		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0054700

Facility Name: Aperion Care Mascoutah

Address: 901 North Tenth St (Number) Mascoutah (City) 62258 (Zip Code)

County: St Clair

Telephone Number: (618) 566-2183 **Fax #** (618) 566-4462

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2017

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 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	55	Skilled (SNF)	55	20,130	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	55	TOTALS	55	20,130	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,826	893	1,487	13,206	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,826	893	1,487	13,206	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.60%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 883

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,967	12,519	7,453	192,939		192,939	5,978	198,917			1
2	Food Purchase		70,921		70,921		70,921	(14)	70,907			2
3	Housekeeping	61,541	26,581		88,122		88,122	124	88,246			3
4	Laundry	9,896	4,744		14,640		14,640		14,640			4
5	Heat and Other Utilities			65,993	65,993		65,993	(11,549)	54,444			5
6	Maintenance	44,360	19,089	65,945	129,394		129,394	(9,260)	120,134			6
7	Other (specify):*							840	840			7
8	**TOTAL General Services**	288,764	133,854	139,391	562,009		562,009	(13,881)	548,128			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800	594	11,394			9
10	Nursing and Medical Records	963,543	108,020	266,876	1,338,439		1,338,439	(45,816)	1,292,623			10
10a	Therapy											10a
11	Activities	38,267	1,598	1,567	41,432		41,432	6	41,438			11
12	Social Services	38,882		9,961	48,843		48,843		48,843			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,476	2,476			15
16	**TOTAL Health Care and Programs**	1,040,692	109,618	289,204	1,439,514		1,439,514	(42,739)	1,396,775			16
	C. General Administration											
17	Administrative	87,618		127,417	215,035		215,035	(112,614)	102,421			17
18	Directors Fees											18
19	Professional Services			197,806	197,806		197,806	(109,929)	87,877			19
20	Dues, Fees, Subscriptions & Promotions			31,064	31,064		31,064	(13,703)	17,361			20
21	Clerical & General Office Expenses	49,908		718,287	768,195		768,195	(648,102)	120,093			21
22	Employee Benefits & Payroll Taxes			189,321	189,321		189,321		189,321			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,692	1,692		1,692	(383)	1,309			24
25	Other Admin. Staff Transportation			11,299	11,299		11,299	496	11,795			25
26	Insurance-Prop.Liab.Malpractice			30,338	30,338		30,338	202	30,540			26
27	Other (specify):*							7,393	7,393			27
28	**TOTAL General Administration**	137,526		1,307,224	1,444,750		1,444,750	(876,641)	568,109			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,466,982	243,472	1,735,819	3,446,273		3,446,273	(933,261)	2,513,012			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,152	99,152		99,152	(46,504)	52,648			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			259	259		259	6,533	6,792			32
33	Real Estate Taxes			14,210	14,210		14,210	638	14,848			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(131,849)	151			34
35	Rent-Equipment & Vehicles			4,379	4,379		4,379	811	5,190			35
36	Other (specify):*			1,419	1,419		1,419	(1,419)				36
37	TOTAL Ownership			251,419	251,419		251,419	(171,791)	79,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,100	151,485	209,585		209,585	(27,744)	181,841			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,561	97,561		97,561		97,561			42
43	Other (specify):*			2,282	2,282		2,282	(2,282)	(0)			43
44	TOTAL Special Cost Centers		58,100	251,328	309,428		309,428	(30,026)	279,402			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,466,982	301,572	2,238,566	4,007,120		4,007,120	(1,135,079)	2,872,041			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 Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,789)	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	(126,867)	30		9
10	Interest and Other Investment Income	(858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(682,510)	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	(64,178)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (896,749)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(238,330)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (238,330)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,135,079)		37

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

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

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

STATE OF ILLINOIS

Aperion Care Mascoutah

ID# 0054700

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (25,303)	19	1
2	Supplemental Insurance	(78)	21	2
3	Credit Card Processing	(292)	21	3
4	Advertising/Marketing	(2,266)	43	4
5	Promotional Products	(16)	43	5
6	Bank Charges	(13,606)	21	6
7	Theft	(30)	21	7
8	Amortization	(1,419)	36	8
9	Other Classified Income	(1)	28	9
10	PAC Dues	(4,895)	20	10
11	Additional R&M	4,911	06	11
12	Non-Allowable Seminar	(547)	24	12
13	Medical Records	(53)	10	13
14	Capitalized R&M	(2,508)	06	14
15	Non Allowable Professional Fees	(532)	19	15
16	Building Company - Licenses & Fees	(245)	20	16
17	Building Company - State Replacement Tax	(404)	21	17
18	Building Company - Accounting Fees	(3,224)	19	18
19	Building Company - Bad Debt Expense	(13,634)	21	19
20	Building Company - Bank Charges	(36)	21	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(64,178)		49

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

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

STATE OF ILLINOIS **Page 5B**

Aperion Care Mascoutah

ID# 0054700
Report Period Beginning: 01/01/20
Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Mascoutah # 0054700 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 A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary				5,978								5,978	1
2	Food Purchase	(47)		33									(14)	2
3	Housekeeping			12			112						124	3
4	Laundry													4
5	Heat and Other Utilities	(11,789)					240						(11,549)	5
6	Maintenance	2,403		595	(12,639)		381						(9,260)	6
7	Other (specify):*			62	778								840	7
8	**TOTAL General Services**	(9,433)		701	(5,883)		733						(13,881)	8
	B. Health Care and Programs													
9	Medical Director			594									594	9
10	Nursing and Medical Records	(53)		1,545	(47,330)		22						(45,816)	10
10a	Therapy													10a
11	Activities			6									6	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			172	2,304								2,476	15
16	**TOTAL Health Care and Programs**	(53)		2,318	(45,026)		22						(42,739)	16
	C. General Administration													
17	Administrative			(112,614)									(112,614)	17
18	Directors Fees													18
19	Professional Services	(29,059)	3,224	6,752	896	(88,615)	438	(2,926)	(639)				(109,929)	19
20	Fees, Subscriptions & Promotions	(15,640)	245	1,509	11	170	2						(13,703)	20
21	Clerical & General Office Expenses	(710,590)	14,074	11,304	165	36,595	349						(648,102)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(547)		92	55	17							(383)	24
25	Other Admin. Staff Transportation			492	4								496	25
26	Insurance-Prop.Liab.Malpractice			202									202	26
27	Other (specify):*			2,924		4,469							7,393	27
28	**TOTAL General Administration**	(755,836)	17,543	(89,339)	1,131	(47,364)	789	(2,926)	(639)				(876,641)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(765,322)	17,543	(86,320)	(49,778)	(47,364)	1,544	(2,926)	(639)				(933,261)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(126,867)	76,552	406	70	72	3,264						(46,504)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(858)	(1)	6,578			814						6,533	32
33	Real Estate Taxes						638						638	33
34	Rent-Facility & Grounds		(120,000)	91			(11,941)						(131,849)	34
35	Rent-Equipment & Vehicles			416		96	298						811	35
36	Other (specify):*	(1,419)											(1,419)	36
37	**TOTAL Ownership**	(129,144)	(43,449)	7,491	70	168	(6,927)						(171,791)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(4,839)	(22,905)		(27,744)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,282)											(2,282)	43
44	**TOTAL Special Cost Centers**	(2,282)								(4,839)	(22,905)		(30,026)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(896,748)	(25,906)	(78,829)	(49,708)	(47,196)	(5,382)	(2,926)	(639)	(4,839)	(22,905)		(1,135,079)	45

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 120,000	Mascoutah Property LLC		$	$ (120,000)	1
2	V	33	Real Estate Tax	14,210	Mascoutah Property LLC		14,210		2
3	V	20	Licenses & Permits		Mascoutah Property LLC		245	245	3
4	V	21	State Replacement Tax		Mascoutah Property LLC		404	404	4
5	V	19	Accounting Fees		Mascoutah Property LLC		3,224	3,224	5
6	V	21	Bad Debt Expense		Mascoutah Property LLC		13,634	13,634	6
7	V	21	Bank Charges		Mascoutah Property LLC		36	36	7
8	V	30	Depreciation		Mascoutah Property LLC		76,552	76,552	8
9	V	32	Interest	1	Mascoutah Property LLC			(1)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 134,211			$ 108,305	$ * (25,906)	14

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Declaration of Trust of Yosef Meystel	17.00%	Aperion Care Bradley	Bradley	Mascoutah Property LLC	Mascoutah	Building Co.	1
2	David A. Berkowitz Revocable Trust	17.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Steven Turofsky	1.50%	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Frederick S. Frankel	1.50%	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	Naftali Wilhelm	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6	Jennifer Spector	1.50%	Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7	Aperion Investor Group CFMGT, LLC	60.00%	Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Midlothian	Midlothian	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Morton Villa	Morton	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Oak Lawn	Oak Lawn				22
23			Aperion Care Peoria Heights	Peoria Heights				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Plum Grove	Palatine				25
26			Aperion Care Princeton	Princeton				26
27			Aperion Care Spring Valley	Spring Valley				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Toluca	Toluca				1
2			Aperion Care West Chicago	Springfield				2
3			Aperin Care West Ridge	Chicago				3
4			Aperion Care Wilmington	Wilmington				4
5			Arbors at Michigan City	Michigan City, IN				5
6			Elevate Care Chicago North	Chicago				6
7			Elevate Care Irving Park	Chicago				7
8			Elevate Care Niles	Niles				8
9			Elevate Care North Branch	Niles				9
10			Elevate Care Northbrook	Northbrook				10
11			Elevate Care Riverwoods	Riverwoods				11
12			Elevate Care Waukegan	Waukegan				12
13			Arcadia of Bloomington	Bloomington				13
14			Arcadia of Danville	Danville				14
15			Arcadia of Clifton	Clifton				15
16			Glennon Place	Bolivar, MO				16
17			Hallmark Living Benton Harbor	Benton Harbo, MI				17
18			Legend Healthcare	Tonganoxie, KS				18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	Aperion Care, Inc.		$ 33	$ 33	15
16	V	3	Housekeeping		Aperion Care, Inc.		12	12	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		560	560	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		35	35	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		62	62	19
20	V	9	Medical Director		Aperion Care, Inc.		594	594	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		1,545	1,545	21
22	V	11	Activities		Aperion Care, Inc.		6	6	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		172	172	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		14,803	14,803	24
25	V	19	Professional Fees		Aperion Care, Inc.		2,655	2,655	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		1,509	1,509	26
27	V	21	Clerical Salary		Aperion Care, Inc.		10,890	10,890	27
28	V	21	Clerical & General		Aperion Care, Inc.		414	414	28
29	V	24	Seminars		Aperion Care, Inc.		92	92	29
30	V	25	Auto & Travel		Aperion Care, Inc.		492	492	30
31	V	26	Insurance		Aperion Care, Inc.		202	202	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		2,924	2,924	32
33	V	30	Depreciaiton		Aperion Care, Inc.		406	406	33
34	V	32	Interest		Aperion Care, Inc.		6,578	6,578	34
35	V	34	Rent		Aperion Care, Inc.		91	91	35
36	V	35	Auto Lease		Aperion Care, Inc.		416	416	36
37	V	17	Management Fee	127,417	Aperion Care, Inc.			(127,417)	37
38	V	19	Home Office	(4,097)	Aperion Care, Inc.			4,097	38
39	Total			$ 123,320			$ 44,491	$ * (78,829)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	$	Aperion Consulting, LLC		$ 5,978	$ 5,978	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,012	1,012	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		22	22	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		778	778	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		20,352	20,352	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		2,304	2,304	20
21	V	19	Professional Fees		Aperion Consulting, LLC		896	896	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		11	11	22
23	V	21	Clerical & General		Aperion Consulting, LLC		165	165	23
24	V	24	Seminars		Aperion Consulting, LLC		55	55	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		4	4	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		70	70	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 81,355			$ 31,647	$ * (49,708)	39

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

STATE OF ILLINOIS

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		1,143	$ 1,143	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		170	170	16
17	V	21	Clerical & General		Aperion Financial, LLC		21,555	21,555	17
18	V	24	Seminars		Aperion Financial, LLC		17	17	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		2,612	2,612	20
21	V	30	Depreciaiton		Aperion Financial, LLC		72	72	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		96	96	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		15,040	15,040	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		1,857	1,857	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Home Office Expense	89,758	Aperion Financial, LLC			(89,758)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 89,758			$ 42,562	$ * (47,196)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Chase Office, LLC		$ 240	$ 240	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		381	381	16
17	V	3	Housekeeping		Chase Office, LLC		112	112	17
18	V	10	Medical Supplies		Chase Office, LLC		22	22	18
19	V	19	Professional Fees		Chase Office, LLC		438	438	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		2	2	20
21	V	21	Office Expense		Chase Office, LLC		349	349	21
22	V	30	Depreciation		Chase Office, LLC		3,264	3,264	22
23	V	32	Interest Expense		Chase Office, LLC		814	814	23
24	V	33	Real Estate Taxes		Chase Office, LLC		638	638	24
25	V	35	Equipment Rental		Chase Office, LLC		298	298	25
26	V	34	Rent	12,000	Chase Office, LLC		59	(11,941)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,000			$ 6,618	$ * (5,382)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 12,772	ProPay HR LLC		$ 9,846	$ (2,926)	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			$ 12,772			$ 9,846	$ * (2,926)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Data Processing	$ 4,200	EMSA PURCHASING GROUP		$ 3,561	$ (639)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,200			$ 3,561	$ * (639)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 8,500	Lifescan Labs of Illinois		$ 3,661	$ (4,839)	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			$ 8,500			$ 3,661	$ * (4,839)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 149,978	Renewal Rehab, LLC		$ 127,073	$ (22,905)	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			$ 149,978			$ 127,073	$ * (22,905)	39

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 12,745	Aperion Incorporated Cell		$ 12,745	$	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			$ 12,745			$ 12,745	$ *	39

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

Facility Name & ID Number: Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.28	0.70%	Alloc Salary	$ 1,738	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.28	0.70%	Alloc Salary	409	21-7	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.28	0.70%	Alloc Salary	799	17-7	3
4	Frederick Frankel	Owner	Administrative	1.50%	See Attached	0.28	0.70%	Alloc Salary	1,738	17-7	4
5	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.28	0.70%	Alloc Salary	1,738	17-7	5
6	Naftali Wilheim	Owner	Clerical	1.50%	See Attached	0.28	0.70%	Alloc Salary	1,581	21-7	6
7	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.19	0.70%	Alloc Salary	215	21-7	7
8	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.28	0.70%	Alloc Salary	827	21-7	8
9	Dovid Spector	Relative	Clerical	0.00%	See Attached	0.28	0.70%	Alloc Salary	573	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 9,618		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 Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Census/Direct Cost	1,899,996	65	$ 4,717	$	13,206	$ 33	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		13,206	12	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	13,206	560	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		13,206	35	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		13,206	62	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		13,206	594	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	13,206	1,545	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		13,206	6	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		13,206	172	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	13,206	14,803	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		13,206	2,655	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		13,206	1,509	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	13,206	10,890	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		13,206	414	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		13,206	92	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		13,206	492	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		13,206	202	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		13,206	2,924	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		13,206	406	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		13,206	6,578	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		13,206	91	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		13,206	416	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 44,491	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	$ 498,880	$ 498,880	13,206	$ 5,978	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	13,206	1,012	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		13,206	22	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		13,206	778	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	13,206	20,352	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		13,206	2,304	6
7	19	Professional Fees	Census	1,488,113	65	100,933		13,206	896	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		13,206	11	8
9	21	Clerical & General	Census	1,488,113	65	18,558		13,206	165	9
10	24	Seminars	Census	1,488,113	65	6,182		13,206	55	10
11	25	Auto & Travel	Census	1,488,113	65	484		13,206	4	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65			13,206		12
13	30	Depreciation	Census	1,488,113	46	7,885		13,206	70	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		$ 31,647	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	$ 34,497	$	13,206	$ 240	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		13,206	381	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		13,206	112	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		13,206	22	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		13,206	438	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		13,206	2	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		13,206	349	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		13,206	3,264	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		13,206	814	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		13,206	638	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		13,206	298	11
12	34	Rent	Actual Census	1,899,996	64	42,922		13,206	59	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 952,148	$		$ 6,618	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380		13,206	1,143	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		13,206	170	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	13,206	21,555	3
4	24	Seminars	Census	1,899,996	65	2,428		13,206	17	4
5	25	Auto & Travel	Census	1,899,996	65			13,206		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		13,206	2,612	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		13,206	72	7
8	32	Interest	Census	1,899,996	65			13,206		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		13,206	96	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	13,206	15,040	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		13,206	1,857	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		$ 42,562	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 9,846	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					$	$		$ 9,846	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 3,661	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,661	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		59	$	$		$ 127,073	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					$	$		$ 127,073	25

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Aperion Incorporated Cell
Street Address: 30 Main Street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 12,745	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 12,745	25

Facility Name & ID Number: Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2							$	$			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Insurance Policies		X					-			259	6
7								-			-	7
8												8
9	TOTAL Facility Related						$	$			$ 259	9
	B. Non-Facility Related*											
10	Interest Income		X								(858)	10
11	Interest Income - Bldg Co.	X									(1)	11
12	Allocated from Aperion Care	X									6,578	12
13	Allocated from Chase Office	X									814	13
14	TOTAL Non-Facility Related						$	$			$ 6,533	14
15	TOTALS (line 9+line14)						$	$			$ 6,792	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 Mascoutah # 0054700 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.

Description	Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$ 13,800	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.)	$ 14,643	2
3. Under or (over) accrual (line 2 minus line 1).	$ 843	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 14,005	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 14,848	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	9,217	8
	2016	9,770	9
	2017	9,969	10
	2018	13,723	11
	2019	14,005	12

2020 Accrual = 2019 Tax
Allocated from Chase Office $638

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Mascoutah COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0054700

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-30.0-300-011	Long Term Care Property	$ 13,718	$ 13,718
2.	10-30.0-300-026	Long Term Care Property	$ 288	$ 288
3.	10-27-307-027-0000	Allocated from Chase Office	$ 72,111	$ 476
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,116	$ 14,482

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 Mascoutah COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0054700

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation***. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,712 B. General Construction Type: Exterior Brick Frame Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2017	$ 18,145	1
2	Allocated from Chase Office LLC			410	2
3	TOTALS			$ 18,555	3

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55		2017	1963	$ 395,749	$ 76,552	39	$ 10,147	$ (66,405)	$ 33,824	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		25,506	1,800		1,185	(614)	5,049	68
69	Financial Statement Depreciation			99,152			(99,152)		69
70	TOTAL (lines 4 thru 69)		$ 421,255	$ 177,504		$ 11,332	$ (166,171)	$ 38,873	70

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 421,255	$ 177,504		$ 11,332	$ (166,171)	$ 38,873	1
2	Cable And Data Access Points Installation	2018	4,354		20	218	218	653	2
3	Security Camera Installation (13,642)	2018	13,424		20	671	671	1,678	3
4	Interior Signage	2018	4,122		20	206	206	429	4
5	Installation Of Generator/Annunciator Panel	2018	5,620		20	281	281	703	5
6	Door Repair - Vertical Rod Panics/Rim Cylinders	2018	2,973		20	149	149	322	6
7	Install New 15 Ton Chiller Unit (70,716)	2019	68,296		20	3,415	3,415	6,830	7
8	All Resident Bathrms Sinks;Install Millwork New Nurses Station	2019	466,511		20	23,326	23,326	46,652	8
9	Replaced Hot Water Heater	2019	5,099		20	255	255	510	9
10	10 Phone System And Voicemail	2019	6,385		20	319	319	638	10
11	Installed Sprinkler System	2019	5,397		20	270	270	540	11
12	Installed New Condensor In Kitchen	2019	3,677		20	184	184	368	12
13	Repaired Chiller Pump	2019	6,531		20	327	327	654	13
14	Split System Heat Pump & Air Handler For South Wing (10,891)	2020	10,268		20	545	545	545	14
15	4 Ton Air Conditioner With Evaporator Coil (5,576)	2020	5,327		20	279	279	279	15
16	Air Conditioner With Evaporator Coil - Conference Room (5,822)	2020	5,511		20	291	291	291	16
17	New Hot Water Heater (11,819)	2020	11,197		20	591	591	591	17
18	Replaced Mixing Valve Cartridge In Chiller For Building Hot Wa	2020	2,543		20	127	127	127	18
19	Replace Leaking Pump On The North Boiler	2020	4,963		20	248	248	248	19
20	Hvac - Replaced 2 Motors And A Blower Dual Shaft	2020	2,508		20	125	125	125	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)		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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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)		$ 1,055,961	$ 177,504		$ 43,160	$ (134,344)	$ 101,056	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	3,690	95	20	95		418	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	207	33	20	10	(23)	104	9
10	Allocated from Aperion Care	2012	59	5	20	3	(2)	23	10
11	Allocated from Aperion Care	2013	25	3	20	1	(2)	9	11
12									12
13	Allocated from Chase Office LLC	2020	74		20	4	4	4	13
14	Allocated from Chase Office LLC	2019	1,879	85	20	94	9	188	14
15	Allocated from Chase Office LLC	2018	17	1	20	1	(0)	3	15
16	Allocated from Chase Office LLC	2017	854	209	20	43	(166)	171	16
17	Allocated from Chase Office LLC	2016	18,702	1,369	20	935	(434)	4,130	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)		$ 25,506	$ 1,800		$ 1,185	$ (614)	$ 5,049	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 25,506	$ 1,800		$ 1,185	$ (614)	$ 5,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 25,506	$ 1,800		$ 1,185	$ (614)	$ 5,049	34

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 82,033	$ 1,933	$ 8,230	$ 6,297	10	$ 25,476	71
72	Current Year Purchases	9,580	12	959	947	10	959	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 91,612	$ 1,945	$ 9,189	$ 7,244		$ 26,435	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		Alloc from Aperion Care	2020	$ 1,497	$ 66	$ 299	$ 233	5	$ 750	76
77										77
78										78
79										79
80	TOTALS			$ 1,497	$ 66	$ 299	$ 233		$ 750	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)	$ 1,167,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,515	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,648	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (126,867)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 128,240	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Aperion Care				91			5
6	Allocated from Chase Office				59			6
7	TOTAL				$ 150 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 4,773 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		$	$ 416	17
18					18
19					19
20					20
21	TOTAL		$	$ 416	21

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

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 84,726	$		$ 84,726	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			27,718			27,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			39,041			39,041	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				48,341		48,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						9,759		9,759	13
14	TOTAL			$		$ 151,485	$ 58,100		$ 209,585	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 Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,114	$ 124,128	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	471,709	471,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,830	33,830	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	295	295	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 628,948	$ 630,962	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,975	13
14	Buildings, at Historical Cost		1,376,775	14
15	Leasehold Improvements, at Historical Cost	827,830	827,830	15
16	Equipment, at Historical Cost	103,763	310,013	16
17	Accumulated Depreciation (book methods)	(194,173)	(428,737)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	165,237	165,237	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 902,657	$ 2,404,093	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,531,605	$ 3,035,055	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 124,203	$ 124,203	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,508	90,508	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,344	4,344	31
32	Accrued Real Estate Taxes(Sch.IX-B)		14,005	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	323,265	323,265	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 542,320	$ 556,325	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,721,452	3,721,452	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,721,452	$ 3,721,452	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,263,772	$ 4,277,777	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,732,167)	$ (1,242,722)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,531,605	$ 3,035,055	48

*(See instructions.)

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,884,077)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,884,077)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(748,860)	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	(99,230)	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)**	$ (848,090)	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)**	$ (2,732,167)	24 *

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

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,478,393	1
2	Discounts and Allowances for all Levels	300,062	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,778,455	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	74,110	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 74,110	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	1,985	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6	19
20	Radiology and X-Ray	2	20
21	Other Medical Services	1,983	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,976	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	858	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 858	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	400,861	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 400,861	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,258,260	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	562,009	31
32	Health Care	1,439,514	32
33	General Administration	1,444,750	33
	B. Capital Expense		
34	Ownership	251,419	34
	C. Ancillary Expense		
35	Special Cost Centers	211,867	35
36	Provider Participation Fee	97,561	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,007,120	40
41	**Income before Income Taxes (line 30 minus line 40)****	(748,860)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (748,860)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 505,311	44
45	Private Pay - Net Inpatient Revenue	163,450	45
46	Medicare - Net Inpatient Revenue	503,299	46
47	Other-(specify) Insurance	199,213	47
48	Other-(specify) Managed Care	1,407,182	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,778,455	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 Mascoutah # 0054700 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	1,299	1,399	$ 64,799	$ 46.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,119	6,363	269,826	42.41	3
4	Licensed Practical Nurses	6,480	6,862	209,913	30.59	4
5	CNAs & Orderlies	21,055	22,017	419,005	19.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,963	2,160	38,267	17.72	9
10	Activity Assistants					10
11	Social Service Workers	1,827	1,922	38,882	20.23	11
12	Dietician					12
13	Food Service Supervisor	2,444	2,918	61,591	21.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,301	9,638	111,376	11.56	15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,087	44,360	21.26	17
18	Housekeepers	5,001	5,140	61,541	11.97	18
19	Laundry	838	854	9,896	11.59	19
20	Administrator	2,104	2,198	87,618	39.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	168	168	3,441	20.48	23
24	Clerical	1,863	2,046	46,467	22.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	62,422	65,772	$ 1,466,982 *	$ 22.30	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	136	$ 7,453	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	77	5,796	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	22	1,567	11-03	44
45	Social Service Consultant	35	2,461	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	7,500	12-03	47
48					48
49	TOTAL (lines 35 - 48)	270	$ 103,259		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	864	$ 82,818	10-03	50
51	Licensed Practical Nurses	535	23,057	10-03	51
52	Certified Nurse Assistants/Aides	2,958	87,523	10-03	52
53	TOTAL (lines 50 - 52)	4,357	$ 193,398		53

Facility Name & ID Number Aperion Care Mascoutah # 0054700 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan R. Garrison	Administrator	0	$ 25,526
Billie Jo Blair	Administrator	0	35,901
Sonya R Lanier	Administrator	0	26,191
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,618

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	$ 127,417
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 127,417

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network Inc.	Eligibility Software	$ 4,862
Aperion Care Inc.	Data Processing	12,083
Creative Technology Solutions	IT Consulting	3,920
EMSA Purchasing Group, LLC	Procurement Solution	4,200
Reside Admissions LLC	Data Processing	3,481
PointClickCare Technologies Inc.	Data Processing	20,934
Synapse PDI, LLC	Data Processing	450
Z-Core Analytics, LLC	Reimbursement Consulting	2,050
Aperion Financial/Aperion Care	Home Office Expense	85,661
ProPay HR	Payroll Processing	12,772
See Attached	Legal	25,666
See Supplemental Schedule		21,727
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 197,805

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,599
Unemployment Compensation Insurance	8,521
FICA Taxes	112,224
Employee Health Insurance	14,818
Employee Meals	787
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	4,875
Employee Benefits - Other	10,497
TOTAL (agree to Schedule V, line 22, col.8)	$ 189,321

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,035
Health Care Worker Background Check	
(Indicate # of checks performed 123)	1,234
Patient Background Checks 54	540
Dues & Subscriptions	7,021
Licenses & Fees	849
See Supplemental Schedule	1,692
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,361

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,145
See Supplemental Schedule	164
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,308

**See instructions.

Facility Name & ID Number **Aperion Care Mascoutah** **# 0054700** **Report Period Beginning: 01/01/20** **Ending: 12/31/20**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $9790**

(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. $ **9,795** Line **10-02**

(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. $ **97,561**
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. $ **787** Has any meal income been offset against related costs? **No** Indicate the amount. $ ____

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

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.