FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0049940

Facility Name: Aperion Care Chicago Heights

Address: 490 West 16th Place (Number) | Chicago Heights (City) | 60411 (Zip Code)

County: Cook

Telephone Number: (708) 481-4444 **Fax #** (708) 481-4606

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2008

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

Paid Preparer
(Signed) 05/21/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA
Partner
(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 Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	100	Intermediate (ICF)	100	36,600	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	69,684		66	69,750	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,684		66	69,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.29%

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 05/21/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/21/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 45 and days of care provided 0

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

STATE OF ILLINOIS

Facility Name & ID Number: Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	251,545	45,578	21,522	318,645		318,645	10,052	328,697			1
2	Food Purchase		349,753		349,753		349,753	(627)	349,126			2
3	Housekeeping	96,910	125,390		222,300		222,300	653	222,953			3
4	Laundry		3,171	62,267	65,438		65,438		65,438			4
5	Heat and Other Utilities			163,507	163,507		163,507	(5,919)	157,588			5
6	Maintenance	292,709	20,656	133,164	446,529		446,529	497	447,026			6
7	Other (specify):*							4,439	4,439			7
8	**TOTAL General Services**	641,164	544,548	380,460	1,566,172		1,566,172	9,096	1,575,268			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200	3,139	10,339			9
10	Nursing and Medical Records	1,733,095	230,348	106,372	2,069,815		2,069,815	47,504	2,117,319			10
10a	Therapy	140,133	277		140,410		140,410		140,410			10a
11	Activities	104,292	7,123	5,483	116,898		116,898	33	116,931			11
12	Social Services	752,178		4,950	757,128		757,128		757,128			12
13	CNA Training											13
14	Program Transportation			540	540		540		540			14
15	Other (specify):*							13,080	13,080			15
16	**TOTAL Health Care and Programs**	2,729,698	237,748	124,545	3,091,991		3,091,991	63,756	3,155,747			16
	C. General Administration											
17	Administrative	38,040		531,139	569,179		569,179	(452,957)	116,222			17
18	Directors Fees											18
19	Professional Services			641,431	641,431	(400)	641,031	(457,127)	183,904			19
20	Dues, Fees, Subscriptions & Promotions			96,789	96,789		96,789	(33,573)	63,216			20
21	Clerical & General Office Expenses	189,865		185,742	375,607		375,607	101,164	476,771			21
22	Employee Benefits & Payroll Taxes			538,158	538,158		538,158		538,158			22
23	Inservice Training & Education											23
24	Travel and Seminar			776	776		776	864	1,640			24
25	Other Admin. Staff Transportation			772	772		772	2,623	3,395			25
26	Insurance-Prop.Liab.Malpractice			133,321	133,321		133,321	1,068	134,389			26
27	Other (specify):*							39,048	39,048			27
28	**TOTAL General Administration**	227,905		2,128,128	2,356,033	(400)	2,355,633	(798,890)	1,556,743			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,598,767	782,296	2,633,133	7,014,196	(400)	7,013,796	(726,038)	6,287,758			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 Chicago Heights #0049940 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			85,841	85,841		85,841	155,936	241,777			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,058	68,058		68,058	899,387	967,445			32
33	Real Estate Taxes			784,706	784,706	400	785,106	3,369	788,475			33
34	Rent-Facility & Grounds			1,170,000	1,170,000		1,170,000	(1,169,205)	795			34
35	Rent-Equipment & Vehicles			12,772	12,772		12,772	4,282	17,054			35
36	Other (specify):*			6,851	6,851		6,851	(6,851)				36
37	**TOTAL Ownership**			2,128,228	2,128,228	400	2,128,628	(113,082)	2,015,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,363	2,439	32,802		32,802	(10,624)	22,178			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			532,817	532,817		532,817		532,817			42
43	Other (specify):*			2,217	2,217		2,217	(2,217)				43
44	**TOTAL Special Cost Centers**		30,363	537,473	567,836		567,836	(12,841)	554,995			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,598,767	812,659	5,298,834	9,710,260		9,710,260	(851,960)	8,858,300			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 Chicago Heights # 0049940 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	(7,185)	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	40,036	30		9
10	Interest and Other Investment Income	(5,255)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(468)	21		18
19	Entertainment				19
20	Contributions	(28,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,577)	21		24
25	Fund Raising, Advertising and Promotional	(2,217)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(22,068)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,188,396)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,338,630)		$	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)	486,669		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 486,669		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (851,961)		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

STATE OF ILLINOIS

Aperion Care Chicago Heights

ID# 0049940

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (1,368)	19	1
2	Credit Card Processing	(1,899)	21	2
3	Bank Charges	(5,424)	21	3
4	Theft & Damage Loss	(106)	21	4
5	Amortization	(6,851)	36	5
6	Vending Commissions	(800)	02	6
7	Additional R&M	7,705	06	7
8	Capitalized R&M	(4,150)	06	8
9	Prior Year Professional Fees	(692)	19	9
10	PAC Dues	(14,011)	20	10
11	Building Company - Professional Fees	(12,065)	19	11
12	Building Company - Amortization	(28,891)	36	12
13	Building Company - Bad Debt	(418,183)	21	13
14	Building Company - Bank Charges	(72)	21	14
15	Building Company - Change in Swap Valuation	(686,202)	36	15
16	Building Company - IL Replacement Tax	(3,142)	21	16
17	Building Company - Licenses & Fees	(245)	20	17
18	Building Company - Bookkeeping Fees	(12,000)	19	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**	(1,188,396)		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 Chicago Heights

ID# 0049940

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

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Summary A

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				10,052								10,052	1
2	Food Purchase	(800)		173									(627)	2
3	Housekeeping			61			592						653	3
4	Laundry													4
5	Heat and Other Utilities	(7,185)					1,266						(5,919)	5
6	Maintenance	3,555		3,142	(8,215)		2,015						497	6
7	Other (specify):*			329	4,110								4,439	7
8	**TOTAL General Services**	(4,430)		3,705	5,947		3,874						9,096	8
	B. Health Care and Programs													
9	Medical Director			3,139									3,139	9
10	Nursing and Medical Records			8,163	39,223		118						47,504	10
10a	Therapy													10a
11	Activities			33									33	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			909	12,171								13,080	15
16	**TOTAL Health Care and Programs**			12,244	51,394		118						63,756	16
	C. General Administration													
17	Administrative			(452,957)									(452,957)	17
18	Directors Fees													18
19	Professional Services	(26,125)	24,065	(7,093)	(135,452)	(308,403)	1,725		(5,846)				(457,127)	19
20	Fees, Subscriptions & Promotions	(42,756)	245	7,972	59	898	9						(33,573)	20
21	Clerical & General Office Expenses	(575,939)	421,397	59,705	870	193,285	1,845						101,164	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			485	290	89							864	24
25	Other Admin. Staff Transportation			2,600	23								2,623	25
26	Insurance-Prop.Liab.Malpractice			1,068									1,068	26
27	Other (specify):*			15,442		23,606							39,048	27
28	**TOTAL General Administration**	(644,820)	445,707	(372,777)	(134,210)	(90,525)	3,580		(5,846)				(798,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(649,250)	445,707	(356,827)	(76,868)	(90,525)	7,571		(5,846)				(726,038)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	40,036	95,770	2,142	370	379	17,239						155,936	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,255)	865,598	34,744			4,300						899,387	32
33	Real Estate Taxes		1				3,368						3,369	33
34	Rent-Facility & Grounds		(1,140,000)	481			(29,686)						(1,169,205)	34
35	Rent-Equipment & Vehicles			2,198		508	1,576						4,282	35
36	Other (specify):*	(721,944)	715,093										(6,851)	36
37	**TOTAL Ownership**	(687,163)	536,462	39,566	370	887	(3,203)						(113,082)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers										(10,290)	(334)	(10,624)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,217)											(2,217)	43
44	**TOTAL Special Cost Centers**	(2,217)									(10,290)	(334)	(12,841)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,338,630)	982,169	(317,262)	(76,498)	(89,638)	4,368		(5,846)		(10,290)	(334)	(851,960)	45

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,140,000	Riviera Realty, LLC		$	$ (1,140,000)	1
2	V	33	Real Estate Tax	784,705	Riviera Realty, LLC		784,706	1	2
3	V	32	Interest	12	Riviera Realty, LLC		865,610	865,598	3
4	V	19	Professional Fees		Riviera Realty, LLC		12,065	12,065	4
5	V	36	Amortization		Riviera Realty, LLC		28,891	28,891	5
6	V	21	Bad Debt		Riviera Realty, LLC		418,183	418,183	6
7	V	21	Bank Charges		Riviera Realty, LLC		72	72	7
8	V	19	Bookkeeping Fee		Riviera Realty, LLC		12,000	12,000	8
9	V	36	Change in Swap Valuation		Riviera Realty, LLC		686,202	686,202	9
10	V	30	Depreciation		Riviera Realty, LLC		95,770	95,770	10
11	V	21	IL Replacement Tax		Riviera Realty, LLC		3,142	3,142	11
12	V	20	Licenses & Fees		Riviera Realty, LLC		245	245	12
13	V								13
14	Total			$ 1,924,717			$ 2,906,886	$ * 982,169	14

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	Dennis Ruben Trust Dtd 12/7/87	4.50%	Aperion Care Bradley	Bradley	Riviera Realty, LLC	Chicago Heights	Building Co.	1
2	Joyce L. Ruben Trust Dtd 11/16/94	4.50%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Sheldon Wrotslovskty	1.00%	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Zalmen Stein	0.50%	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	Gary Bider	1.75%	Aperion Care Demotte	Demotte,IN	Aperion Estates Peru	Peru, IN	ALF	5
6	Rachel Esformes	2.50%	Aperion Care Dolton	Dolton	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7	Rebecca Lafer	2.50%	Aperion Care Elgin	Elgin	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8	Declaration of Trust of Yosef Meystel	33.00%	Aperion Care Evanston	Evanston	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9	Isadore Meystel Revocable Trust	0.60%	Aperion Care Fairfield	Fairfield	Chase Office, LLC	Lincolnwood	Building Co.	9
10	Ronna Weinstock	0.60%	Aperion Care Forest Park	Forest Park	Concerto Dialysis	Lincolnwood	Dialysis	10
11	Jay Meystel Trust	0.80%	Aperion Care Glenwood	Glenwood	Eco-Brite Linen	Skokie	Laundry	11
12	Christina Inofre	0.50%	Aperion Care Highwood	Highwood	Elevate Care, Inc.	Skokie	Consutling	12
13	David A. Berkowitz Revocable Trust	20.50%	Aperion Care International	Chicago	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14	42170 Limited Partnership	7.50%	Aperion Care Jacksonville	Jacksonville	Interbuild Construction	Chicago	Bldg Improvements	14
15	1219 Limited Partnership	7.50%	Aperion Care Kokomo	Kokomo, IN	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16	257 Limited Partnership	7.50%	Aperion Care Litchfield	Litchfield	OnTray, LLC	Lincolnwood	Kitchen Management	16
17	417A, LP	4.25%	Aperion Care Marion	Marion, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marseilles	Marseilles	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Mascoutah	Mascoutah	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Midlothian	Midlothian	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Morton Villa	Morton	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Oak Lawn	Oak Lawn				22
23			Aperion Care Peoria Heights	Peoria Heights				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Plum Grove	Palatine				25
26			Aperion Care Princeton	Princeton				26
27			Aperion Care Spring Valley	Spring Valley				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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 Chicago Heights # 0049940 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.		$ 173	$ 173	15
16	V	3	Housekeeping		Aperion Care, Inc.		61	61	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		2,958	2,958	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		184	184	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		329	329	19
20	V	9	Medical Director		Aperion Care, Inc.		3,139	3,139	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		8,163	8,163	21
22	V	11	Activities		Aperion Care, Inc.		33	33	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		909	909	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		78,183	78,183	24
25	V	19	Professional Fees		Aperion Care, Inc.		14,023	14,023	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		7,972	7,972	26
27	V	21	Clerical Salary		Aperion Care, Inc.		57,517	57,517	27
28	V	21	Clerical & General		Aperion Care, Inc.		2,188	2,188	28
29	V	24	Seminars		Aperion Care, Inc.		485	485	29
30	V	25	Auto & Travel		Aperion Care, Inc.		2,600	2,600	30
31	V	26	Insurance		Aperion Care, Inc.		1,068	1,068	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		15,442	15,442	32
33	V	30	Depreciaiton		Aperion Care, Inc.		2,142	2,142	33
34	V	32	Interest		Aperion Care, Inc.		34,744	34,744	34
35	V	34	Rent		Aperion Care, Inc.		481	481	35
36	V	35	Auto Lease		Aperion Care, Inc.		2,198	2,198	36
37	V	17	Management Fee	531,139	Aperion Care, Inc.			(531,139)	37
38	V	19	Home Office	21,116	Aperion Care, Inc.			(21,116)	38
39	Total			$ 552,255			$ 234,993	$ * (317,262)	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	$	Aperion Consulting, LLC		$ 31,574	$ 31,574	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		5,344	5,344	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		114	114	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		4,110	4,110	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		107,492	107,492	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		12,171	12,171	20
21	V	19	Professional Fees		Aperion Consulting, LLC		4,731	4,731	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		59	59	22
23	V	21	Clerical & General		Aperion Consulting, LLC		870	870	23
24	V	24	Seminars		Aperion Consulting, LLC		290	290	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		23	23	25
26	V	30	Depreciation		Aperion Consulting, LLC		370	370	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	68,269	Aperion Consulting, LLC			(68,269)	33
34	V	10	Behavioral Health		Aperion Consulting, LLC				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	19	Admin Consultant	140,183	Aperion Consulting, LLC			(140,183)	37
38	V								38
39	Total			$ 243,646			$ 167,148	$ * (76,498)	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		6,035	$ 6,035	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		898	898	16
17	V	21	Clerical & General		Aperion Financial, LLC		113,849	113,849	17
18	V	24	Seminars		Aperion Financial, LLC		89	89	18
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		13,798	13,798	19
20	V	30	Depreciaiton		Aperion Financial, LLC		379	379	20
21	V	35	Equipment Rental		Aperion Financial, LLC		508	508	21
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		79,436	79,436	22
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		9,808	9,808	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	314,438	Aperion Financial, LLC			(314,438)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 314,438			$ 224,800	$ * (89,638)	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 1,266	$ 1,266	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		2,015	2,015	16
17	V	3	Housekeeping		Chase Office, LLC		592	592	17
18	V	10	Medical Supplies		Chase Office, LLC		118	118	18
19	V	19	Professional Fees		Chase Office, LLC		2,311	2,311	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		9	9	20
21	V	21	Office Expense		Chase Office, LLC		1,845	1,845	21
22	V	30	Depreciation		Chase Office, LLC		17,239	17,239	22
23	V	32	Interest Expense		Chase Office, LLC		4,300	4,300	23
24	V	33	Real Estate Taxes		Chase Office, LLC		3,368	3,368	24
25	V	35	Equipment Rental		Chase Office, LLC		1,576	1,576	25
26	V	34	Rent	30,000	Chase Office, LLC		314	(29,686)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	19	Data Processing	3,850	EMSA PURCHASING GROUP		3,264	(586)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,850			$ 38,218	$ * 4,368	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 62,267	EcoBrite Linen		$ 62,267	$	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			$ 62,267			$ 62,267	$ *	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	$ 25,518	ProPay HR LLC		$ 19,672	$ (5,846)	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			$ 25,518			$ 19,672	$ * (5,846)	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 89,827	Aperion Incorporated Cell		$ 89,827	$	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			$ 89,827			$ 89,827	$ *	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 18,075	Lifescan Labs of Illinois		$ 7,785	$ (10,290)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,075			$ 7,785	$ * (10,290)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 2,184	Renewal Rehab, LLC		$ 1,850	$ (334)	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			$ 2,184			$ 1,850	$ * (334)	39

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.47	3.67%	Alloc Sal	$ 9,178	17-7	1
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.47	3.67%	Alloc Sal	4,218	17-7	2
3	Jay Meystel	Relative	Clerical	0.00%	See Attached	1.47	3.67%	Alloc Sal	2,159	21-7	3
4	Elisheva Adest	Relative	Clerical	0.00%	See Attached	1.00	3.67%	Alloc Sal	1,138	21-7	4
5	Christina Inofre	Owner	Nursing	0.50%	See Attached	1.84	4.61%	Alloc Sal	7,453	10-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 24,146		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 Chicago Heights # 0049940 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 Chicago Heights # 0049940 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	$	69,750	$ 173	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		69,750	61	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	69,750	2,958	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		69,750	184	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		69,750	329	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		69,750	3,139	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	69,750	8,163	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		69,750	33	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		69,750	909	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	69,750	78,183	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		69,750	14,023	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		69,750	7,972	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	69,750	57,517	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		69,750	2,188	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		69,750	485	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		69,750	2,600	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		69,750	1,068	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		69,750	15,442	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		69,750	2,142	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		69,750	34,744	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		69,750	481	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		69,750	2,198	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 234,993	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	$ 498,880	$ 498,880	69,750	$ 31,574	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	69,750	5,344	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		69,750	114	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		69,750	4,110	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	69,750	107,492	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		69,750	12,171	6
7	19	Professional Fees	Census	1,488,113	65	100,933		69,750	4,731	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		69,750	59	8
9	21	Clerical & General	Census	1,488,113	65	18,558		69,750	870	9
10	24	Seminars	Census	1,488,113	65	6,182		69,750	290	10
11	25	Auto & Travel	Census	1,488,113	65	484		69,750	23	11
12	30	Depreciation	Census	1,488,113	46	7,885		69,750	370	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		$ 167,148	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		69,750	6,035	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		69,750	898	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	69,750	113,849	3
4	24	Seminars	Census	1,899,996	65	2,428		69,750	89	4
5	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		69,750	13,798	5
6	30	Depreciaiton	Census	1,899,996	65	10,323		69,750	379	6
7	35	Equipment Rental	Census	1,899,996	65	13,849		69,750	508	7
8	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	69,750	79,436	8
9	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		69,750	9,808	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		$ 224,800	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	$ 34,497	$	69,750	$ 1,266	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		69,750	2,015	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		69,750	592	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		69,750	118	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		69,750	2,311	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		69,750	9	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		69,750	1,845	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		69,750	17,239	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		69,750	4,300	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		69,750	3,368	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		69,750	1,576	11
12	34	Rent	Actual Census	1,899,996	64	42,922		69,750	314	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	19	Data Processing	Direct						3,264	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 952,148	$		$ 38,218	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct			$	$		$ 62,267	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					$	$		$ 62,267	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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			$	$		$ 19,672	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					$	$		$ 19,672	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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			$	$		$ 89,827	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					$	$		$ 89,827	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 7,785	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 7,785	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Renewal Rehab, LLC
Street Address: 7358 N. Lincoln Ave., Suite 160
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 938-8750
Fax Number: (847) 410-9720

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		59	$	$		$ 1,851	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,851	25

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	First Midwest Bank		X	Mortgage			$	$ 15,155,603			$ 865,610	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				1,997,837			61,928	6
7	Insurance Policies		X								6,130	7
8												8
9	TOTAL Facility Related						$	$ 17,153,440			$ 933,668	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,255)	10
11	Interest Income (Bldg Co)										(12)	11
12	Alloc from Aperion Care										34,744	12
13	Alloc from Chase Office										4,300	13
14	TOTAL Non-Facility Related						$	$			$ 33,777	14
15	TOTALS (line 9+line14)						$	$ 17,153,440			$ 967,445	15

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

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

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	711,600	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.)	$	751,474	2
3. Under or (over) accrual (line 2 minus line 1).	$	39,874	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	748,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	400	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ______ For ______ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	788,474	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	513,822	8
2016	519,707	9
2017	679,884	10
2018	711,216	11
2019	748,106	12

2020 Accrual = 2019 Real Estate Tax (rounded)

Allocation from Chase Office $3368

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Chicago Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049940

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-19-417-018-0000	Long Term Care Property	$ 937.53	$ 937.53
2.	32-19-417-049-0000	Long Term Care Property	$ 560.31	$ 560.31
3.	32-19-417-052-0000	Long Term Care Property	$ 560.31	$ 560.31
4.	32-19-417-053-0000	Long Term Care Property	$ 560.31	$ 560.31
5.	32-19-417-085-0000	Long Term Care Property	$ 1,052.68	$ 1,052.68
6.	32-19-417-098-0000	Long Term Care Property	$ 266.03	$ 266.03
7.	32-19-417-101-0000	Long Term Care Property	$ 1,244.45	$ 1,244.45
8.	32-19-417-102-0000	Long Term Care Property	$ 1,244.45	$ 1,244.45
9.	32-19-417-103-0000	Long Term Care Property	$ 1,244.45	$ 1,244.45
10.	32-19-417-104-0000	Long Term Care Property	$ 1,244.45	$ 1,244.45
		TOTALS	$ 8,914.97	$ 8,914.97

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 Chicago Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049940

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 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-19-417-105-0000	Long Term Care Property	$ 560.31	$ 560.31
2.	32-19-417-106-0000	Long Term Care Property	$ 1,200.21	$ 1,200.21
3.	32-19-417-112-0000	Long Term Care Property	$ 737,430.83	$ 737,430.83
4.	10-27-307-027-0000	Allocated from Chase Office	$ 72,110.55	$ 2,514.86
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 811,301.90	$ 741,706.21

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES ____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,120 B. General Construction Type: Exterior Bricks/Blocks Frame Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	72,000	2008	$ 240,000	1
2	Allocated from Chase Office LLC			2,165	2
3	TOTALS	72,000		$ 242,165	3

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	200		2008	1967	$ 3,912,270	$ 95,770	40	$ 97,807	$ 2,037	$ 1,238,889	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	10,546		20	527	527	6,433	9
10	Various			2009	327,582		20	11,752	11,752	232,905	10
11	Various			2010	106,517		20	3,982	3,982	97,950	11
12	Various			2011	49,798		20	2,490	2,490	24,367	12
13	Various			2012	42,655		20	2,134	2,134	32,921	13
14	Various			2013	97,088		20	3,826	3,826	50,012	14
15	Various			2014	66,208		20	3,310	3,310	21,336	15
16	Various			2015	60,494		20	3,025	3,025	16,975	16
17	Various			2016	26,862		20	1,343	1,343	6,439	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 Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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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)		1,105,185			55,260	55,260	600,909	67
68	Related Party Allocations (Pages 12H & 12I)		134,716	9,506		6,261	(3,245)	26,665	68
69	Financial Statement Depreciation			85,841			(85,841)		69
70	TOTAL (lines 4 thru 69)		$ 5,939,921	$ 191,117		$ 191,717	$ 599	$ 2,355,801	70

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 5,939,921	$ 191,117		$ 191,717	$ 599	$ 2,355,801	1
2	Phone System	2017	11,582		20	579	579	2,316	2
3	Lobby,Front Corridor,Lounge-Door Laminations,Electrical,Floor	2017	53,456		20	2,673	2,673	8,464	3
4	Door Kick Plates, Corner Guards For Lobby (2,639)	2018	2,252		20	113	113	338	4
5	Water Heater For West Wing	2018	3,119		20	156	156	468	5
6	Replace Wardrobe Doors, Handles & Hardware	2018	3,166		20	158	158	448	6
7	Repair Outlets In Resident Rooms & Hallways	2018	5,823		20	291	291	873	7
8	Insulation And Duct Wrap For Kitchen Hood	2019	6,674		20	334	334	668	8
9	Hot Water Heater	2019	7,950		20	398	398	796	9
10	Ptac Heat Pump	2019	2,559		20	128	128	256	10
11	Millwork For Resident Room/Handrail Covers/Bathroom Doors	2019	10,286		20	514	514	1,028	11
12	17 Pairs Window Treatment - Snap Pleat Drapery Benton Chocola	2019	4,051		20	203	203	406	12
13	Ptac Board Compressor, Clean Coils, Evaporators & Condensers	2019	7,085		20	354	354	629	13
14	50 Sets Cubicle Curtains For Resident Rooms	2019	4,862		20	243	243	486	14
15	Repair Of Hot Water Tank; Replace East Wing Hot Water Tank	2020	5,321		20	266	266	266	15
16	Kitchen Hood Exhaut Fan Replacement (3,710)	2020	3,544		20	177	177	177	16
17	4 Ptac Heat Pumps	2020	2,796		20	140	140	140	17
18	6 Ptac Heat Pumps	2020	4,195		20	419	419	419	18
19	Bathroom Door Lamination	2020	27,435		20	1,372	1,372	1,372	19
20	Reconfigure Drain Line & Install New Grease Trap	2020	2,650		20	133	133	133	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)		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	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)		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	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)		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,108,727	$ 191,117		$ 200,367	$ 9,250	$ 2,375,484	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	NURSE CALL SYSTEM	2008	18,272		20	913	913	10,961	9
10	CEILING TILES	2008	33,092		20	1,655	1,655	19,856	10
11	LIGHT FIXTURES	2008	20,266		20	1,013	1,013	12,159	11
12	WROUGHT IRON RAILINGS	2008	6,398		20	320	320	3,839	12
13	FIRE DAMPERS	2008	2,815		20	141	141	1,690	13
14	SECURITY CAMERA SYSTEM	2008	12,685		20	634	634	7,610	14
15	ELECTRIC LOCKS, SWITCHES	2008	5,961		20	298	298	3,576	15
16	ROOFING	2008	117,096		20	5,855	5,855	70,258	16
17	ELECTRICAL	2008	5,068		20	253	253	3,040	17
18	EXHAUST FAN SYSTEM/FIRE DAMPER	2008	16,200		20	810	810	9,720	18
19	REHAB MASTER BATH	2008	19,560		20	978	978	11,736	19
20	DOOR & FRAME	2008	3,096		20	155	155	1,858	20
21	EJECTOR PUMP	2008	7,629		20	381	381	4,576	21
22	SIDEWALKS	2008	12,420		20	621	621	7,452	22
23	ROOFING	2008	114,800		20	5,740	5,740	68,880	23
24	DOORS & FRAMES	2008	14,980		20	749	749	8,988	24
25	REBUILD WALL	2008	3,300		20	165	165	1,835	25
26	REHAB MASTER BATH	2008	10,644		20	532	532	6,386	26
27	WINDOWS	2008	18,972		20	949	949	11,384	27
28	FIRE SPRINKLER SYSTEM	2009	58,790		20	2,940	2,940	32,336	28
29	PUMP-HYDRO PNEUMATIC TANK	2009	14,759		20	738	738	8,118	29
30	WATER MAIN	2009	21,100		20	1,055	1,055	11,605	30
31	SHOWER ROOMS #2 AND #3-Walls, Tiles, Electrical, Paint	2009	11,602		20	580	580	6,381	31
32	RENOVATE ROOMS-Ceiling, Paint, Flooring/Tiles, Electrical	2009	73,641		20	3,682	3,682	40,502	32
33	REBUILD DINING ROOM WALLS	2009	3,558		20	178	178	1,957	33
34	TOTAL (lines 1 thru 33)		$ 626,704	$		$ 31,335	$ 31,335	$ 366,703	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 626,704	$		$ 31,335	$ 31,335	$ 366,703	1
2	EMERGENCY GENERATOR	2009	69,472		20	3,474	3,474	34,737	2
3	REBUILD DINING ROOM WALLS	2009	3,558		20	178	178	1,779	3
4	SUPPLY/INSTALL COOLER/FREEZER	2009	23,450		20	1,173	1,173	11,727	4
5	PTAC's	2009	48,580		20	2,429	2,429	24,290	5
6	ENTRANCE DOOR LOCKS	2009	5,891		20	295	295	2,947	6
7	SLEEVES FOR PTAC	2009	4,724		20	236	236	2,361	7
8	INSTALL ROOM PTAC'S	2009	30,000		20	1,500	1,500	15,000	8
9	CURTAIN WALL REPLACEMENT	2009	27,200		20	1,360	1,360	13,600	9
10	WINDOW REPLACEMENT	2009	23,975		20	1,199	1,199	11,988	10
11	GENERATOR INSTALL	2009	4,952		20	248	248	2,477	11
12	INSTALL HOT WATER RECIRC. SYSTEM	2009	5,500		20	275	275	2,750	12
13	SUPPLY/INSTALL WATER HEATER	2009	8,920		20	446	446	4,460	13
14	DESIGN FIRE PROTECTION SYSTEM	2009	12,000		20	600	600	6,000	14
15	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	15
16	FIRE SPRINKLER SYSTEM	2009	109,181		20	5,459	5,459	54,590	16
17	ALARM SYSTEM	2010	62,230		20	3,112	3,112	28,005	17
18	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	18
19	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,730		20	187	187	1,680	19
20	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	20
21	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	21
22	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	22
23	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,730		20	187	187	1,680	23
24	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	24
25	BATHROOM-TILE, FIXTURES, MIRROR, PAINTING & PLUMBI	2010	3,230		20	162	162	1,455	25
26	ALARM SYSTEM	2010	8,778		20	439	439	3,950	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,105,185	$		$ 55,260	$ 55,260	$ 600,909	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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	19,489	500	20	500		2,207	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	1,094	176	20	55	(121)	547	9
10	Allocated from Aperion Care	2012	310	24	20	16	(8)	124	10
11	Allocated from Aperion Care	2013	132	17	20	7	(10)	46	11
12									12
13	Allocated from Chase Office LLC	2020	389		20	19	19	19	13
14	Allocated from Chase Office LLC	2019	9,926	451	20	496	46	993	14
15	Allocated from Chase Office LLC	2018	89	5	20	4	(0)	13	15
16	Allocated from Chase Office LLC	2017	4,511	1,103	20	226	(877)	902	16
17	Allocated from Chase Office LLC	2016	98,777	7,232	20	4,939	(2,293)	21,813	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)		$ 134,716	$ 9,506		$ 6,261	$ (3,245)	$ 26,665	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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		$ 134,716	$ 9,506		$ 6,261	$ (3,245)	$ 26,665	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
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)		$ 134,716	$ 9,506		$ 6,261	$ (3,245)	$ 26,665	34

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 325,972	$ 10,209	$ 25,996	$ 15,786	10	$ 232,644	71
72	Current Year Purchases	16,686	64	1,673	1,609	10	1,673	72
73	Fully Depreciated Assets	494,853				10	494,853	73
74								74
75	TOTALS	$ 837,511	$ 10,274	$ 27,669	$ 17,396		$ 729,170	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		CHRYSLER VAN	2009	$ 10,320	$	$	$	5	$ 10,320	76
77		09' GMAC SAVANA	2009	37,763				5	37,763	77
78		GMC Savana 2015	2015	51,731		10,346	10,346	5	46,236	78
79		See Attached		16,973	350	3,394	3,044		9,765	79
80	TOTALS			$ 116,787	$ 350	$ 13,740	$ 13,390		$ 104,084	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)	$ 7,305,190	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,741	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,777	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 40,036	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,208,737	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	Renovation-Office/Conf Rm	$ 55,000	92
93	Engineer Svc/Cameras	3,850	93
94	Furniture	3,258	94
95		$ 62,108	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 Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Aperion Care				481			5
6	Allocation from Chase Office				314			6
7	TOTAL				$ 795 **			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: $ 14,856 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	Allocation from Aperion Care		$	$ 2,198	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,198	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 Chicago Heights # 0049940 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff: Units of Service	3 Staff: Cost	4 Outside Practitioner (other than consultant): Units	5 Outside Practitioner (other than consultant): Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 63	$		$ 63	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			2,376			2,376	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				30,363		30,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 2,439	$ 30,363		$ 32,802	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 Chicago Heights # 0049940 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	$ 587,564	$ 1,563,556	1
2	Cash-Patient Deposits	4,234	4,234	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	806,455	806,455	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,863	89,863	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	569	112,889	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,488,685	$ 2,576,997	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		813,733	13
14	Buildings, at Historical Cost		2,124,302	14
15	Leasehold Improvements, at Historical Cost	752,990	2,021,090	15
16	Equipment, at Historical Cost	739,747	1,065,060	16
17	Accumulated Depreciation (book methods)	(1,114,570)	(3,165,222)	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	17,483,850	21,660,012	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,862,017	$ 24,518,975	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,350,702	$ 27,095,972	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 610,188	$ 610,189	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,997,837	1,997,837	29
30	Accrued Salaries Payable	238,067	238,067	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,977	3,977	31
32	Accrued Real Estate Taxes(Sch.IX-B)		748,200	32
33	Accrued Interest Payable	4,628	81,796	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	360,231	1,227,446	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,214,928	$ 4,907,512	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,155,603	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	7,525,553		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,525,553	$ 15,155,603	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,740,481	$ 20,063,115	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,610,221	$ 7,032,857	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,350,702	$ 27,095,972	48

*(See instructions.)

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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**	$ 7,863,163	1
2	Restatements (describe):		2
3	Bad Debts	(18,140)	3
4	Rounding	(3)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,845,020	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,115,201	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	(1,350,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 765,201	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)**	$ 8,610,221	24 *

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

Facility Name & ID Number Aperion Care Chicago Heights # 0049940 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.

	1		
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,799,934	1
2	Discounts and Allowances for all Levels	(5,640,976)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 11,158,958	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	25,970	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 25,970	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,255	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 5,255	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	635,278	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 635,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 11,825,461	30

	2		
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,566,172	31
32	Health Care	3,091,991	32
33	General Administration	2,356,033	33
	B. Capital Expense		
34	Ownership	2,128,228	34
	C. Ancillary Expense		
35	Special Cost Centers	35,019	35
36	Provider Participation Fee	532,817	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 9,710,260	40
41	Income before Income Taxes (line 30 minus line 40)**	2,115,201	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 2,115,201	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 987,067	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care / Insurance	9,880,315	47
48	Other-(specify) PPHP/ISNP	291,576	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,158,958	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 Chicago Heights # 0049940 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	2,032	2,160	$ 106,078	$ 49.11	1
2	Assistant Director of Nursing	1,928	2,491	68,114	27.34	2
3	Registered Nurses	11,433	12,362	443,986	35.92	3
4	Licensed Practical Nurses	17,658	19,605	583,982	29.79	4
5	CNAs & Orderlies	30,734	33,749	490,813	14.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,902	7,620	140,133	18.39	8
9	Activity Director	1,894	2,005	38,098	19.00	9
10	Activity Assistants	5,691	6,026	62,728	10.41	10
11	Social Service Workers	34,272	36,812	752,178	20.43	11
12	Dietician					12
13	Food Service Supervisor	1,964	2,260	56,524	25.01	13
14	Head Cook	4,804	5,213	64,776	12.43	14
15	Cook Helpers/Assistants	11,201	11,842	130,245	11.00	15
16	Dishwashers					16
17	Maintenance Workers	18,609	19,864	292,709	14.74	17
18	Housekeepers	5,047	5,332	96,910	18.18	18
19	Laundry					19
20	Administrator	304	391	19,036	48.69	20
21	Assistant Administrator	472	480	19,004	39.59	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,497	8,800	189,865	21.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,893	2,140	40,122	18.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	195	198	3,466	17.51	33
34	TOTAL (lines 1 - 33)	164,530	179,350	$ 3,598,767 *	$ 20.07	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,522	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	68,269	10-03	38
39	Pharmacist Consultant	Per Unit	26,103	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	86	5,483	11-03	44
45	Social Service Consultant	79	4,950	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	165	$ 145,527		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Aperion Care Chicago Heights # 0049940 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tamara Dobbins	Administrator	0	$ 13,143
Jessica Gardner	Interim Admin	0	5,893
Chelsea Mumford	Asst. Administrator	0	19,004
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 38,040

B. Administrative - Other

Description	Amount
Management Fees - Aperion Care, Inc.	$ 531,139
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 531,139

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 16,995
Propay HR	Payroll Processing	25,518
AbilityNetwork Inc.	Eligibility Software	4,561
Aperion Care, Inc.	Data Processing	15,027
Creative Technology Solutions	IT Consulting	11,725
DGTELL LLC	Telecommunication Service	802
EMSA Purchasing Group LLC	Procurement Solutions	3,850
PointClickCare Technologies	Data Processing	62,280
Reside Admissions	Data Processing	5,080
Z-Core Analytics, LLC	Reimbursement Consulting	580
See Attached	Legal	4,449
See Supplemental Schedule		490,566
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 641,433

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,467
Unemployment Compensation Insurance	29,338
FICA Taxes	275,306
Employee Health Insurance	78,574
Employee Meals	4,058
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	813
Employee Physicals	19,555
Other Employee Benefits	23,046
TOTAL (agree to Schedule V, line 22, col.8)	$ 538,157

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		$ 3,980
Advertising: Employee Recruitment		24,024
Health Care Worker Background Check		844
(Indicate # of checks performed	84)	
Patient Background Checks	292	2,915
Dues & Subscriptions		21,274
Licenses & Fees		1,241
See Supplemental Schedule		8,938
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 63,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	775
See Supplemental Schedule	864
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,639

**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 $28,022**

(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. $ **727** 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. $ **532,817**
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. $ **4,058** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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.