

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0049247</u></p> <p>Facility Name: <u>Aperion Care Forest Park</u></p> <p>Address: <u>8200 W Roosevelt Rd</u> <u>Forest Park</u> <u>60130</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 488-9850</u> Fax # <u>(708) 488-9870</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>7/1/2007</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td colspan="3">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">* Subject to the attached Accountants' Consulting Report</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(847) 282-6300</u></td> <td>Fax # <u>(847) 282-6301</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____			Paid Preparer	(Signed) _____	(Date) _____	* Subject to the attached Accountants' Consulting Report		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u>		Fax # <u>(847) 282-6301</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<p>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</p>																																												

Facility Name & ID Number Aperion Care Forest Park

0049247 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	232	Skilled (SNF)	232	84,912	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,912	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	52,323	1,197	13,688	67,208	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,323	1,197	13,688	67,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.15%

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 227 and days of care provided 6,957

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Aperion Care Forest Park # 0049247 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	517,468	57,096	21,522	596,086		596,086	8,901	604,987		1
2	Food Purchase		402,398		402,398		402,398	(305)	402,093		2
3	Housekeeping	393,452	125,305		518,757		518,757	630	519,387		3
4	Laundry		24,231	181,407	205,638		205,638		205,638		4
5	Heat and Other Utilities			227,916	227,916		227,916	(16,144)	211,772		5
6	Maintenance	89,464	29,050	150,043	268,557		268,557	(5,178)	263,379		6
7	Other (specify):*							4,277	4,277		7
8	TOTAL General Services	1,000,384	638,080	580,888	2,219,352		2,219,352	(7,819)	2,211,533		8
	B. Health Care and Programs										
9	Medical Director			44,000	44,000		44,000	3,024	47,024		9
10	Nursing and Medical Records	5,436,273	666,341	108,146	6,210,760		6,210,760	43,872	6,254,632		10
10a	Therapy	199,362	7,253		206,615		206,615		206,615		10a
11	Activities	242,405	5,564	1,322	249,291		249,291	32	249,323		11
12	Social Services	222,486		3,908	226,394		226,394		226,394		12
13	CNA Training										13
14	Program Transportation			37,803	37,803		37,803		37,803		14
15	Other (specify):*							12,602	12,602		15
16	TOTAL Health Care and Programs	6,100,526	679,158	195,179	6,974,863		6,974,863	59,530	7,034,393		16
	C. General Administration										
17	Administrative	221,537		826,176	1,047,713		1,047,713	(750,843)	296,870		17
18	Directors Fees										18
19	Professional Services			986,181	986,181	(68,055)	918,126	(602,994)	315,132		19
20	Dues, Fees, Subscriptions & Promotions			92,117	92,117		92,117	(16,260)	75,857		20
21	Clerical & General Office Expenses	247,255		790,542	1,037,797		1,037,797	(492,168)	545,629		21
22	Employee Benefits & Payroll Taxes			1,226,219	1,226,219		1,226,219		1,226,219		22
23	Inservice Training & Education										23
24	Travel and Seminar			943	943		943	832	1,775		24
25	Other Admin. Staff Transportation			4,471	4,471		4,471	2,527	6,998		25
26	Insurance-Prop.Liab.Malpractice			1,362,717	1,362,717		1,362,717	1,029	1,363,746		26
27	Other (specify):*							37,625	37,625		27
28	TOTAL General Administration	468,792		5,289,366	5,758,158	(68,055)	5,690,103	(1,820,250)	3,869,853		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,569,702	1,317,238	6,065,433	14,952,373	(68,055)	14,884,318	(1,768,538)	13,115,780		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.

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			416,694	416,694		416,694	(124,154)	292,540		30
31	Amortization of Pre-Op. & Org.			2,585	2,585		2,585	(2,585)			31
32	Interest			76,309	76,309		76,309	33,361	109,670		32
33	Real Estate Taxes			639,027	639,027	68,055	707,082	3,245	710,327		33
34	Rent-Facility & Grounds			1,450,389	1,450,389		1,450,389	(29,234)	1,421,155		34
35	Rent-Equipment & Vehicles			16,835	16,835		16,835	2,887	19,722		35
36	Other (specify):*										36
37	TOTAL Ownership			2,601,839	2,601,839	68,055	2,669,894	(116,479)	2,553,415		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		802,514	987,507	1,790,021		1,790,021	(149,986)	1,640,035		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			479,646	479,646		479,646		479,646		42
43	Other (specify):*			3,022	3,022		3,022	(3,022)			43
44	TOTAL Special Cost Centers		802,514	1,470,175	2,272,689		2,272,689	(153,008)	2,119,681		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,569,702	2,119,752	10,137,447	19,826,901		19,826,901	(2,038,025)	17,788,876		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 Forest Park

0049247

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(17,364)	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	(143,550)	30		9
10	Interest and Other Investment Income	(4,260)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	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	(66,207)	21		18
19	Entertainment				19
20	Contributions	(4,100)	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	(657,366)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(97,713)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (990,632)		\$	30

BHF USE ONLY							
48		49		50		51	

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	2	
		Amount	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)	(1,047,393)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,047,393)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,038,025)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Aperion Care Forest Park

ID# 0049247

Report Period Beginning: 01/01/20

Ending: 12/31/20

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (52,452)	19	1
2	Bank Charges	(7,085)	21	2
3	Theft & Damage Loss	(2,519)	21	3
4	Supplemental Insurance	(26)	21	4
5	Credit Card Processing	(5,325)	21	5
6	Marketing Expense	(3,022)	43	6
7	Amortization	(2,585)	31	7
8	Other Unclassified Income	(25)	21	8
9	Vending Commissions	(400)	02	9
10	Additional R&M	7,573	06	10
11	Capitalized R&M	(9,305)	06	11
12	PAC Dues	(20,771)	20	12
13	Prior Year Professional	(532)	19	13
14	Prior Year Equipment Rental	(1,239)	35	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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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	(97,713)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Forest Park# 0049247

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				8,901								8,901	1
2	Food Purchase	(472)		167									(305)	2
3	Housekeeping			59			571						630	3
4	Laundry													4
5	Heat and Other Utilities	(17,364)					1,220						(16,144)	5
6	Maintenance	(1,732)		3,027	(8,414)		1,941						(5,178)	6
7	Other (specify):*			317	3,960								4,277	7
8	TOTAL General Services	(19,568)		3,570	4,447		3,732						(7,819)	8
	B. Health Care and Programs													
9	Medical Director			3,024									3,024	9
10	Nursing and Medical Records			7,865	35,893		114						43,872	10
10a	Therapy													10a
11	Activities			32									32	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			875	11,727								12,602	15
16	TOTAL Health Care and Programs			11,797	47,620		114						59,530	16
	C. General Administration													
17	Administrative			(750,843)									(750,843)	17
18	Directors Fees													18
19	Professional Services	(52,984)		(85,144)	4,558	(460,713)	1,694		(10,405)				(602,994)	19
20	Fees, Subscriptions & Promotions	(24,871)		7,681	56	865	9						(16,260)	20
21	Clerical & General Office Expenses	(738,553)		57,529	838	186,240	1,778						(492,168)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			467	279	86							832	24
25	Other Admin. Staff Transportation			2,505	22								2,527	25
26	Insurance-Prop.Liab.Malpractice			1,029									1,029	26
27	Other (specify):*			14,879		22,746							37,625	27
28	TOTAL General Administration	(816,408)		(751,895)	5,753	(250,776)	3,481		(10,405)				(1,820,250)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(835,976)		(736,529)	57,820	(250,776)	7,327		(10,405)				(1,768,538)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(143,550)		2,064	356	365	16,610						(124,154)	30
31	Amortization of Pre-Op. & Org.	(2,585)											(2,585)	31
32	Interest	(4,260)		33,478			4,143						33,361	32
33	Real Estate Taxes						3,245						3,245	33
34	Rent-Facility & Grounds			464			(29,698)						(29,234)	34
35	Rent-Equipment & Vehicles	(1,239)		2,118		490	1,518						2,887	35
36	Other (specify):*													36
37	TOTAL Ownership	(151,634)		38,124	356	855	(4,180)						(116,479)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(149,986)			(149,986)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,022)											(3,022)	43
44	TOTAL Special Cost Centers	(3,022)								(149,986)			(153,008)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(990,632)		(698,405)	58,176	(249,921)	3,147		(10,405)	(149,986)			(2,038,025)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Declaration of Trust of Yosef Meystel	47.75%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	David A. Berkowitz Revocable Trust	47.75%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	David Kleiner	1.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Mordechai Groner	1.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Isaac Scheiner Ugma Rachel Scheiner	1.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Jacob Scheiner Ugma Ari Scheiner	0.50%	Aperion Care Demotte	Demotte,IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Jacob Scheiner Ugma Dov Scheiner	0.50%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jacob Scheiner Ugma Nosson Scheiner	0.50%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9			Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10			Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	11
12			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	12
13			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	13
14			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	14
15			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	15
16			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	16
17			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	17
18			Aperion Care Marseilles	Marseilles	Renewal Rehab, LLC	Lincolnwood	Therapy Services	18
19			Aperion Care Mascoutah	Mascoutah	San Antonio Property, LLC	San Antonio, TX	Building Co.	19
20			Aperion Care Midlothian	Midlothian				20
21			Aperion Care Morton Villa	Morton				21
22			Aperion Care Oak Lawn	Oak Lawn				22
23			Aperion Care Peoria Heights	Peoria Heights				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Plum Grove	Palatine				25
26			Aperion Care Princeton	Princeton				26
27			Aperion Care Spring Valley	Spring Valley				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number

Aperion Care Forest Park

0049247

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	Aperion Care, Inc.		\$ 167	\$	167	15
16	V	3 Housekeeping		Aperion Care, Inc.		59		59	16
17	V	6 Maintenance Salary		Aperion Care, Inc.		2,850		2,850	17
18	V	6 Repairs & Maintenance		Aperion Care, Inc.		177		177	18
19	V	7 Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		317		317	19
20	V	9 Medical Director		Aperion Care, Inc.		3,024		3,024	20
21	V	10 Salary - Nurse		Aperion Care, Inc.		7,865		7,865	21
22	V	11 Activities		Aperion Care, Inc.		32		32	22
23	V	15 Payroll Taxes / Group Insurance		Aperion Care, Inc.		875		875	23
24	V	17 Administrative Salaries		Aperion Care, Inc.		75,333		75,333	24
25	V	19 Professional Fees		Aperion Care, Inc.		13,512		13,512	25
26	V	20 Fees, Subscriptions		Aperion Care, Inc.		7,681		7,681	26
27	V	21 Clerical Salary		Aperion Care, Inc.		55,421		55,421	27
28	V	21 Clerical & General		Aperion Care, Inc.		2,109		2,109	28
29	V	24 Seminars		Aperion Care, Inc.		467		467	29
30	V	25 Auto & Travel		Aperion Care, Inc.		2,505		2,505	30
31	V	26 Insurance		Aperion Care, Inc.		1,029		1,029	31
32	V	27 Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		14,879		14,879	32
33	V	30 Depreciaiton		Aperion Care, Inc.		2,064		2,064	33
34	V	32 Interest		Aperion Care, Inc.		33,478		33,478	34
35	V	34 Rent		Aperion Care, Inc.		464		464	35
36	V	35 Auto Lease		Aperion Care, Inc.		2,118		2,118	36
37	V	17 Management Fee	826,176	Aperion Care, Inc.				(826,176)	37
38	V	19 Home Office	98,656	Aperion Care, Inc.				(98,656)	38
39	Total		\$ 924,832			\$ 226,427	\$ *	(698,405)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1		Aperion Consulting, LLC		\$ 30,423	\$ 30,423	15
16	V	6		Aperion Consulting, LLC		5,149	5,149	16
17	V	6		Aperion Consulting, LLC		110	110	17
18	V	7		Aperion Consulting, LLC		3,960	3,960	18
19	V	10		Aperion Consulting, LLC		103,575	103,575	19
20	V	15		Aperion Consulting, LLC		11,727	11,727	20
21	V	19		Aperion Consulting, LLC		4,558	4,558	21
22	V	20		Aperion Consulting, LLC		56	56	22
23	V	21		Aperion Consulting, LLC		838	838	23
24	V	24		Aperion Consulting, LLC		279	279	24
25	V	25		Aperion Consulting, LLC		22	22	25
26	V	27		Aperion Consulting, LLC				26
27	V	30		Aperion Consulting, LLC		356	356	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V	10	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	10		Aperion Consulting, LLC				34
35	V	01	21,522	Aperion Consulting, LLC			(21,522)	35
36	V	06	13,673	Aperion Consulting, LLC			(13,673)	36
37	V							37
38	V							38
39	Total		\$ 102,877			\$ 161,053	\$ * 58,176	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Fees		Aperion Financial, LLC		5,815	\$ 5,815
16	V	20 Fees, Subscriptions		Aperion Financial, LLC		865	865
17	V	21 Clerical & General		Aperion Financial, LLC		109,699	109,699
18	V	24 Seminars		Aperion Financial, LLC		86	86
19	V	25 Auto & Travel		Aperion Financial, LLC			
20	V	27 Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		13,295	13,295
21	V	30 Depreciaton		Aperion Financial, LLC		365	365
22	V	32 Interest		Aperion Financial, LLC			
23	V	35 Equipment Rental		Aperion Financial, LLC		490	490
24	V	21 Clerical & General -IL Only		Aperion Financial, LLC		76,541	76,541
25	V	27 Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		9,451	9,451
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V	19 Home Office Expense	466,528	Aperion Financial, LLC			(466,528)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 466,528			\$ 216,607	\$ * (249,921)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Chase Office, LLC		\$ 1,220	\$ 1,220
16	V	6 Repairs & Maintenance		Chase Office, LLC		1,941	1,941
17	V	3 Housekeeping		Chase Office, LLC		571	571
18	V	10 Medical Supplies		Chase Office, LLC		114	114
19	V	19 Professional Fees		Chase Office, LLC		2,227	2,227
20	V	20 Dues & Subscriptions		Chase Office, LLC		9	9
21	V	21 Office Expense		Chase Office, LLC		1,778	1,778
22	V	30 Depreciation		Chase Office, LLC		16,610	16,610
23	V	32 Interest Expense		Chase Office, LLC		4,143	4,143
24	V	33 Real Estate Taxes		Chase Office, LLC		3,245	3,245
25	V	35 Equipment Rental		Chase Office, LLC		1,518	1,518
26	V	34 Rent	30,000	Chase Office, LLC		302	(29,698)
27	V						
28	V						
29	V						
30	V	19 Data Processing	3,500	EMSA Purchasing Group		2,967	(533)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 33,500			\$ 36,647	\$ * 3,147

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04 Laundry Services	\$ 181,407	EcoBrite Linen		\$ 181,407	\$	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		\$ 181,407			\$ 181,407	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 45,415	ProPay HR LLC		\$ 35,010	\$ (10,405)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 45,415			\$ 35,010	\$ * (10,405)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 982,080	Renewal Rehab, LLC		\$ 832,094	\$ (149,986)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 982,080			\$ 832,094	\$ * (149,986)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 949,982	Aperion Incorporated Cell		\$ 949,982	\$	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		\$ 949,982			\$ 949,982	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary Services	\$ 226,515	Concerto Dialysis		\$ 226,515	\$	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		\$ 226,515			\$ 226,515	\$ *	39

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

Facility Name & ID Number

Aperion Care Forest Park

0049247

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.41	3.54%	Alloc Sal	\$ 8,843	17-7	1	
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	1.41	3.54%	Alloc Sal	2,081	21-7	2	
3	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.97	3.54%	Alloc Sal	1,097	21-7	3	
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.41	3.54%	Alloc Sal	4,065	17-7	4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 16,086		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 Forest Park

0049247

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Aperion Care Forest Park

0049247

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

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

Name of Related Organization

Aperion Care, Inc.

Street Address

4655 W. Chase Avenue

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-8300

Fax Number

(

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Census/Direct Cost	1,899,996	65	\$ 4,717	\$ 67,208	\$ 167	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663	67,208	59	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	67,208	2,850	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009	67,208	177	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146	67,208	317	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500	67,208	3,024	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	67,208	7,865	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912	67,208	32	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060	67,208	875	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	67,208	75,333	10
11	17	Management Fees	Census/Direct Cost	1,899,996	65	250,000	67,208		11
12	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984	67,208	13,512	12
13	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158	67,208	7,681	13
14	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	67,208	55,421	14
15	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611	67,208	2,109	15
16	24	Seminars	Census/Direct Cost	1,899,996	65	13,215	67,208	467	16
17	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828	67,208	2,505	17
18	26	Insurance	Census/Direct Cost	1,899,996	65	29,094	67,208	1,029	18
19	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479	67,208	14,879	19
20	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358	67,208	2,064	20
21	32	Interest	Census/Direct Cost	1,899,996	65	946,429	67,208	33,478	21
22	34	Rent	Census/Direct Cost	1,899,996	65	13,110	67,208	464	22
23	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876	67,208	2,118	23
24									24
25	TOTALS					\$ 6,943,967	\$ 4,262,818	\$ 226,427	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	46	\$ 498,880	\$ 498,880	67,208	\$ 30,423	1
2	6	Maintenance Salary-Illinois Only	Census	46	84,435	84,435	67,208	5,149	2
3	6	Repairs & Maintenance	Census	65	2,434		67,208	110	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	46	64,932		67,208	3,960	4
5	10	Salary Nurse-Illinois	Census	46	1,698,414	1,698,414	67,208	103,575	5
6	15	Emp. Ben HC-Illinois	Census	46	192,301		67,208	11,727	6
7	19	Professional Fees	Census	65	100,933		67,208	4,558	7
8	20	Fees, Subscriptions	Census	65	1,250		67,208	56	8
9	21	Clerical & General	Census	65	18,558		67,208	838	9
10	24	Seminars	Census	65	6,182		67,208	279	10
11	25	Auto & Travel	Census	65	484		67,208	22	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	65			67,208		12
13	30	Depreciation	Census	46	7,885		67,208	356	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		\$ 161,053	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380	67,208	5,815	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450	67,208	865	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	109,699	3
4	24	Seminars	Census	1,899,996	65	2,428	67,208	86	4
5	25	Auto & Travel	Census	1,899,996	65		67,208		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858	67,208	13,295	6
7	30	Depreciaton	Census	1,899,996	65	10,323	67,208	365	7
8	32	Interest	Census	1,899,996	65		67,208		8
9	35	Equipment Rental	Census	1,899,996	65	13,849	67,208	490	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	76,541	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211	67,208	9,451	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	\$ 216,607	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	\$ 34,497	\$ 67,208	\$ 1,220	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886	67,208	1,941	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134	67,208	571	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211	67,208	114	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958	67,208	2,227	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256	67,208	9	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267	67,208	1,778	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583	67,208	16,610	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136	67,208	4,143	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748	67,208	3,245	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550	67,208	1,518	11
12	34	Rent	Actual Census	1,899,996	64	42,922	67,208	302	12
13									13
14									14
15									15
16	19	Data Processing	Direct					2,967	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 952,148	\$	\$ 36,647	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	4	Laundry Services	Direct		\$	\$		\$ 181,407	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				\$	\$		\$ 181,407	25

Facility Name & ID Number Aperion Care Forest Park

0049247

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

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 35,010	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				\$	\$		\$ 35,010	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Renewal Rehab, LLC

Street Address

7358 N. Lincoln Ave., Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 938-8750

Fax Number

(847) 410-9720

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	59	\$	\$		\$ 832,094	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				\$	\$		\$ 832,094	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		\$ 949,982	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				\$	\$		\$ 949,982	25

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Concerto Dialysis, LLC

Street Address

5255 GOLF RD / 4600 W Touhy Ave #100

City / State / Zip Code

SKOKIE, IL 60077 / Lincolnwood, IL 60712

Phone Number

(847) 663 - 8300 / (847) 233-1200

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services	Direct		\$	\$		\$ 226,515	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				\$	\$		\$ 226,515	25

Facility Name & ID Number

Aperion Care Forest Park

0049247

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$	1					
2													2					
3													3					
4													4					
5													5					
	Working Capital																	
6	First Midwest Bank		X	Line of Credit				2,534,499				75,334	6					
7	Insurance Policies		X									975	7					
8	See Supplemental Schedule											37,621	8					
9	TOTAL Facility Related						\$	\$ 2,534,499				\$ 113,930	9					
	B. Non-Facility Related*																	
10	Interest Income		X									(4,260)	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$ (4,260)	14					
15	TOTALS (line 9+line14)						\$	\$ 2,534,499				\$ 109,670	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number Aperion Care Forest Park

0049247

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.	\$ <u>610,491</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$ <u>628,004</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$ <u>17,513</u>	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$ <u>624,759</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$ <u>68,055</u>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>202,984</u> For <u>16-18</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$ <u>710,327</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<u>2015</u>	<u>480,683</u>	<u>8</u>
	<u>2016</u>	<u>488,707</u>	<u>9</u>
	<u>2017</u>	<u>596,478</u>	<u>10</u>
	<u>2018</u>	<u>610,491</u>	<u>11</u>
	<u>2019</u>	<u>624,759</u>	<u>12</u>

2020 Tax Accrual = 2019 Expense
Allocated from Chase Office LLC: \$3,245

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

FACILITY IDPH LICENSE NUMBER 0049247

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>15-24-100-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>624,758.63</u>	\$ <u>624,758.63</u>
2. <u>10-27-307-027-0000</u>	<u>Home Office</u>	\$ <u>72,110.55</u>	\$ <u>2,423.21</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>696,869.18</u></u>	\$ <u><u>627,181.84</u></u>

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 Forest Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049247

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Forest Park

0049247

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,467 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from Chase Office</u>			<u>\$ 2,087</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 2,087	3

Facility Name & ID Number Aperion Care Forest Park

0049247

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	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	Various	2007		15,031		20	751	751	11,039
10	Various	2008		91,692		20	2,644	2,644	82,572
11	Various	2009		60,525		20	579	579	55,596
12	Various	2010		247,742		20	11,457	11,457	175,195
13	Various	2011		240,578		20	12,030	12,030	130,022
14	Various	2012		323,677		20	16,045	16,045	144,375
15	Various	2013		154,638		20	7,733	7,733	63,813
16	Various	2014		333,264		20	16,067	16,067	116,382
17	Various	2015		453,321		20	22,668	22,668	127,366
18	Various	2016		146,843		20	7,344	7,344	33,709
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			129,807	9,160	6,033	(3,127)	25,693	68
69				416,694		(416,694)		69
70		\$	2,197,118	\$	103,351	\$	965,762	70

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

Facility Name & ID Number Aperion Care Forest Park# 0049247

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,197,118	\$ 425,854		\$ 103,351	\$ (322,503)	\$ 965,762	1
2	Data & Voice Cables - 4Th Floor Office	2017	3,659		20	183	183	732	2
3	Oxygen Room Replacement Doors	2017	4,530		20	227	227	888	3
4	Radiation Dampers, Insulation - Fire Dampers	2017	11,675		20	584	584	2,287	4
5	Doors, Lighting, Millwork, Plumbing, Walls - 2Nd Floor	2017	394,230		20	19,711	19,711	77,203	5
6	Repair Leak & Replace Parts - Chiller	2017	19,066		20	953	953	3,416	6
7	Wall Covering,Bumpers,Signs,Lighting,Cable,Cork Boards,Count	2017	1,077,015		20	53,851	53,851	192,965	7
8	Install Cylinder For Elevator (53,100)	2017	53,048		20	2,652	2,652	8,399	8
9	Cable / Wiring - Phone Service	2017	4,710		20	236	236	746	9
10	Install New Roller Guides, Replace Door - Elevator	2017	6,371		20	319	319	1,248	10
11	Replace Main Breaker Assembly, Circuit Board - Elevator	2017	5,132		20	257	257	941	11
12	Install New Door Motor - Elevator	2017	3,073		20	154	154	564	12
13	Install New Edge Detector - Elevator	2017	3,409		20	170	170	625	13
14	Replace Motor For Air Cooler - Elevator	2017	3,612		20	181	181	663	14
15	Heating Coils - Rms 212, 211, 221, 224	2017	2,861		20	143	143	572	15
16	Hmv Board, Iox Board - Elevator	2017	5,472		20	274	274	844	16
17	Flushed & Cleaned Fresh Air Intake - Main A/C	2017	8,084		20	404	404	1,482	17
18	Flame Rod, Utc Comodule, Spark Ignition - Kitchen Heater	2017	4,411		20	221	221	828	18
19	New Motor - 4Th Floor Convectur Unit	2017	2,961		20	148	148	530	19
20	Boiler	2018	14,320		20	716	716	2,088	20
21	Repaired 2Nd Floor Therapy Room - Fire Dampler / Flooring	2018	5,886		20	294	294	760	21
22	Solid Slate Starters On Elevator	2018	5,550		20	278	278	671	22
23	Compressor For Chiller	2018	35,172		20	1,759	1,759	3,737	23
24	Ot Gym - Electrical, Flooring, Millwork, Wall Surfaces (207,498)	2018	200,565		20	10,028	10,028	29,249	24
25	Mechanical Door Repair	2018	3,870		20	194	194	581	25
26	A/C Repair In Room 305 & 318	2018	4,229		20	211	211	511	26
27	Furnish & Install 2 New Solid State Starters On 3 Controllers	2018	3,885		20	194	194	469	27
28	Power Supply Replacement	2018	6,920		20	346	346	1,038	28
29	Kitchen Pump Repair	2018	2,731		20	137	137	319	29
30	Refigeration System	2019	6,500		20	325	325	650	30
31	Replace Comp In Rtaa Chiller	2019	8,755		20	438	438	584	31
32	Waunderguard Management System	2019	12,560		20	628	628	785	32
33	4Th Flr Dining & Resident Rooms-Ceilings/Electrical/Floors/Wall	2019	254,672		20	12,734	12,734	25,468	33
34	TOTAL (lines 1 thru 33)		\$ 4,376,052	\$ 425,854		\$ 212,301	\$ (213,553)	\$ 1,327,605	34

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

Facility Name & ID Number Aperion Care Forest Park

0049247

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	2	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 12B, Carried Forward		\$ 4,376,052	\$ 425,854		\$ 212,301	\$ (213,553)	\$ 1,327,605	1
2	Rear Entrance Blower Motor, Installed New Motor For 1St Floor	2019	7,976		20	399	399	1,197	2
3	Repaired Ac/Chiller System	2019	2,903		20	145	145	435	3
4	Installed 2 Motors For Exhaust Fan	2019	2,863		20	143	143	429	4
5	Roof Repair	2019	2,500		20	125	125	375	5
6	Installed New Jockey Pump	2019	2,695		20	135	135	405	6
7	Installed New Hanger Rollers And Door - Elevator	2019	5,921		20	296	296	888	7
8	Rebuilt Building Boiler Pump	2020	2,837		20	142	142	142	8
9	Fire Alarm Panel Repair (\$15,497)	2020	13,630		20	682	682	682	9
10	Major Parking Lot Repairs	2020	15,719		20	786	786	786	10
11	Replace Electronic Expansion Valve On Chiller	2020	18,512		20	926	926	926	11
12	New Motor For Trane Rtu Air Conditioner (\$4,088)	2020	3,922		20	196	196	196	12
13	Security Camera (\$15,718)	2020	14,640		20	732	732	732	13
14	A/C Repair - Damaged Wiring, New Drive Motor	2020	2,606		20	130	130	130	14
15	Air Heat Unit Fan Motor Repair - Admin Office And Lobby	2020	2,965		20	148	148	148	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,475,741	\$ 425,854		\$ 217,285	\$ (208,568)	\$ 1,335,076	34

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

Facility Name & ID Number Aperion Care Forest Park

0049247

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		\$ 4,475,741	\$ 425,854		\$ 217,285	\$ (208,568)	\$ 1,335,076	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,475,741	\$ 425,854		\$ 217,285	\$ (208,568)	\$ 1,335,076	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,475,741	\$ 425,854		\$ 217,285	\$ (208,568)	\$ 1,335,076	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 4,475,741	\$ 425,854		\$ 217,285	\$ (208,568)	\$ 1,335,076	34

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

Facility Name & ID Number Aperion Care Forest Park

0049247

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 Building Company		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	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	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	<u>Allocated from Chase Office LLC</u>	<u>2016</u>	<u>18,779</u>	<u>482</u>	<u>20</u>	<u>482</u>		<u>2,127</u>	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from Aperion Care</u>	<u>2010</u>	<u>1,054</u>	<u>169</u>	<u>20</u>	<u>53</u>	<u>(117)</u>	<u>527</u>	9
10	<u>Allocated from Aperion Care</u>	<u>2012</u>	<u>299</u>	<u>23</u>	<u>20</u>	<u>15</u>	<u>(8)</u>	<u>120</u>	10
11	<u>Allocated from Aperion Care</u>	<u>2013</u>	<u>127</u>	<u>16</u>	<u>20</u>	<u>6</u>	<u>(10)</u>	<u>44</u>	11
12									12
13	<u>Allocated from Chase Office LLC</u>	<u>2020</u>	<u>375</u>		<u>20</u>	<u>19</u>	<u>19</u>	<u>19</u>	13
14	<u>Allocated from Chase Office LLC</u>	<u>2019</u>	<u>9,564</u>	<u>434</u>	<u>20</u>	<u>478</u>	<u>44</u>	<u>956</u>	14
15	<u>Allocated from Chase Office LLC</u>	<u>2018</u>	<u>85</u>	<u>5</u>	<u>20</u>	<u>4</u>	<u>(0)</u>	<u>13</u>	15
16	<u>Allocated from Chase Office LLC</u>	<u>2017</u>	<u>4,347</u>	<u>1,063</u>	<u>20</u>	<u>217</u>	<u>(845)</u>	<u>869</u>	16
17	<u>Allocated from Chase Office LLC</u>	<u>2016</u>	<u>95,177</u>	<u>6,968</u>	<u>20</u>	<u>4,759</u>	<u>(2,209)</u>	<u>21,018</u>	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)		\$ 129,807	\$ 9,160		\$ 6,033	\$ (3,127)	\$ 25,693	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	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 12H, Carried Forward		\$ 129,807	\$ 9,160		\$ 6,033	\$ (3,127)	\$ 25,693	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 129,807	\$ 9,160		\$ 6,033	\$ (3,127)	\$ 25,693	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 727,147	\$ 9,837	\$ 72,852	\$ 63,014	10	\$ 292,647	71
72	Current Year Purchases	8,750	62	879	818	10	879	72
73	Fully Depreciated Assets	357,599				10	357,599	73
74								74
75	TOTALS	\$ 1,093,496	\$ 9,899	\$ 73,731	\$ 63,832		\$ 651,125	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care Inc	2020	\$ 7,618	\$ 337	\$ 1,524	\$ 1,187	5	\$ 3,815	76
77										77
78										78
79										79
80	TOTALS			\$ 7,618	\$ 337	\$ 1,524	\$ 1,187		\$ 3,815	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)	\$ 5,578,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 436,090	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 292,540	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (143,550)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,990,016	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Forest Park Property

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:	<u>232</u>		\$ <u>1,420,389</u>			3
4	Additions						4
5	<u>Allocated from Aperion Care Inc</u>			<u>464</u>			5
6	<u>Allocated from Chase Office</u>			<u>302</u>			6
7	TOTAL	232		\$ <u>1,421,155</u>			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2021</u>	\$ _____
13.	<u>/2022</u>	\$ _____
14.	<u>/2023</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 17,604 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	<u>Allocated from Aperion Care Inc</u>		\$ _____	\$ <u>2,118</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>2,118</u>	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 407,613	\$		\$ 407,613	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			126,246			126,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			447,641			447,641	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				439,382		439,382	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Attached</u>					6,007	363,132		369,139	13
14	TOTAL			\$		\$ 987,507	\$ 802,514		\$ 1,790,021	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 Forest Park

0049247

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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 700,319	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,545,094		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	134,386		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	276,729		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,656,528	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	4,064,613		15
16	Equipment, at Historical Cost	780,209		16
17	Accumulated Depreciation (book methods)	(3,020,124)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	964,015		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,788,713	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,445,241	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,981,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,534,499		29
30	Accrued Salaries Payable	572,172		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,117		31
32	Accrued Real Estate Taxes(Sch.IX-B)	624,759		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	2,786,035		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,519,195	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,519,195	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,073,954)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,445,241	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,393,312)	1
2	Restatements (describe):		2
3	<u>Bad Debts</u>	(67,613)	3
4	<u>Rounding</u>	6	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,460,919)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	403,165	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	(16,200)	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)	\$ 386,965	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)	\$ (2,073,954)	24 *

* This must agree with page 17, line 47.

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	\$ 21,744,030	1
2	Discounts and Allowances for all Levels	(3,239,204)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 18,504,826	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	302,448	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 302,448	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	26,355	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	958	19
20	Radiology and X-Ray	1,338	20
21	Other Medical Services	10,070	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 38,721	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,260	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,260	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	1,379,811	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,379,811	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,230,066	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,219,352	31
32	Health Care	6,974,863	32
33	General Administration	5,758,158	33
B. Capital Expense			
34	Ownership	2,601,839	34
C. Ancillary Expense			
35	Special Cost Centers	1,793,043	35
36	Provider Participation Fee	479,646	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,826,901	40
41	Income before Income Taxes (line 30 minus line 40)**	403,165	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 403,165	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,285,691	44
45	Private Pay - Net Inpatient Revenue	386,983	45
46	Medicare - Net Inpatient Revenue	4,638,749	46
47	Other-(specify) <u>Insurance</u>	2,196,090	47
48	Other-(specify) <u>Managed Care/PPHP/ISNP</u>	8,997,313	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 18,504,826	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 Forest Park

0049247

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	1,992	2,195	\$ 126,004	\$ 57.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,383	38,824	1,395,353	35.94	3
4	Licensed Practical Nurses	47,049	51,060	1,861,702	36.46	4
5	CNAs & Orderlies	94,579	102,172	2,012,140	19.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,454	8,847	199,362	22.53	8
9	Activity Director	1,816	1,916	45,109	23.54	9
10	Activity Assistants	10,558	11,766	189,545	16.11	10
11	Social Service Workers	8,279	9,163	222,486	24.28	11
12	Dietician					12
13	Food Service Supervisor	4,102	4,502	95,017	21.11	13
14	Head Cook	4,431	4,733	82,344	17.40	14
15	Cook Helpers/Assistants	19,732	21,775	340,107	15.62	15
16	Dishwashers					16
17	Maintenance Workers	3,659	4,037	89,464	22.16	17
18	Housekeepers	23,037	25,590	393,452	15.38	18
19	Laundry					19
20	Administrator	2,211	2,237	149,833	66.98	20
21	Assistant Administrator	1,920	2,102	71,704	34.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,332	11,406	247,255	21.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	41,074	19.75	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	610	610	7,751	12.71	33
34	TOTAL (lines 1 - 33)	279,144	305,015	\$ 7,569,702 *	\$ 24.82	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	44,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	462	27,804	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	24	1,322	11-03	44
45	Social Service Consultant	64	3,908	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	550	\$ 166,238		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	68	\$ 4,216	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	303	8,444	10-03	52
53	TOTAL (lines 50 - 52)	371	\$ 12,660		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Martin Lee</u>	<u>Administrator</u>	<u>0</u>	\$ <u>149,833</u>	<u>Workers' Compensation Insurance</u>	\$ <u>222,442</u>	<u>IDPH License Fee</u>	\$ <u>3,980</u>	
<u>Barajas-Moran, Iliana</u>	<u>Admin in Training</u>	<u>0</u>	\$ <u>71,704</u>	<u>Unemployment Compensation Insurance</u>	<u>41,174</u>	<u>Advertising: Employee Recruitment</u>	<u>19,816</u>	
				<u>FICA Taxes</u>	<u>579,082</u>	<u>Health Care Worker Background Check</u>	<u>1,105</u>	
				<u>Employee Health Insurance</u>	<u>285,637</u>	(Indicate # of checks performed <u>111</u>)	<u>4,165</u>	
				<u>Employee Meals</u>	<u>7,233</u>	<u>Patient Background Checks</u>	<u>417</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>35,255</u>	
				<u>Union Pension Fund</u>	<u>49,507</u>	<u>Licenses & Fees</u>	<u>2,925</u>	
				<u>401K Expense</u>	<u>2,670</u>			
				<u>Employee Physicals</u>	<u>4,275</u>			
				<u>Employee Benefits - Other</u>	<u>34,197</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>221,537</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>1,226,217</u>	
(List each licensed administrator separately.)							\$ <u>75,857</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Aperion Care - Mgmt Fees</u>			\$ <u>826,176</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	<u>943</u>
							<u>See Supplemental Schedule</u>	<u>832</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>826,176</u>	TOTAL			(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ <u>1,775</u>	
C. Professional Services								
Vendor/Payee	Type							
<u>See Attached</u>	<u>Legal</u>	\$	<u>118,403</u>					
<u>ProPay HR</u>	<u>Payroll Processing</u>		<u>45,415</u>					
<u>Aperion Care, Inc</u>	<u>Home Office Expense</u>		<u>98,656</u>					
<u>Aperion Financial</u>	<u>Home Office Expense</u>		<u>466,528</u>					
<u>Marcum LLP</u>	<u>Accounting</u>		<u>19,055</u>					
<u>Ability Network</u>	<u>Eligibility Software</u>		<u>6,475</u>					
<u>Aperion Care, Inc</u>	<u>Data Processing</u>		<u>26,633</u>					
<u>Creative Technology Solutions</u>	<u>IT Consulting</u>		<u>15,365</u>					
<u>Emsa Purchasing Group</u>	<u>Procurement Solutions</u>		<u>3,500</u>					
<u>Dgtell LLC</u>	<u>Data Processing</u>		<u>815</u>					
<u>See Supplemental Schedule</u>			<u>185,336</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>986,181</u>					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Forest Park# 0049247Report Period Beginning: 01/01/20Ending: 12/31/20**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$41,542
- (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. \$ 55,842 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. \$ 479,646
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. \$ 7,233 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.