,144	76
77		Allocated from Aperion Consultin	2018	1,286	212	257	45	5	1,029	77
78										78
79										79
80	TOTALS			\$ 3,050	\$ 479	\$ 610	\$ 130		\$ 2,174	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)	\$ 448,508	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,430	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,410)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 49,419	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	Lobby Flooring/	\$ 3,500	92
93	3rd Floor room shower		93
94	Wood door	3,390	94
95		\$ 6,890	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: American Realty Cap Healthcare Trust Inc

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:		213		\$ 336,869			3
4	Additions							4
5								5
6								6
7	TOTAL		213		\$ 336,869			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: \$ 15,078 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 Inc.</u>		\$ _____	\$ 3,493	17
18	<u>Allocated from Aperion Care Consulting LLC</u>		\$ _____	600	18
19					19
20					20
21	TOTAL		\$ _____	\$ 4,093	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.

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	\$		\$ 176,141	\$		\$ 176,141	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			29,707			29,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			203,208			203,208	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				70,056		70,056	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,697	53,734		60,431	13
14	TOTAL			\$		\$ 415,753	\$ 123,790		\$ 539,543	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 West Chicago, Llc**

0054817

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	\$ 66,964	\$	1
2	Cash-Patient Deposits	5,957		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,783,010		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,360		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	917,179		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,879,470	\$	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	128,176		15
16	Equipment, at Historical Cost	66,753		16
17	Accumulated Depreciation (book methods)	(13,807)		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>	163,689		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 344,811	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,224,281	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 698,204	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	287,625		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,528		31
32	Accrued Real Estate Taxes(Sch.IX-B)	347,875		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,346,232	\$	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>	503,725		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 503,725	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,849,957	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,374,324	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,224,281	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 196,609	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 196,609	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,177,715	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,177,715	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)	\$ 1,374,324	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care West Chicago, Llc

0054817

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	\$ 13,902,140	1
2	Discounts and Allowances for all Levels	(3,248,132)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,654,008	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	330,492	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 330,492	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	551	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	226	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,879	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,656	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,422	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,422	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)	\$ 10,991,578	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,740,767	31
32	Health Care	3,654,263	32
33	General Administration	2,565,207	33
B. Capital Expense			
34	Ownership	743,281	34
C. Ancillary Expense			
35	Special Cost Centers	554,077	35
36	Provider Participation Fee	556,268	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,813,863	40
41	Income before Income Taxes (line 30 minus line 40)**	1,177,715	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,177,715	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,951,034	44
45	Private Pay - Net Inpatient Revenue	306,475	45
46	Medicare - Net Inpatient Revenue	876,348	46
47	Other-(specify) <u>Insurance</u>	68,842	47
48	Other-(specify) <u>Managed Care</u>	7,451,309	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,654,008	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 West Chicago, Llc

0054817

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,140	\$ 124,075	\$ 57.98	1
2	Assistant Director of Nursing	2,091	2,245	97,672	43.51	2
3	Registered Nurses	1,996	21,475	780,194	36.33	3
4	Licensed Practical Nurses	28,756	30,150	892,721	29.61	4
5	CNAs & Orderlies	60,166	63,448	990,443	15.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,299	2,483	67,652	27.25	8
9	Activity Director	1,197	1,242	29,862	24.04	9
10	Activity Assistants	9,381	9,789	129,663	13.25	10
11	Social Service Workers	14,922	15,622	341,027	21.83	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	92,704	44.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,604	19,855	220,943	11.13	15
16	Dishwashers					16
17	Maintenance Workers	3,733	3,996	91,074	22.79	17
18	Housekeepers	28,745	31,318	329,710	10.53	18
19	Laundry					19
20	Administrator	1,776	1,840	109,421	59.47	20
21	Assistant Administrator	1,478	1,523	58,588	38.47	21
22	Other Administrative					22
23	Office Manager	1,680	1,713	37,789	22.06	23
24	Clerical	8,957	9,452	170,743	18.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,277	1,358	18,792	13.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	191,034	221,729	\$ 4,583,073 *	\$ 20.67	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	79	\$ 4,434	01-03	35
36	Medical Director	45	10,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	34	27,638	10-03	38
39	Pharmacist Consultant	334	22,052	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	26	1,700	11-03	44
45	Social Service Consultant	62	4,109	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	580	\$ 69,933		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Gina M. McCarthy</u>	<u>Administrator</u>	<u>0.00%</u>	\$ <u>109,421</u>	<u>Workers' Compensation Insurance</u>	\$ <u>127,491</u>	<u>IDPH License Fee</u>	\$ <u>2,568</u>	
<u>Zev Brody</u>	<u>Assistant Administrator</u>	<u>0.00%</u>	<u>58,588</u>	<u>Unemployment Compensation Insurance</u>	<u>64,857</u>	<u>Advertising: Employee Recruitment</u>	<u>876</u>	
				<u>FICA Taxes</u>	<u>336,456</u>	<u>Health Care Worker Background Check</u>	<u>408</u>	
				<u>Employee Health Insurance</u>	<u>77,780</u>	<u>(Indicate # of checks performed <u>41</u>)</u>		
				<u>Employee Meals</u>	<u>6,369</u>	<u>Patient Background Checks</u>	<u>1,005</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues</u>	<u>26,850</u>	
				<u>Employee Physicals</u>	<u>1,520</u>	<u>Subscriptions</u>		
				<u>Employee Benefits - Other</u>	<u>13,495</u>	<u>Licences and Permits</u>	<u>2,567</u>	
				<u>Uniforms</u>	<u>5,111</u>	<u>Allocated from Aperion Care Inc.</u>	<u>11,657</u>	
						<u>See Supplemental Schedule</u>	<u>4,900</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>168,009</u>	TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>633,079</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>50,831</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees</u>			\$ <u>494,540</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>494,540</u>					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Marcum LLP</u>	<u>Accounting</u>		\$ <u>6,180</u>					
<u>ProPay</u>	<u>Payroll Processing</u>		<u>22,494</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>247,046</u>					
<u>Creative Technology Solutions</u>	<u>IT Consulting</u>		<u>30,844</u>					
<u>PointClickCare Technologies Inc.</u>	<u>EMR / Billing Software</u>		<u>38,735</u>					
<u>DGTELL</u>	<u>Surveillance</u>		<u>5,861</u>					
<u>Aperion Care</u>	<u>Data Processing</u>		<u>42,540</u>					
<u>American Data</u>	<u>Data Processing</u>		<u>3,607</u>					
<u>Pinnacle Financial Services</u>	<u>Financial Services</u>		<u>3,472</u>					
<u>Cononus Pact</u>	<u>Data Analytics</u>		<u>3,062</u>					
<u>See Attached</u>	<u>Legal</u>		<u>2,875</u>					
<u>See Supplemental Schedule</u>			<u>44,243</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>450,957</u>	TOTAL		\$		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care West Chicago, Llc# 0054817

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 \$34,693
- (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? _____
- (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? 20 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,061 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? X YES _____ 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. \$ 556,268
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. \$ 6,369 Has any meal income been offset against related costs? Yes 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? N/A 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? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees