		FOR BHF USE			

LL1

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: 0048496

Facility Name: Aperion Care Burbank

Address: 5701 W 79th Street (Number) Burbank (City) 60459 (Zip Code)

County: Cook

Telephone Number: (708) 499-5400 Fax # (708) 499-5571

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2006

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		

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

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,496	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	56	TOTALS	56	20,496	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,103	1,066	8,270	19,439	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,103	1,066	8,270	19,439	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.84%

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 10/1/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2006 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 7,424

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 Burbank # 0048496 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	242,083	17,614	21,522	281,219		281,219	(12,722)	268,497			1
2	Food Purchase		116,290		116,290		116,290	(16)	116,274			2
3	Housekeeping	87,103	46,206		133,309		133,309	182	133,491			3
4	Laundry	66,025	10,627	82,081	158,733		158,733		158,733			4
5	Heat and Other Utilities			89,036	89,036		89,036	(6,587)	82,449			5
6	Maintenance	81,178	17,521	110,430	209,129		209,129	(13,182)	195,947			6
7	Other (specify):*							1,237	1,237			7
8	TOTAL General Services	476,389	208,258	303,069	987,716		987,716	(31,087)	956,629			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000	875	24,875			9
10	Nursing and Medical Records	1,627,442	155,893	76,022	1,859,357		1,859,357	(35,416)	1,823,941			10
10a	Therapy	99,038			99,038		99,038		99,038			10a
11	Activities	109,306	5,534	1,804	116,644		116,644	9	116,653			11
12	Social Services	100,864		1,966	102,830		102,830		102,830			12
13	CNA Training											13
14	Program Transportation			7,097	7,097		7,097		7,097			14
15	Other (specify):*							3,645	3,645			15
16	TOTAL Health Care and Programs	1,936,650	161,427	110,889	2,208,966		2,208,966	(30,887)	2,178,079			16
	C. General Administration											
17	Administrative	143,092		346,733	489,825		489,825	(324,944)	164,881			17
18	Directors Fees											18
19	Professional Services			357,835	357,835	(400)	357,435	(233,730)	123,705			19
20	Dues, Fees, Subscriptions & Promotions			27,989	27,989		27,989	(12,369)	15,620			20
21	Clerical & General Office Expenses	64,268		308,578	372,846		372,846	(198,735)	174,111			21
22	Employee Benefits & Payroll Taxes			441,411	441,411		441,411		441,411			22
23	Inservice Training & Education											23
24	Travel and Seminar			932	932		932	241	1,173			24
25	Other Admin. Staff Transportation			181	181		181	731	912			25
26	Insurance-Prop.Liab.Malpractice			257,770	257,770		257,770	298	258,068			26
27	Other (specify):*							10,883	10,883			27
28	TOTAL General Administration	207,360		1,741,429	1,948,789	(400)	1,948,389	(757,626)	1,190,763			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,620,399	369,685	2,155,387	5,145,471	(400)	5,145,071	(819,600)	4,325,471			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 Burbank #0048496 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		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			89,666	89,666		89,666	35,341	125,007			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,201	50,201		50,201	289,354	339,555			32
33	Real Estate Taxes					400	400	272,320	272,720			33
34	Rent-Facility & Grounds			930,000	930,000		930,000	(929,778)	222			34
35	Rent-Equipment & Vehicles			5,633	5,633		5,633	1,194	6,827			35
36	Other (specify):*			3,396	3,396		3,396	37,984	41,380			36
37	TOTAL Ownership			1,078,896	1,078,896	400	1,079,296	(293,585)	785,711			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,836	631,941	780,777		780,777	(106,422)	674,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,571	98,571		98,571		98,571			42
43	Other (specify):*			3,187	3,187		3,187	(3,187)				43
44	TOTAL Special Cost Centers		148,836	733,699	882,535		882,535	(109,609)	772,926			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,620,399	518,521	3,967,982	7,106,902		7,106,902	(1,222,794)	5,884,108			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 Burbank # 0048496 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 Refer- ence	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	(6,940)	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	8,761	30		9
10	Interest and Other Investment Income	(2,179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	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	(171)	21		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	(243,124)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,746)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,899)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (326,862)		$	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)	(895,932)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (895,932)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,222,794)		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 Burbank

ID# 0048496

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (1,368)	19	1
2	Bank Charges	(6,060)	21	2
3	Theft & Damage Loss	(170)	21	3
4	Supplemental Insurance	(12,663)	21	4
5	Credit Card Processing	(64)	21	5
6	Advertising/Marketing	(209)	43	6
7	Marketing - Food	(1,612)	43	7
8	Promotional Products	(232)	43	8
9	Amortization	(3,396)	36	9
10	Additional R&M	4,960	06	10
11	Capitalized R&M	(7,426)	06	11
12	PAC Dues	(4,359)	20	12
13	Senior Living Media	(1,134)	43	13
14	Bldg Co - Accounting	(11,330)	19	14
15	Bldg Co - Amortization	(4,560)	36	15
16	Bldg Co - License & Permits	(245)	20	16
17	Bldg Co - State Replacement Tax	(2,500)	21	17
18	Prior Period Professional Fees	(532)	19	18
19	Bldg Co - Bookkeeping Fees	(12,000)	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**	(64,899)		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 Burbank

ID# 0048496

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Burbank # 0048496 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				(12,722)								(12,722)	1
2	Food Purchase	(64)		48									(16)	2
3	Housekeeping			17			165						182	3
4	Laundry													4
5	Heat and Other Utilities	(6,940)					353						(6,587)	5
6	Maintenance	(2,466)		875	(12,152)		562						(13,182)	6
7	Other (specify):*			92	1,145								1,237	7
8	**TOTAL General Services**	(9,470)		1,032	(23,729)		1,080						(31,087)	8
	B. Health Care and Programs													
9	Medical Director			875									875	9
10	Nursing and Medical Records			2,275	(37,724)		33						(35,416)	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			253	3,392								3,645	15
16	**TOTAL Health Care and Programs**			3,412	(34,332)		33						(30,887)	16
	C. General Administration													
17	Administrative			(324,944)									(324,944)	17
18	Directors Fees													18
19	Professional Services	(25,229)	23,330	13,087	1,318	(242,384)	5	(3,856)					(233,730)	19
20	Fees, Subscriptions & Promotions	(15,104)	245	2,222	16	250	3						(12,369)	20
21	Clerical & General Office Expenses	(272,498)	2,500	16,640	242	53,867	514						(198,735)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			135	81	25							241	24
25	Other Admin. Staff Transportation			725	6								731	25
26	Insurance-Prop.Liab.Malpractice			298									298	26
27	Other (specify):*			4,304		6,579							10,883	27
28	**TOTAL General Administration**	(312,831)	26,075	(287,535)	1,663	(181,663)	522	(3,856)					(757,626)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(322,301)	26,075	(283,090)	(56,398)	(181,663)	1,634	(3,856)					(819,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Burbank # 0048496 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	8,761	20,970	597	103	106	4,804						35,341	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,179)	280,652	9,683			1,198						289,354	32
33	Real Estate Taxes		271,381				939						272,320	33
34	Rent-Facility & Grounds		(900,000)	134			(29,913)						(929,778)	34
35	Rent-Equipment & Vehicles			613		142	439						1,194	35
36	Other (specify):*	(7,956)	45,940										37,984	36
37	**TOTAL Ownership**	(1,374)	(281,057)	11,027	103	248	(22,532)						(293,585)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(96,145)		(10,277)		(106,422)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,187)											(3,187)	43
44	**TOTAL Special Cost Centers**	(3,187)							(96,145)		(10,277)		(109,609)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(326,862)	(254,983)	(272,063)	(56,295)	(181,415)	(20,897)	(3,856)	(96,145)		(10,277)		(1,222,794)	45

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 900,000	Exceptional Care NRC Realty LLC		$	$ (900,000)	1
2	V	19	Accounting Fees		Exceptional Care NRC Realty LLC		11,330	11,330	2
3	V	36	Amortization Expense		Exceptional Care NRC Realty LLC		4,560	4,560	3
4	V	19	Bookeeping Fee		Exceptional Care NRC Realty LLC		12,000	12,000	4
5	V	36	Insurance Expense - MIP		Exceptional Care NRC Realty LLC		41,380	41,380	5
6	V	20	Licenses & Permits		Exceptional Care NRC Realty LLC		245	245	6
7	V	33	Real Estate Taxes		Exceptional Care NRC Realty LLC		271,381	271,381	7
8	V	21	State Replacement Tax		Exceptional Care NRC Realty LLC		2,500	2,500	8
9	V	30	Depreciation		Exceptional Care NRC Realty LLC		20,970	20,970	9
10	V	32	Interest	121	Exceptional Care NRC Realty LLC		280,773	280,652	10
11	V								11
12	V								12
13	V								13
14	Total			$ 900,121			$ 645,138	$ * (254,983)	14

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

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Burbank # 0048496 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	Declaration of Trust of Yosef Meystel	60.00%	Aperion Care Bradley	Bradley	Exceptional Care NRC Realty LLC		Building Co.	1
2	1219 Limited Partnership	10.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	42170 Limited Partnership	10.00%	Aperion Care Capitol	Capitol	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Chesed L'Avrohom Nachlas David	1.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	257 Limited Partnership	19.00%	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 Burbank # 0048496 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 Burbank # 0048496 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	Aperion Care, Inc.		$ 48	$ 48	15
16	V	3	Housekeeping		Aperion Care, Inc.		17	17	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		824	824	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		51	51	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		92	92	19
20	V	9	Medical Director		Aperion Care, Inc.		875	875	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,275	2,275	21
22	V	11	Activities		Aperion Care, Inc.		9	9	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		253	253	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		21,789	21,789	24
25	V	19	Professional Fees		Aperion Care, Inc.		3,908	3,908	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,222	2,222	26
27	V	21	Clerical Salary		Aperion Care, Inc.		16,030	16,030	27
28	V	21	Clerical & General		Aperion Care, Inc.		610	610	28
29	V	24	Seminars		Aperion Care, Inc.		135	135	29
30	V	25	Auto & Travel		Aperion Care, Inc.		725	725	30
31	V	26	Insurance		Aperion Care, Inc.		298	298	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		4,304	4,304	32
33	V	30	Depreciaiton		Aperion Care, Inc.		597	597	33
34	V	32	Interest		Aperion Care, Inc.		9,683	9,683	34
35	V	34	Rent		Aperion Care, Inc.		134	134	35
36	V	35	Auto Lease		Aperion Care, Inc.		613	613	36
37	V	17	Management Fee	346,733	Aperion Care, Inc.			(346,733)	37
38	V	19	Home Office	(9,179)	Aperion Care, Inc.			9,179	38
39	Total			$ 337,555			$ 65,491	$ * (272,063)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	$	Aperion Consulting, LLC		$ 8,800	$ 8,800	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,489	1,489	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		32	32	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,145	1,145	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		29,958	29,958	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		3,392	3,392	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,318	1,318	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		16	16	22
23	V	21	Clerical & General		Aperion Consulting, LLC		242	242	23
24	V	24	Seminars		Aperion Consulting, LLC		81	81	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		6	6	25
26	V	30	Depreciation		Aperion Consulting, LLC		103	103	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	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	34
35	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,877			$ 46,582	$ * (56,295)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		1,682	$ 1,682	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		250	250	16
17	V	21	Clerical & General		Aperion Financial, LLC		31,729	31,729	17
18	V	24	Seminars		Aperion Financial, LLC		25	25	18
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		3,845	3,845	19
20	V	30	Depreciaiton		Aperion Financial, LLC		106	106	20
21	V	35	Equipment Rental		Aperion Financial, LLC		142	142	21
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		22,138	22,138	22
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		2,734	2,734	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	244,066	Aperion Financial, LLC			(244,066)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 244,066			$ 62,651	$ * (181,415)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Chase Office, LLC		$ 353	$ 353	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		562	562	16
17	V	3	Housekeeping		Chase Office, LLC		165	165	17
18	V	10	Medical Supplies		Chase Office, LLC		33	33	18
19	V	19	Professional Fees		Chase Office, LLC		644	644	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		514	514	21
22	V	30	Depreciation		Chase Office, LLC		4,804	4,804	22
23	V	32	Interest Expense		Chase Office, LLC		1,198	1,198	23
24	V	33	Real Estate Taxes		Chase Office, LLC		939	939	24
25	V	35	Equipment Rental		Chase Office, LLC		439	439	25
26	V	34	Rent	30,000	Chase Office, LLC		87	(29,913)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	19	Data Processing	4,200	Emsa Purchasing Group		3,561	(639)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 34,200			$ 13,303	$ * (20,897)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 16,833	ProPay HR LLC		$ 12,977	$ (3,856)	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			$ 16,833			$ 12,977	$ * (3,856)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 629,539	Renewal Rehab, LLC		$ 533,394	$ (96,145)	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			$ 629,539			$ 533,394	$ * (96,145)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 82,081	EcoBrite Linen		$ 82,081	$	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			$ 82,081			$ 82,081	$ *	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 18,052	Lifescan Labs of Illinois		$ 7,775	$ (10,277)	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			$ 18,052			$ 7,775	$ * (10,277)	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 213,774	Aperion Incorporated Cell		$ 213,774	$	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			$ 213,774			$ 213,774	$ *	39

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yosef Meystel	Relative	Administrative	0%	See Attached	0.41	1.02%	Alloc Salary	$ 2,558	17-7	1
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.41	1.02%	Alloc Salary	602	21-7	2
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.28	1.02%	Alloc Salary	317	21-7	3
4											4
5											5
6											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	$ 3,477		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 Burbank # 0048496 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 Burbank # 0048496 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	$	19,439	$ 48	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		19,439	17	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	19,439	824	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		19,439	51	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		19,439	92	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		19,439	875	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	19,439	2,275	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		19,439	9	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		19,439	253	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	19,439	21,789	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		19,439	3,908	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		19,439	2,222	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	19,439	16,030	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		19,439	610	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		19,439	135	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		19,439	725	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		19,439	298	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		19,439	4,304	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		19,439	597	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		19,439	9,683	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		19,439	134	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		19,439	613	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 65,491	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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	19,439	$ 8,800	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	19,439	1,489	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		19,439	32	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		19,439	1,145	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	19,439	29,958	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		19,439	3,392	6
7	19	Professional Fees	Census	1,488,113	65	100,933		19,439	1,318	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		19,439	16	8
9	21	Clerical & General	Census	1,488,113	65	18,558		19,439	242	9
10	24	Seminars	Census	1,488,113	65	6,182		19,439	81	10
11	25	Auto & Travel	Census	1,488,113	65	484		19,439	6	11
12	30	Depreciation	Census	1,488,113	46	7,885		19,439	103	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		$ 46,582	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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		19,439	1,682	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		19,439	250	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	19,439	31,729	3
4	24	Seminars	Census	1,899,996	65	2,428		19,439	25	4
5	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		19,439	3,845	5
6	30	Depreciaiton	Census	1,899,996	65	10,323		19,439	106	6
7	35	Equipment Rental	Census	1,899,996	65	13,849		19,439	142	7
8	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	19,439	22,138	8
9	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		19,439	2,734	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		$ 62,651	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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 and Emsa Purchasing Group
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	$	19,439	$ 353	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		19,439	562	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		19,439	165	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		19,439	33	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		19,439	644	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		19,439	3	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		19,439	514	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		19,439	4,804	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		19,439	1,198	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		19,439	939	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		19,439	439	11
12	34	Rent	Actual Census	1,899,996	64	42,922		19,439	87	12
13										13
14										14
15										15
16										16
17										17
18	19	Data Processing	Direct						3,561	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 952,148	$		$ 13,303	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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			$	$		$ 12,977	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					$	$		$ 12,977	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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	$	$		$ 533,394	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					$	$		$ 533,394	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
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	4	Laundry Services	Direct			$	$		$ 82,081	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					$	$		$ 82,081	25

Facility Name & ID Number Aperion Care Burbank # 0048496 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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: ( )

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.

	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			$	$		$ 7,775	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					$	$		$ 7,775	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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			$	$		$ 213,774	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					$	$		$ 213,774	25

Facility Name & ID Number Aperion Care Burbank # 0048496 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital One		X	Mortgage			$	$ 6,684,485			$ 280,773	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				1,329,037			49,258	6
7	Insurance Policies		X	Insurance							943	7
8												8
9	TOTAL Facility Related						$	$ 8,013,522			$ 330,974	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,179)	10
11	Interest Income - Bldg Co		X								(121)	11
12	Allocated from Aperion Care	X									9,683	12
13	Allocated from Chase Office	X									1,198	13
14	TOTAL Non-Facility Related						$	$			$ 8,581	14
15	TOTALS (line 9+line14)						$	$ 8,013,522			$ 339,555	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 41,380 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 Burbank # 0048496 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	268,976	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.)	$	264,615	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,361)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	276,680	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.)**	$	400	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.	$	272,719	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	183,130	8
	2016	190,210	9
	2017	247,687	10
	2018	256,167	11
	2019	263,676	12

2020 Accrual = $263,676 x 1.05 = $276,680

Allocated from Chase Office $939

	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 Burbank COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048496

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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	19-32-204-006-0000	Long-Term Care Property	$ 6,813.88	$ 6,813.88
2.	19-32-205-023-0000	Long-Term Care Property	$ 256,862.32	$ 256,862.32
3.	10-27-307-027-0000	Alloc. From Chase Office, LLC	$ 72,110.55	$ 700.88
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 335,786.75	$ 264,377.08

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 Burbank COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048496

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 Burbank # 0048496 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,728 B. General Construction Type: Exterior Brick Frame Steel 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	$ 124,143	1
2	Allocated from Chase Office LLC			604	2
3	TOTALS			$ 124,747	3

Facility Name & ID Number Aperion Care Burbank # 0048496 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	56		2013	1972	$ 1,902,416	$ 20,970	39	$ 48,780	$ 27,810	$ 390,240	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	4,773		20	239	239	4,217	9
10	Various			2008	51,421		20	275	275	51,352	10
11	Various			2009	34,839		20	148	148	33,642	11
12	Various			2010	124,446		20	6,223	6,223	84,003	12
13	Various			2011	25,485		20	1,274	1,274	12,993	13
14	Various			2012	222,218		20	11,111	11,111	116,328	14
15	Various			2013	38,915		20	1,946	1,946	14,644	15
16	Various			2014	22,834		20	942	942	11,407	16
17	Various			2015	136,954		20	6,848	6,848	38,518	17
18	Various			2016	110,245		20	5,512	5,512	25,263	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Burbank # 0048496 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
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		37,545	2,649		1,745	(904)	7,431	68
69	Financial Statement Depreciation			89,666			(89,666)		69
70	TOTAL (lines 4 thru 69)		$ 2,712,091	$ 113,285		$ 85,043	$ (28,243)	$ 790,038	70

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,712,091	$ 113,285		$ 85,043	$ (28,243)	$ 790,038	1
2	Replaced Panel & Door Holders - Fire Alarm System	2017	6,029		20	301	301	1,193	2
3	200 Gallon Storage Tank - Main Water Heater	2017	6,300		20	315	315	1,089	3
4	Replace 16 Outlets In Patient Rms With Hospital Grade Level	2018	8,300		20	415	415	1,038	4
5	Resurface Parking Lot (24,803)	2018	22,988		20	1,149	1,149	2,777	5
6	Steel Railing Installation (4,008)	2018	3,645		20	182	182	440	6
7	Awnig Installation (29,123)	2018	27,090		20	1,355	1,355	3,161	7
8	Concrete Sidewalk (13,200)	2018	12,256		20	613	613	1,379	8
9	Install 24 Volt Transformer & Exterior Lighting Sensors	2018	9,865		20	493	493	1,027	9
10	Elevator Repair	2018	3,163		20	158	158	237	10
11	Nursing Station Outlet	2019	2,500		20	125	125	188	11
12	Elevator Repair	2019	4,197		20	210	210	315	12
13	Elevator Repair	2019	4,536		20	227	227	340	13
14	Generator Repair	2019	3,743		20	187	187	281	14
15	Boiler Repair	2019	2,920		20	146	146	219	15
16	Repair Patio By Main Entrance	2020	3,560		20	178	178	178	16
17	Fire Alarm System Panel (5,082)	2020	4,585		20	229	229	229	17
18	Install Elevator Motor	2020	4,736		20	237	237	237	18
19	Heater Repair-Replaced Gas Valve, Blower Motor, Temp Control	2020	2,691		20	135	135	135	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)		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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	TOTAL (lines 1 thru 33)		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,845,194	$ 113,285		$ 91,697	$ (21,588)	$ 804,501	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		$	$		$	$	$	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)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	5,432	139	20	139		615	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	305	49	20	15	(34)	152	9
10	Allocated from Aperion Care	2012	86	7	20	4	(2)	35	10
11	Allocated from Aperion Care	2013	37	5	20	2	(3)	13	11
12									12
13	Allocated from Chase Office LLC	2020	108		20	5	5	5	13
14	Allocated from Chase Office LLC	2019	2,766	126	20	138	13	277	14
15	Allocated from Chase Office LLC	2018	25	1	20	1	(0)	4	15
16	Allocated from Chase Office LLC	2017	1,257	307	20	63	(245)	251	16
17	Allocated from Chase Office LLC	2016	27,529	2,015	20	1,376	(639)	6,079	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)		$ 37,545	$ 2,649		$ 1,745	$ (904)	$ 7,431	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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		$ 37,545	$ 2,649		$ 1,745	$ (904)	$ 7,431	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)		$ 37,545	$ 2,649		$ 1,745	$ (904)	$ 7,431	34

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	$ 328,027	$ 2,845	$ 32,841	$ 29,995	10	$ 244,718	71
72	Current Year Purchases	265	18	28	10	10	28	72
73	Fully Depreciated Assets	163,702				10	163,702	73
74								74
75	TOTALS	$ 491,994	$ 2,863	$ 32,868	$ 30,005		$ 408,448	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	$ 2,204	$ 97	$ 441	$ 344	5	$ 1,103	76
77										77
78										78
79										79
80	TOTALS			$ 2,204	$ 97	$ 441	$ 344		$ 1,103	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)	$ 3,464,138	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 116,246	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 125,007	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,761	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,214,052	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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 Aperion Care				134			5
6	Allocated from Chase Office				87			6
7	TOTAL				$ 221 **			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: $ 6,214 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		$	$ 613	17
18					18
19					19
20					20
21	TOTAL		$	$ 613	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 Burbank # 0048496 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 263,416	$		$ 263,416	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			62,488			62,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			306,037			306,037	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				139,218		139,218	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						9,618		9,618	13
14	TOTAL			$		$ 631,941	$ 148,836		$ 780,777	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Aperion Care Burbank # 0048496 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	$ 530,247	$ 603,035	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,084,592	1,084,592	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,697	67,590	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	506	346,128	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,672,042	$ 2,101,345	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		239,130	13
14	Buildings, at Historical Cost		817,826	14
15	Leasehold Improvements, at Historical Cost	920,229	920,229	15
16	Equipment, at Historical Cost	380,673	662,847	16
17	Accumulated Depreciation (book methods)	(883,057)	(1,323,379)	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	8,640,783	8,769,220	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,058,628	$ 10,085,873	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,730,670	$ 12,187,218	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 501,912	$ 501,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,329,037	1,329,037	29
30	Accrued Salaries Payable	266,561	266,561	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,829	8,829	31
32	Accrued Real Estate Taxes(Sch.IX-B)		276,680	32
33	Accrued Interest Payable	3,398	25,680	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,400,203	1,400,203	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,509,940	$ 3,808,901	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,684,485	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,684,485	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,509,940	$ 10,493,386	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,220,730	$ 1,693,832	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,730,670	$ 12,187,218	48

*(See instructions.)

Facility Name & ID Number Aperion Care Burbank # 0048496 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**	$ 6,291,107	1
2	Restatements (describe):		2
3	Bad Debt	(27,206)	3
4	Rounding	(2)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,263,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,356,831	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	(400,000)	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)**	$ 956,831	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)**	$ 7,220,730	24 *

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

Facility Name & ID Number Aperion Care Burbank # 0048496 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	$ 5,157,780	1
2	Discounts and Allowances for all Levels	2,569,607	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,727,387	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	85,440	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 85,440	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	4,716	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18	19
20	Radiology and X-Ray	16	20
21	Other Medical Services	11,910	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,660	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,179	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,179	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	632,067	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 632,067	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,463,733	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	987,716	31
32	Health Care	2,208,966	32
33	General Administration	1,948,789	33
	B. Capital Expense		
34	Ownership	1,078,896	34
	C. Ancillary Expense		
35	Special Cost Centers	783,964	35
36	Provider Participation Fee	98,571	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,106,902	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,356,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,356,831	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 553,566	44
45	Private Pay - Net Inpatient Revenue	256,802	45
46	Medicare - Net Inpatient Revenue	4,822,807	46
47	Other-(specify) Insurance	359,752	47
48	Other-(specify) Managed Care	1,734,460	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,727,387	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,008	2,632	$ 130,910	$ 49.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,754	15,760	526,994	33.44	3
4	Licensed Practical Nurses	7,856	9,376	291,649	31.11	4
5	CNAs & Orderlies	35,439	39,376	677,889	17.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,526	4,061	99,038	24.39	8
9	Activity Director	1,848	1,959	40,095	20.47	9
10	Activity Assistants	4,283	4,862	69,211	14.24	10
11	Social Service Workers	3,758	4,134	100,864	24.40	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,240	51,752	23.10	13
14	Head Cook	5,311	5,753	100,804	17.52	14
15	Cook Helpers/Assistants	5,402	5,789	89,527	15.47	15
16	Dishwashers					16
17	Maintenance Workers	3,828	4,124	81,178	19.68	17
18	Housekeepers	4,642	5,375	87,103	16.21	18
19	Laundry	3,747	4,263	66,025	15.49	19
20	Administrator	2,072	2,168	143,092	66.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,757	4,019	64,268	15.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,278	115,890	$ 2,620,399 *	$ 22.61	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,522	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	Per Unit	8,340	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,804	11-03	44
45	Social Service Consultant	30	1,966	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	$ 125,314		49

C. CONTRACT NURSES

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

Facility Name & ID Number Aperion Care Burbank # 0048496 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Akeem Abiola	Administrator	0	$ 143,092
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 143,092

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	$ 346,733
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 346,733

C. Professional Services

Vendor/Payee	Type	Amount
ProPay HR	Payroll Processing	$ 16,833
Marcum LLP	Accounting	19,055
National Datacare Corporation	Resident Trust Fund Services	2,151
Achieve Accreditation	Accreditation	9,900
Interbuild	Energy Procurement	953
GCHMO	Liasion Service	4,900
Personnel Planners	Unemployment Consultant	1,000
Skidelsky & Associates	2018 Specific Objection	400
NRC Health Solutions	Data Processing	2,103
Pinnacle Financial Solutions	Financial Consultant	1,607
See Attached	Legal	8,331
See Supplemental Schedule		290,602
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 357,835

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,892
Unemployment Compensation Insurance	9,258
FICA Taxes	200,461
Employee Health Insurance	114,748
Employee Meals	2,003
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	3,688
Union Pension Fund	20,010
Employee Benefits - Other	9,219
Employee Benefit Other - Covid	3,132
TOTAL (agree to Schedule V, line 22, col.8)	$ 441,411

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		1,275
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks	127	1,274
Dues & Subscriptions		9,387
Licenses & Fees		1,194
See Supplemental Schedule		2,491
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 15,621

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	932
See Supplemental Schedule	241
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,173

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $8,718**

(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. $ **11,016** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,571**
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. $ **2,003** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ ____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **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.