FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0054783

Facility Name: Aperion Care Capitol

Address: 555 W Carpenter Road (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: (217) 525-1880 Fax # (217) 525-7762

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2017

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	251	Skilled (SNF)	251	91,866	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	251	TOTALS	251	91,866	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	29,751	623	4,303	34,677	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,751	623	4,303	34,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 37.75%

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 11/1/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 2,368

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 Capitol # 0054783 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		
	A. General Services	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
1	Dietary	389,927	38,980	36,804	465,711		465,711	(5,825)	459,886			1
2	Food Purchase		195,071		195,071		195,071	(1,219)	193,852			2
3	Housekeeping	196,423	64,091		260,514		260,514	325	260,839			3
4	Laundry	99,377	13,101		112,478		112,478		112,478			4
5	Heat and Other Utilities			270,878	270,878		270,878	(31,619)	239,259			5
6	Maintenance	43,613	23,902	103,393	170,908		170,908	(16,480)	154,428			6
7	Other (specify):*							2,207	2,207			7
8	TOTAL General Services	729,340	335,145	411,075	1,475,560		1,475,560	(52,611)	1,422,949			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800	1,560	30,360			9
10	Nursing and Medical Records	2,855,177	228,026	562,170	3,645,373		3,645,373	(11,052)	3,634,321			10
10a	Therapy	3,871	2,269		6,140		6,140		6,140			10a
11	Activities	187,094	2,792	4,241	194,127		194,127	17	194,144			11
12	Social Services	202,080		3,185	205,265		205,265		205,265			12
13	CNA Training											13
14	Program Transportation			9,052	9,052		9,052		9,052			14
15	Other (specify):*							6,503	6,503			15
16	TOTAL Health Care and Programs	3,248,222	233,087	607,448	4,088,757		4,088,757	(2,972)	4,085,785			16
	C. General Administration											
17	Administrative	144,998		314,427	459,425		459,425	(275,558)	183,867			17
18	Directors Fees											18
19	Professional Services			390,653	390,653		390,653	(182,098)	208,555			19
20	Dues, Fees, Subscriptions & Promotions			110,879	110,879		110,879	(23,987)	86,892			20
21	Clerical & General Office Expenses	107,665		526,324	633,989		633,989	(348,003)	285,986			21
22	Employee Benefits & Payroll Taxes			592,550	592,550		592,550		592,550			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,785	1,785		1,785	120	1,905			24
25	Other Admin. Staff Transportation			16,334	16,334		16,334	1,304	17,638			25
26	Insurance-Prop.Liab.Malpractice			441,082	441,082		441,082	531	441,613			26
27	Other (specify):*							19,413	19,413			27
28	TOTAL General Administration	252,663		2,394,034	2,646,697		2,646,697	(808,278)	1,838,419			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,230,225	568,232	3,412,557	8,211,014		8,211,014	(863,862)	7,347,152			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 Capitol #0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,010	41,010		41,010	(14,323)	26,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,027	17,027		17,027	16,827	33,854			32
33	Real Estate Taxes			104,764	104,764		104,764	(13,797)	90,967			33
34	Rent-Facility & Grounds			12,000	12,000		12,000	(11,605)	395			34
35	Rent-Equipment & Vehicles			12,207	12,207		12,207	2,129	14,336			35
36	Other (specify):*			1,770	1,770		1,770	(1,770)				36
37	TOTAL Ownership			188,778	188,778		188,778	(22,538)	166,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		260,378	422,636	683,014		683,014	(64,883)	618,131			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,717	342,717		342,717		342,717			42
43	Other (specify):*			2,855	2,855		2,855	(2,855)	0			43
44	TOTAL Special Cost Centers		260,378	768,208	1,028,586		1,028,586	(67,738)	960,848			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,230,225	828,610	4,369,543	9,428,378		9,428,378	(954,137)	8,474,241			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 Capitol # 0054783 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	(32,249)	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	(24,330)	30		9
10	Interest and Other Investment Income	(2,584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	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	(37,115)	21		18
19	Entertainment				19
20	Contributions	(3,400)	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	(435,826)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(62,750)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (598,289)		$	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)	(355,848)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,848)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (954,137)		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 Capitol

ID# 0054783

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (1,435)	21	1
2	Credit Card Processing	(725)	21	2
3	Marketing Expense	(1,620)	43	3
4	Promotional Products	(1,235)	43	4
5	Amortization	(1,770)	36	5
6	Vending Commissions	(1,270)	02	6
7	Other Unclassified Income	(150)	21	7
8	Additional R&M	4,283	06	8
9	Capitalized R&M	(12,367)	06	9
10	Chamber of Commerce	(1,045)	20	10
11	PAC Dues	(23,985)	20	11
12	Non-Allowable Legal	(4,941)	19	12
13	Prior Period Professional Fees	(832)	19	13
14	Prior Period Seminar Expense	(309)	24	14
15	Theft & Damage Loss	121	21	15
16	Real Estate Tax	(15,471)	33	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(62,750)		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 Capitol

ID# 0054783

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	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 Capitol # 0054783 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				(5,825)								(5,825)	1
2	Food Purchase	(1,305)		86									(1,219)	2
3	Housekeeping			30			294						325	3
4	Laundry													4
5	Heat and Other Utilities	(32,249)					630						(31,619)	5
6	Maintenance	(8,084)		1,561	(10,959)		1,002						(16,480)	6
7	Other (specify):*			164	2,043								2,207	7
8	**TOTAL General Services**	(41,638)		1,841	(14,741)		1,926						(52,611)	8
	B. Health Care and Programs													
9	Medical Director			1,560									1,560	9
10	Nursing and Medical Records			4,058	(15,169)		59						(11,052)	10
10a	Therapy													10a
11	Activities			17									17	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			452	6,051								6,503	15
16	**TOTAL Health Care and Programs**			6,087	(9,118)		59						(2,972)	16
	C. General Administration													
17	Administrative			(275,558)									(275,558)	17
18	Directors Fees													18
19	Professional Services	(5,773)		31,878	2,352	(204,760)	1,149	(6,305)	(639)				(182,098)	19
20	Fees, Subscriptions & Promotions	(28,430)		3,963	29	446	5						(23,987)	20
21	Clerical & General Office Expenses	(475,130)		29,683	432	96,094	917						(348,003)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(309)		241	144	44							120	24
25	Other Admin. Staff Transportation			1,293	11								1,304	25
26	Insurance-Prop.Liab.Malpractice			531									531	26
27	Other (specify):*			7,677		11,736							19,413	27
28	**TOTAL General Administration**	(509,642)		(200,292)	2,968	(96,440)	2,071	(6,305)	(639)				(808,278)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(551,279)		(192,363)	(20,891)	(96,440)	4,056	(6,305)	(639)				(863,862)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Capitol # 0054783 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	**PAGES**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**PAGE**	**SUMMARY TOTALS**	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**(24,330)**		**1,065**	**184**	**188**	**8,570**						**(14,323)**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(2,584)**		**17,273**			**2,138**						**16,827**	**32**
33	Real Estate Taxes	**(15,471)**					**1,675**						**(13,797)**	**33**
34	Rent-Facility & Grounds			**239**			**(11,844)**						**(11,605)**	**34**
35	Rent-Equipment & Vehicles			**1,093**		**253**	**783**						**2,129**	**35**
36	Other (specify):*	**(1,770)**											**(1,770)**	**36**
37	**TOTAL Ownership**	**(44,155)**		**19,671**	**184**	**441**	**1,322**						**(22,538)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers									**(427)**	**(64,456)**		**(64,883)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*	**(2,855)**											**(2,855)**	**43**
44	**TOTAL Special Cost Centers**	**(2,855)**								**(427)**	**(64,456)**		**(67,738)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(598,289)**		**(172,693)**	**(20,707)**	**(95,999)**	**5,378**	**(6,305)**	**(639)**	**(427)**	**(64,456)**		**(954,137)**	**45**

Facility Name & ID Number Aperion Care Capitol # 0054783 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. [ ] YES [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Capitol # 0054783 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	David Berkowitz Revocable Trust	30.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	Steven Turofsky	1.50%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Frederick S. Frankel Trust	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	4
5	Naftali Wilhelm	1.50%	Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Jennifer Spector	1.50%	Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	257 Ltd	1.34%	Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	1219 Ltd	1.33%	Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	8
9	42170 Ltd	1.33%	Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	9
10	Yosef Meystel Delta Trust	15.00%	Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	10
11	David Berkowitz Delta Trust	15.00%	Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	11
12			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	18
19			Aperion Care Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	19
20			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	20
21			Aperion Care Morton Villa	Morton				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 Capitol # 0054783 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 Capitol # 0054783 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.		$ 86	$ 86	15
16	V	3	Housekeeping		Aperion Care, Inc.		30	30	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,470	1,470	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		91	91	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		164	164	19
20	V	9	Medical Director		Aperion Care, Inc.		1,560	1,560	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		4,058	4,058	21
22	V	11	Activities		Aperion Care, Inc.		17	17	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		452	452	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		38,869	38,869	24
25	V	19	Professional Fees		Aperion Care, Inc.		6,972	6,972	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,963	3,963	26
27	V	21	Clerical Salary		Aperion Care, Inc.		28,595	28,595	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,088	1,088	28
29	V	24	Seminars		Aperion Care, Inc.		241	241	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,293	1,293	30
31	V	26	Insurance		Aperion Care, Inc.		531	531	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		7,677	7,677	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,065	1,065	33
34	V	32	Interest		Aperion Care, Inc.		17,273	17,273	34
35	V	34	Rent		Aperion Care, Inc.		239	239	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,093	1,093	36
37	V	17	Management Fee	314,427	Aperion Care, Inc.			(314,427)	37
38	V	19	Home Office	(24,906)	Aperion Care, Inc.			24,906	38
39	Total			$ 289,521			$ 116,828	$ * (172,693)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 15,697	$ 15,697	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,657	2,657	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		57	57	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		2,043	2,043	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		53,441	53,441	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		6,051	6,051	20
21	V	19	Professional Fees		Aperion Consulting, LLC		2,352	2,352	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		29	29	22
23	V	21	Clerical & General		Aperion Consulting, LLC		432	432	23
24	V	24	Seminars		Aperion Consulting, LLC		144	144	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		11	11	25
26	V	30	Depreciation		Aperion Consulting, LLC		184	184	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,975	Aperion Consulting, LLC			(67,975)	33
34	V	10	Behavioral Health	634	Aperion Consulting, LLC			(634)	34
35	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	35
36	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	36
37	V								37
38	V								38
39	Total			$ 103,805			$ 83,098	$ * (20,707)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		3,000	$ 3,000	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		446	446	16
17	V	21	Clerical & General		Aperion Financial, LLC		56,601	56,601	17
18	V	24	Seminars		Aperion Financial, LLC		44	44	18
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		6,860	6,860	19
20	V	30	Depreciaiton		Aperion Financial, LLC		188	188	20
21	V	35	Equipment Rental		Aperion Financial, LLC		253	253	21
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		39,493	39,493	22
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,876	4,876	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	207,760	Aperion Financial, LLC			(207,760)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 207,760			$ 111,761	$ * (95,999)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 630	$ 630	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,002	1,002	16
17	V	3	Housekeeping		Chase Office, LLC		294	294	17
18	V	10	Medical Supplies		Chase Office, LLC		59	59	18
19	V	19	Professional Fees		Chase Office, LLC		1,149	1,149	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		5	5	20
21	V	21	Office Expense		Chase Office, LLC		917	917	21
22	V	30	Depreciation		Chase Office, LLC		8,570	8,570	22
23	V	32	Interest Expense		Chase Office, LLC		2,138	2,138	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,675	1,675	24
25	V	35	Equipment Rental		Chase Office, LLC		783	783	25
26	V	34	Rent	12,000	Chase Office, LLC		156	(11,844)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,000			$ 17,378	$ * 5,378	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	$ 27,522	ProPay HR LLC		$ 21,217	$ (6,305)	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			$ 27,522			$ 21,217	$ * (6,305)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	Data Processing	$ 4,200	EMSA PURCHASING GROUP		$ 3,561	$ (639)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,200			$ 3,561	$ * (639)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 750	Lifescan Labs of Illinois		$ 323	$ (427)	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			$ 750			$ 323	$ * (427)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	$ 422,047	Renewal Rehab, LLC		$ 357,591	$ (64,456)	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			$ 422,047			$ 357,591	$ * (64,456)	39

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

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 391,528	Aperion Incorporated Cell		$ 391,528	$	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			$ 391,528			$ 391,528	$ *	39

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

Facility Name & ID Number: Aperion Care Capitol # 0054783 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	0.00%	See Attached	0.73	1.83%	Alloc Sal	$ 4,563	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.73	1.83%	Alloc Sal	1,073	21-7	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.73	1.83%	Alloc Sal	2,097	17-7	3
4	Fred Frankel	Relative	Administrative	0.00%	See Attached	0.73	1.83%	Alloc Sal	4,563	17-7	4
5	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.73	1.83%	Alloc Sal	4,563	17-7	5
6	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.73	1.83%	Alloc Sal	4,151	21-7	6
7	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.50	1.83%	Alloc Sal	566	21-7	7
8	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.73	1.83%	Alloc Sal	2,173	21-7	8
9	Dovid Spector	Relative	Clerical	0.00%	See Attached	0.73	1.83%	Alloc Sal	1,505	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 25,254		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 Capitol # 0054783 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 Capitol # 0054783 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 [ ]

Name of Related Organization: Aperion Care, Inc.
Street Address: 4655 W. Chase Avenue
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 262-8300
Fax Number: ( )

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

	1 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	$	34,677	$ 86	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		34,677	30	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	34,677	1,470	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		34,677	91	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		34,677	164	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		34,677	1,560	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	34,677	4,058	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		34,677	17	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		34,677	452	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	34,677	38,869	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		34,677	6,972	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		34,677	3,963	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	34,677	28,595	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		34,677	1,088	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		34,677	241	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		34,677	1,293	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		34,677	531	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		34,677	7,677	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		34,677	1,065	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		34,677	17,273	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		34,677	239	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		34,677	1,093	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 116,828	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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

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: ( )

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	1	Dietician Salary - Illinois Only	Census	1,102,074	46	$ 498,880	$ 498,880	34,677	$ 15,697	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	34,677	2,657	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		34,677	57	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		34,677	2,043	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	34,677	53,441	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		34,677	6,051	6
7	19	Professional Fees	Census	1,488,113	65	100,933		34,677	2,352	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		34,677	29	8
9	21	Clerical & General	Census	1,488,113	65	18,558		34,677	432	9
10	24	Seminars	Census	1,488,113	65	6,182		34,677	144	10
11	25	Auto & Travel	Census	1,488,113	65	484		34,677	11	11
12	30	Depreciation	Census	1,488,113	46	7,885		34,677	184	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		$ 83,098	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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 [ ]

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

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

	1 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		34,677	3,000	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		34,677	446	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	34,677	56,601	3
4	24	Seminars	Census	1,899,996	65	2,428		34,677	44	4
5	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		34,677	6,860	5
6	30	Depreciaiton	Census	1,899,996	65	10,323		34,677	188	6
7	35	Equipment Rental	Census	1,899,996	65	13,849		34,677	253	7
8	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	34,677	39,493	8
9	27	Emp. Ben. - Gen. Admin.- IL Onl	Census/Direct Alloc	1,208,651	46	218,211		34,677	4,876	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		$ 111,761	25

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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	5	Utilities	Actual Census	1,899,996	64	$ 34,497	$	34,677	$ 630	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		34,677	1,002	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		34,677	294	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		34,677	59	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		34,677	1,149	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		34,677	5	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		34,677	917	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		34,677	8,570	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		34,677	2,138	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		34,677	1,675	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		34,677	783	11
12	34	Rent	Actual Census	1,899,996	64	42,922		34,677	156	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 952,148	$		$ 17,378	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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			$	$		$ 21,217	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 21,217	25

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct			$	$		$ 3,561	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,561	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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 [ ]

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	( )

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			$	$		$ 323	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					$	$		$ 323	25

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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	Therapy Services	Direct			$	$		$ 357,591	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					$	$		$ 357,591	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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			$	$		$ 391,528	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					$	$		$ 391,528	25

Facility Name & ID Number Aperion Care Capitol # 0054783 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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Congressional Bank		X	Line of Credit							16,318	6
7	Interest - Insurance Policies		X								709	7
8	See Supplemental Schedule										19,411	8
9	TOTAL Facility Related						$	$			$ 36,438	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,584)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,584)	14
15	TOTALS (line 9+line14)						$	$			$ 33,854	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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 Capitol # 0054783 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.

1. Real Estate Tax accrual used on 2019 report.	$	105,006	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.)	$	98,824	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,182)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	97,149	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	90,967	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	99,834	8
	2016	100,811	9
	2017	102,831	10
	2018	105,006	11
	2019	97,150	12

2020 Accrual = $97,150 x 1.14 = $110,934 (rounded)

Allocated from Chase Office LLC: 1,675

	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 CALCULATIOI	$	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 Capitol COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0054783

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 nursin 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.	14-28.0-401-006	Long Term Care Property	$ 4,547.36	$ 4,547.36
2.	14-28.0-401-018	Long Term Care Property	$ 92,602.20	$ 92,602.20
3.	10-27-307-027-0000	Home Office Allocation	$ 72,110.55	$ 1,250.29
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 169,260.11	$ 98,399.85

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 Capitol COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0054783

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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**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 Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior Brick Frame Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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 [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Chase Office LLC			1,077	1
2					2
3	TOTALS			$ 1,077	3

Facility Name & ID Number Aperion Care Capitol # 0054783 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Capitol # 0054783 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
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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)		66,976	4,726		3,113	(1,613)	13,257	68
69	Financial Statement Depreciation			41,010			(41,010)		69
70	TOTAL (lines 4 thru 69)		$ 66,976	$ 45,736		$ 3,113	$ (42,623)	$ 13,257	70

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

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 66,976	$ 45,736		$ 3,113	$ (42,623)	$ 13,257	1
2	Install New Phone Lines	2018	4,100		20	205	205	581	2
3	New Drain Installed In Kitchen	2018	2,880		20	144	144	384	3
4	Painting 4Th Floor Ceiling, Hallways & Door Jams	2018	12,995		20	650	650	1,570	4
5	Security System	2018	10,788		20	539	539	1,528	5
6	Thru The Wall A/C	2018	2,863		20	143	143	382	6
7	Thru The Wall A/C	2018	4,321		20	216	216	558	7
8	Thru The Wall A/C	2018	3,859		20	193	193	482	8
9	Replacement Of Exhaust Fans (28,800)	2018	28,364		20	1,418	1,418	2,954	9
10	Hvac Cooler	2018	20,057		20	1,003	1,003	2,257	10
11	A/C Heat	2019	5,414		20	271	271	519	11
12	Frigidaire 9000 Ptac With Wall Sleeve	2019	9,872		20	494	494	905	12
13	16 Bed Wall Fixtures	2019	4,025		20	201	201	309	13
14	A/C Units	2019	62,476		20	3,124	3,124	4,611	14
15	Installed Remote Annunciator With Cables/Emergency Generator	2019	2,510		20	126	126	252	15
16	Repaired Fire Sprinkler Heads And Pipes	2019	2,723		20	136	136	272	16
17	Roof Exhaust Fans-Motor,Capacitator,Belt Repair	2020	3,866		20	193	193	193	17
18	New Video Surveillance Cameras-1St Flr Hall, Side Lobby,3Rd Flr	2020	2,728		20	136	136	136	18
19	Fire Damper Repair	2020	5,224		20	261	261	261	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)		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	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)		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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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)		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	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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17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 256,040	$ 45,736		$ 12,567	$ (33,170)	$ 31,412	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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
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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 Capitol # 0054783 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
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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)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	9,689	248	20	248		1,097	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	544	87	20	27	(60)	272	9
10	Allocated from Aperion Care	2012	154	12	20	8	(4)	62	10
11	Allocated from Aperion Care	2013	66	8	20	3	(5)	23	11
12									12
13	Allocated from Chase Office LLC	2020	193		20	10	10	10	13
14	Allocated from Chase Office LLC	2019	4,935	224	20	247	23	493	14
15	Allocated from Chase Office LLC	2018	44	2	20	2	(0)	7	15
16	Allocated from Chase Office LLC	2017	2,243	548	20	112	(436)	449	16
17	Allocated from Chase Office LLC	2016	49,108	3,595	20	2,455	(1,140)	10,845	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)		$ 66,976	$ 4,726		$ 3,113	$ (1,613)	$ 13,257	34

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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		$ 66,976	$ 4,726		$ 3,113	$ (1,613)	$ 13,257	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 66,976	$ 4,726		$ 3,113	$ (1,613)	$ 13,257	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 86,299	$ 5,076	$ 8,702	$ 3,626	10	$ 27,592	71
72	Current Year Purchases	15,240	32	1,526	1,494	10	1,526	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 101,539	$ 5,108	$ 10,228	$ 5,120		$ 29,118	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2013 Ford E350 Gsohen Bus	2018	$ 15,534	$	$ 3,107	$ 3,107	5	$ 8,285	76
77		Allocated from Aperion Care In	2020	3,931	174	786	612	5	1,969	77
78										78
79										79
80	TOTALS			$ 19,465	$ 174	$ 3,893	$ 3,719		$ 10,254	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)	$ 378,121	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,018	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,688	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,330)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 70,784	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 Capitol # 0054783 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:
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 Inc				239			5
6	Allocated from Chase Office				156			6
7	TOTAL				$ 395 **			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: $ 13,243 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 Inc		$	$ 1,093	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,093	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Aperion Care Capitol # 0054783 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	$		$ 147,712	$		$ 147,712	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			64,749			64,749	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			210,055			210,055	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				239,715		239,715	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					120	20,663		20,783	13
14	TOTAL			$		$ 422,636	$ 260,378		$ 683,014	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 Capitol # 0054783 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	$ 633,745	$	1
2	Cash-Patient Deposits	1,500		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	900,912		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,359		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	530		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,620,046	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	143,035		15
16	Equipment, at Historical Cost	137,282		16
17	Accumulated Depreciation (book methods)	(89,380)		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	218,657		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 409,594	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,029,640	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 604,364	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	347,759		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,110		31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,149		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	858,457		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,927,839	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	4,854,817		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,854,817	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,782,656	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,753,016)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,029,640	$	48

*(See instructions.)

Facility Name & ID Number Aperion Care Capitol # 0054783 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**	$ (4,072,018)	1
2	Restatements (describe):		2
3	Bad Debt	(31,432)	3
4	Rounding	(6)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,103,456)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(649,560)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (649,560)	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)**	$ (4,753,016)	24 *

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

Facility Name & ID Number Aperion Care Capitol # 0054783 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	$ 7,861,841	1
2	Discounts and Allowances for all Levels	(841,150)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,020,691	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	277,741	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 277,741	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	15,256	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	131	19
20	Radiology and X-Ray	126	20
21	Other Medical Services	2,290	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,803	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,584	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,459,999	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,459,999	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,778,818	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,475,560	31
32	Health Care	4,088,757	32
33	General Administration	2,646,697	33
	B. Capital Expense		
34	Ownership	188,778	34
	C. Ancillary Expense		
35	Special Cost Centers	685,869	35
36	Provider Participation Fee	342,717	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,428,378	40
41	**Income before Income Taxes (line 30 minus line 40)****	(649,560)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (649,560)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,086,454	44
45	Private Pay - Net Inpatient Revenue	142,020	45
46	Medicare - Net Inpatient Revenue	1,337,734	46
47	Other-(specify) Insurance	399,537	47
48	Other-(specify) Managed Care	4,054,946	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,020,691	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	978	1,061	$ 58,351	$ 55.00	1
2	Assistant Director of Nursing	1,718	1,790	83,837	46.84	2
3	Registered Nurses	7,039	7,291	330,877	45.38	3
4	Licensed Practical Nurses	25,729	28,143	964,175	34.26	4
5	CNAs & Orderlies	62,978	68,000	1,375,604	20.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	126	126	3,871	30.72	8
9	Activity Director	1,737	1,884	37,536	19.92	9
10	Activity Assistants	9,005	10,045	149,558	14.89	10
11	Social Service Workers	7,491	8,095	201,672	24.91	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,163	48,198	22.28	13
14	Head Cook	2,135	2,202	34,249	15.55	14
15	Cook Helpers/Assistants	16,828	18,385	307,480	16.72	15
16	Dishwashers					16
17	Maintenance Workers	1,888	1,972	43,613	22.12	17
18	Housekeepers	12,053	12,945	196,423	15.17	18
19	Laundry	6,182	6,674	99,377	14.89	19
20	Administrator	2,024	2,268	144,998	63.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,944	2,073	55,249	26.65	23
24	Clerical	2,686	2,899	52,416	18.08	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	2,137	2,382	42,333	17.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	48	48	408	8.50	33
34	TOTAL (lines 1 - 33)	166,630	180,446	$ 4,230,225 *	$ 23.44	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	$ 36,804	01-03	35
36	Medical Director	Monthly	28,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	71,675	10-03	38
39	Pharmacist Consultant	135	12,914	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	53	4,241	11-03	44
45	Social Service Consultant	40	3,185	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Per Visit	2,000	10-03	47
48	Behavioral Health Consultant	8	634	10-03	48
49	TOTAL (lines 35 - 48)	236	$ 160,253		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,756	$ 125,403	10-03	50
51	Licensed Practical Nurses	5,098	349,544	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,854	$ 474,947		53

Facility Name & ID Number Aperion Care Capitol # 0054783 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Gary Coulter	Administrator	0	$	69,485
Jackie Liddell	Administrator	0		75,513
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	144,998

B. Administrative - Other

Description		Amount
Aperion Care Inc. - Management Fees	$	314,427
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	314,427

C. Professional Services

Vendor/Payee	Type		Amount
Marcum LLP	Accounting	$	19,055
See Attached	Legal		36,475
Aperion Financial	Home Office Expense		182,854
Synapse PDI, LLC	Data Processing		300
Propay HR	Payroll Processing		27,522
OnTray, LLC	Survey Prep Services		1,000
Personnel Planners	Unemployment Consulting		1,725
GCHMO	Liaison Service		2,900
2401 Incorporated	Architectural Consultant		2,500
Pinnacle Financial Services	Financial Consultant		1,532
NRC Health Solutions	Data Processing		2,103
See Supplemental Schedule			112,687
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	390,653

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	109,949
Unemployment Compensation Insurance		41,490
FICA Taxes		323,612
Employee Health Insurance		93,020
Employee Meals		2,661
Illinois Municipal Retirement Fund (IMRF)*		
401K Expense		
Employee Physicals		360
Other Employee Benefits		21,458
TOTAL (agree to Schedule V, line 22, col.8)	$	592,551

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		$	1,990
Advertising: Employee Recruitment			5,199
Health Care Worker Background Check			
(Indicate # of checks performed	205)		2,051
Patient Background Checks	107		1,070
Dues & Subscriptions			68,092
Licenses & Fees			4,047
See Supplemental Schedule			4,443
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)		$	86,892

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		1,476
See Supplemental Schedule		429
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	1,905

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $47,969**

(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. $ **12,724** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **342,717**
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. $ **2,661** 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? **Yes**
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.