		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052688

Facility Name: Aperion Care Bridgeport

Address: 900 E Corporation St (Number) Bridgeport (City) 62417 (Zip Code)

County: Lawrence

Telephone Number: (618) 945-2091 **Fax #** (618) 945-9017

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2014

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,816	2,310	3,072	24,198	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,816	2,310	3,072	24,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.78%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 2,557

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	173,595	18,106	7,944	199,645		199,645	10,954	210,599			1
2	Food Purchase		135,142		135,142		135,142	(69)	135,073			2
3	Housekeeping	100,747	46,766		147,513		147,513	227	147,740			3
4	Laundry	41,225	5,639		46,864		46,864		46,864			4
5	Heat and Other Utilities			79,507	79,507		79,507	(10,053)	69,454			5
6	Maintenance	42,064	21,770	66,904	130,738		130,738	(1,748)	128,990			6
7	Other (specify):*							1,540	1,540			7
8	**TOTAL General Services**	357,631	227,423	154,355	739,409		739,409	851	740,260			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000	1,089	10,089			9
10	Nursing and Medical Records	1,482,078	170,395	82,380	1,734,853		1,734,853	(27,517)	1,707,336			10
10a	Therapy	55,309	3,099		58,408		58,408		58,408			10a
11	Activities	129,159	2,422	2,025	133,606		133,606	12	133,618			11
12	Social Services	175,164		1,980	177,144		177,144		177,144			12
13	CNA Training											13
14	Program Transportation			12,196	12,196		12,196		12,196			14
15	Other (specify):*							4,537	4,537			15
16	**TOTAL Health Care and Programs**	1,841,710	175,916	107,581	2,125,207		2,125,207	(21,879)	2,103,328			16
	C. General Administration											
17	Administrative	108,595		234,133	342,728		342,728	(207,009)	135,719			17
18	Directors Fees											18
19	Professional Services			305,137	305,137		305,137	(149,069)	156,068			19
20	Dues, Fees, Subscriptions & Promotions			38,355	38,355		38,355	(17,137)	21,218			20
21	Clerical & General Office Expenses	109,310		201,015	310,325		310,325	(78,720)	231,605			21
22	Employee Benefits & Payroll Taxes			356,721	356,721		356,721		356,721			22
23	Inservice Training & Education											23
24	Travel and Seminar			703	703		703	253	956			24
25	Other Admin. Staff Transportation			6,251	6,251		6,251	910	7,161			25
26	Insurance-Prop.Liab.Malpractice			65,029	65,029		65,029	371	65,400			26
27	Other (specify):*							13,547	13,547			27
28	**TOTAL General Administration**	217,905		1,207,344	1,425,249		1,425,249	(436,855)	988,394			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,417,246	403,339	1,469,280	4,289,865		4,289,865	(457,883)	3,831,982			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 Bridgeport #0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			58,632	58,632		58,632	65,388	124,020			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,568	32,568		32,568	169,253	201,821			32
33	Real Estate Taxes							27,779	27,779			33
34	Rent-Facility & Grounds			450,000	450,000		450,000	(449,724)	276			34
35	Rent-Equipment & Vehicles			12,154	12,154		12,154	1,485	13,639			35
36	Other (specify):*			3,223	3,223		3,223	23,710	26,933			36
37	**TOTAL Ownership**			556,577	556,577		556,577	(162,109)	394,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,189	424,040	564,229		564,229	(65,649)	498,580			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,216	189,216		189,216		189,216			42
43	Other (specify):*			7,591	7,591		7,591	(7,591)				43
44	**TOTAL Special Cost Centers**		140,189	620,847	761,036		761,036	(73,240)	687,796			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,417,246	543,528	2,646,704	5,607,478		5,607,478	(693,232)	4,914,246			45

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,492)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,108)	30		9
10	Interest and Other Investment Income	(2,573)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(159,858)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,186)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (225,846)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(467,386)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (467,386)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (693,232)		37

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

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

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

Aperion Care Bridgeport

ID# 0052688

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Alllowable Legal	$ (1,368)	19	1
2	Bank Charges	(5,637)	21	2
3	Theft & Damage Loss	(741)	21	3
4	Supplemental Insurance	(825)	21	4
5	Credit Card Processing	(369)	21	5
6	Marketing	(7,591)	43	6
7	Amortization	(3,223)	36	7
8	Additional R&M	8,242	06	8
9	Non Allowable Seminar	(47)	24	9
10	PAC Dues	(9,737)	20	10
11	Bldg Co - Licenses and permits	(245)	20	11
12	Bldg Co - Accounting Fees	(11,330)	19	12
13	Bldg Co - Amortization	(3,978)	36	13
14	Bldg Co - State Replacement Tax	(805)	21	14
15	Prior Period Professional Fees	(532)	19	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**	(38,186)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Aperion Care Bridgeport

IDF **0052688**

Report Period Beginning: **01/01/20**

Ending: **12/31/20**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		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

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				10,954								10,954	1
2	Food Purchase	(129)		60									(69)	2
3	Housekeeping			21			205						227	3
4	Laundry													4
5	Heat and Other Utilities	(10,492)					439						(10,053)	5
6	Maintenance	8,242		1,090	(11,779)		699						(1,748)	6
7	Other (specify):*			114	1,426								1,540	7
8	**TOTAL General Services**	(2,379)		1,285	601		1,344						851	8
	B. Health Care and Programs													
9	Medical Director			1,089									1,089	9
10	Nursing and Medical Records			2,832	(30,390)		41						(27,517)	10
10a	Therapy													10a
11	Activities			12									12	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			315	4,222								4,537	15
16	**TOTAL Health Care and Programs**			4,248	(26,168)		41						(21,879)	16
	C. General Administration													
17	Administrative			(207,009)									(207,009)	17
18	Directors Fees													18
19	Professional Services	(13,230)	23,330	17,779	1,641	(173,868)	802	(4,884)				(639)	(149,069)	19
20	Fees, Subscriptions & Promotions	(20,482)	245	2,766	20	311	3						(17,137)	20
21	Clerical & General Office Expenses	(168,235)	805	20,713	302	67,055	640						(78,720)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(47)		168	101	31							253	24
25	Other Admin. Staff Transportation			902	8								910	25
26	Insurance-Prop.Liab.Malpractice			371									371	26
27	Other (specify):*			5,357		8,190							13,547	27
28	**TOTAL General Administration**	(201,994)	24,380	(158,953)	2,072	(98,281)	1,445	(4,884)				(639)	(436,855)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(204,373)	24,380	(153,421)	(23,495)	(98,281)	2,830	(4,884)				(639)	(457,883)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(4,108)	62,513	743	128	131	5,981						65,388	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,573)	158,281	12,054			1,492						169,253	32
33	Real Estate Taxes		26,611				1,168						27,779	33
34	Rent-Facility & Grounds		(420,000)	167			(29,891)						(449,724)	34
35	Rent-Equipment & Vehicles			763		176	547						1,485	35
36	Other (specify):*	(7,201)	30,911										23,710	36
37	**TOTAL Ownership**	(13,882)	(141,684)	13,726	128	307	(20,704)						(162,109)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(63,598)	(2,051)			(65,649)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,591)											(7,591)	43
44	**TOTAL Special Cost Centers**	(7,591)							(63,598)	(2,051)			(73,240)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(225,846)	(117,304)	(139,694)	(23,367)	(97,974)	(17,874)	(4,884)	(63,598)	(2,051)		(639)	(693,232)	45

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 420,000	900 East Corporation Street LLC		$	$ (420,000)	1
2	V	20	Licenses and permits		900 East Corporation Street LLC		245	245	2
3	V	19	Accounting Fees		900 East Corporation Street LLC		11,330	11,330	3
4	V	36	Amortization		900 East Corporation Street LLC		3,978	3,978	4
5	V	36	Insurance - MIP		900 East Corporation Street LLC		26,933	26,933	5
6	V	19	Bookeeping Fees - Aperion		900 East Corporation Street LLC		12,000	12,000	6
7	V	33	Real Estate Tax		900 East Corporation Street LLC		26,611	26,611	7
8	V	21	State Replacement Tax		900 East Corporation Street LLC		805	805	8
9	V	30	Depreciation Expense		900 East Corporation Street LLC		62,513	62,513	9
10	V	32	Interest	229	900 East Corporation Street LLC		158,281	158,281	10
11	V								11
12	V								12
13	V								13
14	Total			$ 420,229			$ 302,925	$ * (117,304)	14

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	FREDRICK S. FRANKEL TRUST	1.50%	Aperion Care Bradley	Bradley	900 East Corporation Street LLC		Building Co.	1
2	STEVEN TUROFSKY	1.50%	Aperion Care Burbank	Burbank	Aperion Care Demotte	Demotte, IN	ALF	2
3	DECLARATION OF TRUST OF YOSEF MEYSTEL	48.50%	Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	DAVID A BERKOWITZ REVOCABLE TRUST	48.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5			Aperion Care Demotte	Demotte,IN	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Dolton	Dolton	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Elgin	Elgin	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Evanston	Evanston	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Fairfield	Fairfield	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Forest Park	Forest Park	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Glenwood	Glenwood	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Highwood	Highwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care International	Chicago	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care Jacksonville	Jacksonville	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Kokomo	Kokomo, IN	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Litchfield	Litchfield	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Marion	Marion, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marseilles	Marseilles	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Mascoutah	Mascoutah	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Midlothian	Midlothian	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Morton Villa	Morton	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Oak Lawn	Oak Lawn				22
23			Aperion Care Peoria Heights	Peoria Heights				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Plum Grove	Palatine				25
26			Aperion Care Princeton	Princeton				26
27			Aperion Care Spring Valley	Spring Valley				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			Aperion Care Toluca	Toluca				1
2			Aperion Care West Chicago	Springfield				2
3			Aperin Care West Ridge	Chicago				3
4			Aperion Care Wilmington	Wilmington				4
5			Arbors at Michigan City	Michigan City, IN				5
6			Elevate Care Chicago North	Chicago				6
7			Elevate Care Irving Park	Chicago				7
8			Elevate Care Niles	Niles				8
9			Elevate Care North Branch	Niles				9
10			Elevate Care Northbrook	Northbrook				10
11			Elevate Care Riverwoods	Riverwoods				11
12			Elevate Care Waukegan	Waukegan				12
13			Arcadia of Bloomington	Bloomington				13
14			Arcadia of Danville	Danville				14
15			Arcadia of Clifton	Clifton				15
16			Glennon Place	Bolivar, MO				16
17			Hallmark Living Benton Harbor	Benton Harbo, MI				17
18			Legend Healthcare	Tonganoxie, KS				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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	Aperion Care, Inc.		$ 60	$ 60	15
16	V	3	Housekeeping		Aperion Care, Inc.		21	21	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,026	1,026	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		64	64	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		114	114	19
20	V	9	Medical Director		Aperion Care, Inc.		1,089	1,089	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,832	2,832	21
22	V	11	Activities		Aperion Care, Inc.		12	12	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		315	315	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		27,123	27,123	24
25	V	19	Professional Fees		Aperion Care, Inc.		4,865	4,865	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,766	2,766	26
27	V	21	Clerical Salary		Aperion Care, Inc.		19,954	19,954	27
28	V	21	Clerical & General		Aperion Care, Inc.		759	759	28
29	V	24	Seminars		Aperion Care, Inc.		168	168	29
30	V	25	Auto & Travel		Aperion Care, Inc.		902	902	30
31	V	26	Insurance		Aperion Care, Inc.		371	371	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		5,357	5,357	32
33	V	30	Depreciaiton		Aperion Care, Inc.		743	743	33
34	V	32	Interest		Aperion Care, Inc.		12,054	12,054	34
35	V	34	Rent		Aperion Care, Inc.		167	167	35
36	V	35	Auto Lease		Aperion Care, Inc.		763	763	36
37	V	17	Management Fee	234,133	Aperion Care, Inc.			(234,133)	37
38	V	19	Home Office	(12,914)	Aperion Care, Inc.			12,914	38
39	Total			$ 221,219			$ 81,525	$ * (139,694)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	$	Aperion Consulting, LLC		$ 10,954	$ 10,954	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,854	1,854	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		40	40	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,426	1,426	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		37,292	37,292	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		4,222	4,222	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,641	1,641	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		20	20	22
23	V	21	Clerical & General		Aperion Consulting, LLC		302	302	23
24	V	24	Seminars		Aperion Consulting, LLC		101	101	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		8	8	25
26	V	30	Depreciation		Aperion Consulting, LLC		128	128	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 81,355			$ 57,988	$ * (23,367)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		2,094	$ 2,094	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		311	311	16
17	V	21	Clerical & General		Aperion Financial, LLC		39,497	39,497	17
18	V	24	Seminars		Aperion Financial, LLC		31	31	18
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		4,787	4,787	19
20	V	30	Depreciaiton		Aperion Financial, LLC		131	131	20
21	V	35	Equipment Rental		Aperion Financial, LLC		176	176	21
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		27,558	27,558	22
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		3,403	3,403	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	19	Home Office Expense	175,962	Aperion Financial, LLC			(175,962)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,962			$ 77,988	$ * (97,974)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Chase Office, LLC		$ 439	$ 439	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		699	699	16
17	V	3	Housekeeping		Chase Office, LLC		205	205	17
18	V	10	Medical Supplies		Chase Office, LLC		41	41	18
19	V	19	Professional Fees		Chase Office, LLC		802	802	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		640	640	21
22	V	30	Depreciation		Chase Office, LLC		5,981	5,981	22
23	V	32	Interest Expense		Chase Office, LLC		1,492	1,492	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,168	1,168	24
25	V	35	Equipment Rental		Chase Office, LLC		547	547	25
26	V	34	Rent	30,000	Chase Office, LLC		109	(29,891)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 30,000			$ 12,126	$ * (17,874)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 21,319	ProPay HR LLC		$ 16,435	$ (4,884)	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			$ 21,319			$ 16,435	$ * (4,884)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 416,427	Renewal Rehab, LLC		$ 352,829	$ (63,598)	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			$ 416,427			$ 352,829	$ * (63,598)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 3,602	Lifescan Labs of Illinois		$ 1,551	$ (2,051)	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			$ 3,602			$ 1,551	$ * (2,051)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 21,641	Aperion Incorporated Cell		$ 21,641	$	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			$ 21,641			$ 21,641	$ *	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Data Processing	$ 4,200	EMSA Purchasing Group		$ 3,561	$ (639)	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			$ 4,200			$ 3,561	$ * (639)	39

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.51	1.27%	Alloc. Salary	$ 3,184	17-7	1
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.51	1.27%	Alloc. Salary	1,463	17-7	2
3	Fred Frankel	Owner	Administrative	0.00%	See Attached	0.51	1.27%	Alloc. Salary	3,184	17-7	3
4	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.51	1.27%	Alloc. Salary	3,184	17-7	4
5	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.51	1.27%	Alloc. Salary	749	21-7	5
6	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.35	1.27%	Alloc. Salary	395	21-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 12,159		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 Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Census/Direct Cost	1,899,996	65	$ 4,717	$	24,198	$ 60	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		24,198	21	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	24,198	1,026	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		24,198	64	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		24,198	114	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		24,198	1,089	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	24,198	2,832	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		24,198	12	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		24,198	315	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	24,198	27,123	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		24,198	4,865	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		24,198	2,766	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	24,198	19,954	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		24,198	759	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		24,198	168	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		24,198	902	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		24,198	371	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		24,198	5,357	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		24,198	743	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		24,198	12,054	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		24,198	167	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		24,198	763	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 81,525	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	$ 498,880	$ 498,880	24,198	$ 10,954	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	24,198	1,854	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		24,198	40	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		24,198	1,426	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	24,198	37,292	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		24,198	4,222	6
7	19	Professional Fees	Census	1,488,113	65	100,933		24,198	1,641	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		24,198	20	8
9	21	Clerical & General	Census	1,488,113	65	18,558		24,198	302	9
10	24	Seminars	Census	1,488,113	65	6,182		24,198	101	10
11	25	Auto & Travel	Census	1,488,113	65	484		24,198	8	11
12	30	Depreciation	Census	1,488,113	46	7,885		24,198	128	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					$ 2,676,688	$ 2,281,729		$ 57,988	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

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: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380		24,198	2,094	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		24,198	311	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	24,198	39,497	3
4	24	Seminars	Census	1,899,996	65	2,428		24,198	31	4
5	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		24,198	4,787	5
6	30	Depreciaiton	Census	1,899,996	65	10,323		24,198	131	6
7	35	Equipment Rental	Census	1,899,996	65	13,849		24,198	176	7
8	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	24,198	27,558	8
9	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		24,198	3,403	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					$ 5,678,004	$ 4,811,281		$ 77,988	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: Chase Office, LLC
Street Address: 4655 W. Chase Ave.
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 262-3800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	$ 34,497	$	24,198	$ 439	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		24,198	699	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		24,198	205	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		24,198	41	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		24,198	802	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		24,198	3	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		24,198	640	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		24,198	5,981	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		24,198	1,492	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		24,198	1,168	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		24,198	547	11
12	34	Rent	Actual Census	1,899,996	64	42,922		24,198	109	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					$ 952,148	$		$ 12,126	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W. Main St.
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: ((847) 905 3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 16,435	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					$	$		$ 16,435	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: Renewal Rehab, LLC
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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		59	$	$		$ 352,829	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					$	$		$ 352,829	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: LIFESCAN LABS OF ILLINOIS, LLC
Street Address: 5255 GOLF RD
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847) 663 - 8300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 1,551	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					$	$		$ 1,551	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 21,641	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					$	$		$ 21,641	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [X] NO [ ]

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

Name of Related Organization: EMSA PURCHASING GROUP
Street Address: 4655 W. CHASE AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 262-3800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct			$	$		$ 3,561	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					$	$		$ 3,561	25

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capital One		X	Mortgage			$	$ 3,773,722			$ 158,510	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Insurance Policies		X								948	6
7	First Midwest Bank		X	Line of Credit				674,744			31,620	7
8												8
9	TOTAL Facility Related						$	$ 4,448,466			$ 191,078	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,573)	10
11	Interest Income - Bldg Co		X								(229)	11
12	Allocated from Aperion Care	X									12,054	12
13	Allocated from Chase Office	X									1,492	13
14	TOTAL Non-Facility Related						$	$			$ 10,744	14
15	TOTALS (line 9+line14)						$	$ 4,448,466			$ 201,822	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,933 Line # 36

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

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 29,100	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.)		$ 28,344	2
3. Under or (over) accrual (line 2 minus line 1).		$ (756)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 28,535	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.)		$	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.		$ 27,779	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	27,327	8
	2016	27,116	9
	2017	28,113	10
	2018	28,077	11
	2019	27,176	12

2020 Accrual = $27,176 x 1.05 = $28,535

Allocated from Chase Office $1,168

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bridgeport COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0052688

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-000-701-0A	Long Term Care Property	$ 27,175.80	$ 27,175.80
2.	10-27-307-027-0000	Allocated From Chase Office	$ 72,110.55	$ 872.47
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 99,286.35	$ 28,048.27

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Bridgeport COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0052688

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	2,014		$ 180,000	1
2	Allocated from Chase Office LLC			751	2
3	TOTALS	2,014		$ 180,751	3

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2014	1976	$ 2,438,000	$ 62,513	39	$ 62,513	$ (0)	$ 437,591	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	21,608		20	836	836	12,390	9
10	Various			2015	17,500		20	875	875	14,667	10
11	Various			2016	7,598		20	380	380	1,652	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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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											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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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	Related Building Company (Pages 12F & 12G)		259,158			12,958	12,958	12,958	67
68	Related Party Allocations (Pages 12H & 12I)		46,736	3,298		2,172	(1,126)	9,251	68
69	Financial Statement Depreciation			58,632			(58,632)		69
70	TOTAL (lines 4 thru 69)		$ 2,790,600	$ 124,443		$ 79,734	$ (44,709)	$ 488,508	70

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 2,790,600	$ 124,443		$ 79,734	$ (44,709)	$ 488,508	1
2	Electrical In Rms 14 & 50- Remove And Install New Ductless Syst	2017	4,934		20	247	247	946	2
3	Carpet, Tiling, Cove Base - Living & Activity Rooms	2017	4,023		20	201	201	804	3
4	Water Heater - Boiler Room	2017	5,910		20	296	296	1,109	4
5	Air Conditioner - Indoor & Outdoor Unit	2017	3,482		20	174	174	609	5
6	Kitchen-Basket Strainer,Drain Pipe,New Trap,Other Piping,Wate	2017	3,445		20	172	172	545	6
7	120 Gal Electric Water Heater	2018	6,100		20	305	305	712	7
8	2 Fujitsu Ductless Split Four Rooms	2018	21,680		20	1,084	1,084	2,620	8
9	13 Kw Cummins Generator On Mounting Pad	2018	7,355		20	368	368	828	9
10	New Control Panel & Fuse Boxes For Generator	2018	2,583		20	129	129	290	10
11	Water Heaters And Flooring (13,429)	2018	13,332		20	667	667	1,945	11
12	Roof (146,226)	2018	144,096		20	7,205	7,205	18,613	12
13	Pavement Sealing And Striping (7,709)	2018	7,079		20	354	354	826	13
14	Asphalt Patch (6,100)	2018	5,616		20	281	281	655	14
15	Air Conditioning Units	2018	5,741		20	287	287	694	15
16	Replaced Electrical Panels In Hallway (9,886)	2018	8,894		20	445	445	1,112	16
17	Storage Unit	2019	6,301		20	315	315	604	17
18	Replace Roof Top Unit W/5 Ton Gas Electric Contained Unit	2019	8,950		20	448	448	672	18
19	Replaced Electric Panels In Hallway 1 And 2	2019	6,400		20	320	320	640	19
20	Plumbing	2019	3,916		20	196	196	392	20
21	Baseboard Heaters & Thermostats-Rms 1,3,12,14,18,19,21,22,23,2	2019	2,738		20	137	137	274	21
22	32 Channel Camera Monitor	2020	15,797		20	790	790	790	22
23	32 Cat5E Cables For Voice	2020	7,400		20	370	370	370	23
24	Installation Of Electric Water Heater (8,177)	2020	7,803		20	390	390	390	24
25	Installation Of In-Ground Drainage (18,212)	2020	16,678		20	834	834	834	25
26	Replacement Of 2 Ductless Split Systems For Rooms 3 & 5 (8,380)	2020	7,219		20	361	361	361	26
27	Seeding & Strawing Of Grass For Damage Caused By Drain Line	2020	4,408		20	220	220	220	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	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)		$ 3,122,480	$ 124,443		$ 96,330	$ (28,113)	$ 526,364	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Replace Flooring, Handrails, Ceiling Tiles, Light in Common Are	2020	250,000		20	12,500	12,500	12,500	9
10	Water Softener	2020	9,158		20	458	458	458	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)		$ 259,158	$		$ 12,958	$ 12,958	$ 12,958	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 259,158	$		$ 12,958	$ 12,958	$ 12,958	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 259,158	$		$ 12,958	$ 12,958	$ 12,958	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	6,761	173	20	173		766	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	379	61	20	19	(42)	190	9
10	Allocated from Aperion Care	2012	108	8	20	5	(3)	43	10
11	Allocated from Aperion Care	2013	46	6	20	2	(4)	16	11
12									12
13	Allocated from Chase Office LLC	2020	135		20	7	7	7	13
14	Allocated from Chase Office LLC	2019	3,444	156	20	172	16	344	14
15	Allocated from Chase Office LLC	2018	31	2	20	2	(0)	5	15
16	Allocated from Chase Office LLC	2017	1,565	383	20	78	(304)	313	16
17	Allocated from Chase Office LLC	2016	34,268	2,509	20	1,713	(795)	7,568	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)		$ 46,736	$ 3,298		$ 2,172	$ (1,126)	$ 9,251	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 46,736	$ 3,298		$ 2,172	$ (1,126)	$ 9,251	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 46,736	$ 3,298		$ 2,172	$ (1,126)	$ 9,251	34

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

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 259,412	$ 3,542	$ 25,669	$ 22,127	10	$ 141,385	71
72	Current Year Purchases	14,704	22	1,472	1,450	10	1,472	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 274,117	$ 3,564	$ 27,141	$ 23,577		$ 142,857	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	2020	$ 2,743	$ 121	$ 549	$ 428	5	$ 1,374	76
77										77
78										78
79										79
80	TOTALS			$ 2,743	$ 121	$ 549	$ 428		$ 1,374	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)	$ 3,580,091	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,128	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,020	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,108)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 670,595	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	Reno - kitchen, laundry rm,	$ 2,585,575	92
93	plumbing, pt, gym additions		93
94			94
95		$ 2,585,575	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.

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Chase Office				109			5
6	Allocated from Aperion Care				167			6
7	TOTAL				$ 276 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 12,877 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		$	$ 763	17
18					18
19					19
20					20
21	TOTAL		$	$ 763	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 Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

	1	2	3	4	5	6	7	8	
	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	$		$ 145,843	$		$ 145,843	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			123,724			123,724	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			146,859			146,859	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 prescrpts				118,054		118,054	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					7,614	22,135		29,749	13
14	TOTAL			$		$ 424,040	$ 140,189		$ 564,229	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.

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Bridgeport **#** 0052688 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/20 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 568,963	$ 601,835	1
2	Cash-Patient Deposits	250	250	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	575,680	575,680	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,139	53,139	6
7	Other Prepaid Expenses		6,150	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	11	131,580	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,198,043	$ 1,368,634	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		2,438,000	14
15	Leasehold Improvements, at Historical Cost	365,109	624,267	15
16	Equipment, at Historical Cost	174,007	326,007	16
17	Accumulated Depreciation (book methods)	(195,141)	(776,917)	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): See Attached	4,182,893	4,294,944	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,526,868	$ 7,086,301	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,724,911	$ 8,454,935	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,743	$ 218,743	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	674,744	674,744	29
30	Accrued Salaries Payable	136,457	136,457	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,799	2,799	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,535	32
33	Accrued Interest Payable	1,733	14,312	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	536,296	536,296	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,570,772	$ 1,611,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,773,722	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,867,779	2,867,779	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,867,779	$ 6,641,501	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,438,551	$ 8,253,387	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,286,360	$ 201,548	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,724,911	$ 8,454,935	48

***(See instructions.)**

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 872,816	1
2	Restatements (describe):		2
3	Bad Debt	(37,162)	3
4	Rounding	(2)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 835,652	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	450,708	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)**	$ 450,708	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)**	$ 1,286,360	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,637,685	1
2	Discounts and Allowances for all Levels	525,049	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,162,734	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,875	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,875	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	6,842	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87	19
20	Radiology and X-Ray	23	20
21	Other Medical Services	6,037	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,989	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,573	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,573	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	617,015	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 617,015	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,058,186	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	739,409	31
32	Health Care	2,125,207	32
33	General Administration	1,425,249	33
	B. Capital Expense		
34	Ownership	556,577	34
	C. Ancillary Expense		
35	Special Cost Centers	571,820	35
36	Provider Participation Fee	189,216	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,607,478	40
41	**Income before Income Taxes (line 30 minus line 40)****	450,708	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 450,708	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 587,220	44
45	Private Pay - Net Inpatient Revenue	438,017	45
46	Medicare - Net Inpatient Revenue	1,405,103	46
47	Other-(specify) Insurance	123,037	47
48	Other-(specify) Managed Care	2,609,357	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,162,734	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 Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,192	2,264	$ 87,922	$ 38.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,395	6,929	218,826	31.58	3
4	Licensed Practical Nurses	18,610	20,222	543,031	26.85	4
5	CNAs & Orderlies	38,048	41,418	614,150	14.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,999	2,191	55,309	25.24	8
9	Activity Director	1,872	2,160	34,917	16.17	9
10	Activity Assistants	8,946	9,386	94,242	10.04	10
11	Social Service Workers	4,938	5,360	141,593	26.42	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,414	38,083	15.78	13
14	Head Cook	1,596	1,786	16,857	9.44	14
15	Cook Helpers/Assistants	11,489	12,214	118,655	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,074	2,186	42,064	19.24	17
18	Housekeepers	9,141	9,592	100,747	10.50	18
19	Laundry	3,617	4,286	41,225	9.62	19
20	Administrator	1,944	2,160	108,595	50.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,992	4,320	109,310	25.30	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	1,705	1,787	18,149	10.16	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,227	2,389	33,571	14.05	33
34	TOTAL (lines 1 - 33)	122,785	133,063	$ 2,417,246 *	$ 18.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	151	$ 7,944	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	232	10,802	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	2,025	11-03	44
45	Social Service Consultant	26	1,980	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	436	$ 99,433		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	109	3,896	10-03	52
53	TOTAL (lines 50 - 52)	109	$ 3,896		53

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Haynes	Administrator	0	$ 108,595
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,595

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	$ 234,133
TOTAL (agree to Schedule V, line 17, col. 3)	$ 234,133
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 19,055
National Datacare Corporation	Resident Trust Fund Services	2,286
Interbuild	Energy Procurement	953
GCHMO	Liaison Service	4,900
Personnel Planners	Unemployment Consultant	1,100
NRC Health	Data Processing	2,103
Pinnacle Financial Services	Financial Consultant	1,532
Ability Network Inc.	Eligibility Sfoftware	6,468
Aperion Care	Data Processing	21,294
Creative Technology Solutions	IT Consulting	5,530
See Attached	Legal	8,331
See Supplemental Schedule		231,585
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 305,136

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,510
Unemployment Compensation Insurance	14,690
FICA Taxes	184,919
Employee Health Insurance	64,968
Employee Meals	106
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	1,285
Employee Physicals	240
Employee Benefits - Other	16,871
Employee Benefit Other - Covid	3,132
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,721

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,543
Health Care Worker Background Check	1,550
(Indicate # of checks performed 155)	
Patient Background Checks 70	705
Dues & Subscriptions	13,417
Licenses & Fees	903
See Supplemental Schedule	3,100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	656
See Supplemental Schedule	300
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 956

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Bridgeport # 0052688 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 $19,475**

(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. $ **10,750** 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. $ **189,216**
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 benefits on Schedule V. $ **106** 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? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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 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.