

Facility Name & ID Number Aperion Care Spring Valley

0053611 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	98	Skilled (SNF)	98	35,868	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	98	TOTALS	98	35,868	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,067	390	9,175	11,632	8
9	SNF/PED					9
10	ICF	18,641	2,823		21,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,708	3,213	9,175	33,096	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.27%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/15

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/01/15 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 98 and days of care provided 7,836

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	215,712	27,166	21,522	264,400		264,400	(6,540)	257,860		1
2	Food Purchase		187,281		187,281		187,281	(99)	187,182		2
3	Housekeeping	133,682	65,964		199,646		199,646	310	199,956		3
4	Laundry	61,239	13,911		75,150		75,150		75,150		4
5	Heat and Other Utilities			101,096	101,096		101,096	(10,656)	90,440		5
6	Maintenance	41,656	37,032	86,957	165,645		165,645	(8,327)	157,318		6
7	Other (specify):*							2,106	2,106		7
8	TOTAL General Services	452,289	331,354	209,575	993,218		993,218	(23,206)	970,012		8
	B. Health Care and Programs										
9	Medical Director			26,700	26,700		26,700	1,489	28,189		9
10	Nursing and Medical Records	2,110,544	255,385	126,142	2,492,071		2,492,071	(13,042)	2,479,029		10
10a	Therapy	35,797	4,382		40,179		40,179		40,179		10a
11	Activities	161,143	1,996	277	163,416		163,416	16	163,432		11
12	Social Services	90,890		3,162	94,052		94,052		94,052		12
13	CNA Training										13
14	Program Transportation			1,320	1,320		1,320		1,320		14
15	Other (specify):*							6,206	6,206		15
16	TOTAL Health Care and Programs	2,398,374	261,763	157,601	2,817,738		2,817,738	(5,331)	2,812,407		16
	C. General Administration										
17	Administrative	116,261		427,674	543,935		543,935	(285,725)	258,210		17
18	Directors Fees										18
19	Professional Services			462,941	462,941		462,941	(288,552)	174,389		19
20	Dues, Fees, Subscriptions & Promotions			66,657	66,657		66,657	(48,689)	17,968		20
21	Clerical & General Office Expenses	73,748		338,261	412,009		412,009	(186,215)	225,794		21
22	Employee Benefits & Payroll Taxes			479,267	479,267		479,267		479,267		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,688	2,688		2,688	409	3,097		24
25	Other Admin. Staff Transportation			2,131	2,131		2,131	1,245	3,376		25
26	Insurance-Prop.Liab.Malpractice			56,940	56,940		56,940	507	57,447		26
27	Other (specify):*							18,528	18,528		27
28	TOTAL General Administration	190,009		1,836,559	2,026,568		2,026,568	(788,492)	1,238,076		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,040,672	593,117	2,203,735	5,837,524		5,837,524	(817,029)	5,020,495		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aperion Care Spring Valley

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,061	114,061		114,061	21,451	135,512			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,590	31,590		31,590	380,007	411,597			32
33	Real Estate Taxes			61,951	61,951		61,951	1,598	63,549			33
34	Rent-Facility & Grounds			630,000	630,000		630,000	(629,623)	377			34
35	Rent-Equipment & Vehicles			18,693	18,693		18,693	2,032	20,725			35
36	Other (specify):*			2,585	2,585		2,585	(2,585)	0			36
37	TOTAL Ownership			858,880	858,880		858,880	(227,119)	631,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		256,329	628,541	884,870		884,870	(135,398)	749,472			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,839	217,839		217,839		217,839			42
43	Other (specify):*			12,736	12,736		12,736	(12,736)				43
44	TOTAL Special Cost Centers		256,329	859,116	1,115,445		1,115,445	(148,134)	967,311			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,040,672	849,446	3,921,731	7,811,849		7,811,849	(1,192,282)	6,619,567			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,257)	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	(125,798)	30		9
10	Interest and Other Investment Income	(1,235)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(181)	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	(9,814)	21		18
19	Entertainment				19
20	Contributions	(49,500)	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	(272,709)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(236,304)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (727,798)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(464,483)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (464,483)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,192,281)		37

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

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

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Supplemental Insurance	\$ (2,985)	21	1
2	Credit Card Processing	(90)	21	2
3	Bank Charges	(919)	21	3
4	Theft	(5)	21	4
5	Amortization	(2,585)	36	5
6	PAC Dues	(3,430)	20	6
7	Non-Allowable Legal	(4,509)	19	7
8	Marketing Expense	(12,736)	43	8
9	Additional R&M	14,194	06	9
10	Capitalized R&M	(13,884)	06	10
11	Misc. Income	(25)	21	11
12	Other Professional Fees - Prior Year	(532)	19	12
13	Building Company - Licenses & Permits	(322)	20	13
14	Building Company - Professional Fees	(166,758)	19	14
15	Building Company - Accounting Fees	(6,438)	19	15
16	Building Company - Amortization	(23,249)	36	16
17	Building Company - Bank Fees	(32)	21	17
18	Building Company - Bookkeeping Fees	(12,000)	19	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(236,304)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(6,540)								(6,540)	1
2	Food Purchase	(181)		82									(99)	2
3	Housekeeping			29			281						310	3
4	Laundry													4
5	Heat and Other Utilities	(11,257)					601						(10,656)	5
6	Maintenance	310		1,490	(11,083)		956						(8,327)	6
7	Other (specify):*			156	1,950								2,106	7
8	TOTAL General Services	(11,128)		1,757	(15,673)		1,838						(23,206)	8
	B. Health Care and Programs													
9	Medical Director			1,489									1,489	9
10	Nursing and Medical Records			3,873	(16,971)		56						(13,042)	10
10a	Therapy													10a
11	Activities			16									16	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			431	5,775								6,206	15
16	TOTAL Health Care and Programs			5,809	(11,196)		56						(5,331)	16
	C. General Administration													
17	Administrative			(285,725)									(285,725)	17
18	Directors Fees													18
19	Professional Services	(190,237)	185,196	(21,149)	2,245	(259,101)	1,097	(5,963)	(639)				(288,552)	19
20	Fees, Subscriptions & Promotions	(53,252)	322	3,783	28	426	4						(48,689)	20
21	Clerical & General Office Expenses	(307,579)	32	28,330	413	91,713	876						(186,215)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			230	137	42							409	24
25	Other Admin. Staff Transportation			1,234	11								1,245	25
26	Insurance-Prop.Liab.Malpractice			507									507	26
27	Other (specify):*			7,327		11,201							18,528	27
28	TOTAL General Administration	(551,068)	185,549	(265,462)	2,834	(155,719)	1,977	(5,963)	(639)				(788,492)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(562,195)	185,549	(257,896)	(24,035)	(155,719)	3,871	(5,963)	(639)				(817,029)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Spring Valley # 0053611 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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(125,798)	137,698	1,017	175	180	8,180						21,451	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,235)	362,716	16,486			2,040						380,007	32
33	Real Estate Taxes						1,598						1,598	33
34	Rent-Facility & Grounds		(600,000)	228			(29,851)						(629,623)	34
35	Rent-Equipment & Vehicles			1,043		241	748						2,032	35
36	Other (specify):*	(25,834)	23,249										(2,585)	36
37	TOTAL Ownership	(152,867)	(76,337)	18,774	175	421	(17,285)						(227,119)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(40,320)	(95,078)		(135,398)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(12,736)											(12,736)	43
44	TOTAL Special Cost Centers	(12,736)								(40,320)	(95,078)		(148,134)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(727,799)	109,213	(239,122)	(23,860)	(155,298)	(13,415)	(5,963)	(639)	(40,320)	(95,078)		(1,192,282)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	34 Rent	\$ 600,000	1300 N Greenwood		\$	(600,000)	1	
2	V	34 Real Estate Tax	61,951	1300 N Greenwood		61,951	0	2	
3	V	20 Licenses and Permits		1300 N Greenwood		322	322	3	
4	V	19 Other Professional		1300 N Greenwood		166,758	166,758	4	
5	V	19 Accounting Fees		1300 N Greenwood		6,438	6,438	5	
6	V	36 Amortization Expense		1300 N Greenwood		23,249	23,249	6	
7	V	21 Bank Charges		1300 N Greenwood		32	32	7	
8	V	19 Bookkeeping Fees		1300 N Greenwood		12,000	12,000	8	
9	V	30 Depreciation Expense		1300 N Greenwood		137,698	137,698	9	
10	V	32 Interest Expense		1300 N Greenwood		362,716	362,716	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 661,951			\$ 771,163	\$ *	109,213	14

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

Facility Name & ID Number

Aperion Care Spring Valley

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Report Period Beginning:

01/01/20

Ending:

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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	Yosef Meystel Delta Trust	24.50%	Aperion Care Bradley	Bradley	1300 N Greenwood	Spring Valley	Building Co.	1
2	David Berkowitz Delta Trust	24.50%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Michael Rosen Revocable Trust	24.00%	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Steven Turofsky	1.00%	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	Michelle Koder	1.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6	Frederick S. Frankel Trust	1.25%	Aperion Care Demotte	Demotte, IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7	Morris Esformes	4.75%	Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8	Jack Yolinsky Revocable Trust Agreement Dated 2/18/11	4.75%	Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9	Robin Miller Revocable Trust Agreement Dated 7/18/18	4.75%	Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10	Jack Yolinsky	4.75%	Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11	David J. Wirtenberg	4.75%	Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consulting	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 Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Morton Villa	Morton				22
23			Aperion Care Oak Lawn	Oak Lawn				23
24			Aperion Care Peoria Heights	Peoria Heights				24
25			Aperion Care Peru	Peru, IN				25
26			Aperion Care Plum Grove	Palatine				26
27			Aperion Care Princeton	Princeton				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

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VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	Aperion Care, Inc.		\$ 82	\$	82	15
16	V	3 Housekeeping		Aperion Care, Inc.		29		29	16
17	V	6 Maintenance Salary		Aperion Care, Inc.		1,403		1,403	17
18	V	6 Repairs & Maintenance		Aperion Care, Inc.		87		87	18
19	V	7 Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		156		156	19
20	V	9 Medical Director		Aperion Care, Inc.		1,489		1,489	20
21	V	10 Salary - Nurse		Aperion Care, Inc.		3,873		3,873	21
22	V	11 Activities		Aperion Care, Inc.		16		16	22
23	V	15 Payroll Taxes / Group Insurance		Aperion Care, Inc.		431		431	23
24	V	17 Administrative Salaries		Aperion Care, Inc.		37,097		37,097	24
25	V	17 Management Fees	427,674	Aperion Care, Inc.		104,852		(322,822)	25
26	V	19 Professional Fees		Aperion Care, Inc.		6,654		6,654	26
27	V	20 Fees, Subscriptions		Aperion Care, Inc.		3,783		3,783	27
28	V	21 Clerical Salary		Aperion Care, Inc.		27,291		27,291	28
29	V	21 Clerical & General		Aperion Care, Inc.		1,038		1,038	29
30	V	24 Seminars		Aperion Care, Inc.		230		230	30
31	V	25 Auto & Travel		Aperion Care, Inc.		1,234		1,234	31
32	V	26 Insurance		Aperion Care, Inc.		507		507	32
33	V	27 Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		7,327		7,327	33
34	V	30 Depreciaton		Aperion Care, Inc.		1,017		1,017	34
35	V	32 Interest		Aperion Care, Inc.		16,486		16,486	35
36	V	34 Rent		Aperion Care, Inc.		228		228	36
37	V	35 Auto Lease		Aperion Care, Inc.		1,043		1,043	37
38	V	19 Home Office	27,802	Aperion Care, Inc.				(27,802)	38
39	Total		\$ 455,476			\$ 216,354	\$ *	(239,122)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1		Aperion Consulting, LLC		\$ 14,982	\$ 14,982
16	V	6		Aperion Consulting, LLC		2,536	2,536
17	V	6		Aperion Consulting, LLC		54	54
18	V	7		Aperion Consulting, LLC		1,950	1,950
19	V	10		Aperion Consulting, LLC		51,004	51,004
20	V	15		Aperion Consulting, LLC		5,775	5,775
21	V	19		Aperion Consulting, LLC		2,245	2,245
22	V	20		Aperion Consulting, LLC		28	28
23	V	21		Aperion Consulting, LLC		413	413
24	V	24		Aperion Consulting, LLC		137	137
25	V	25		Aperion Consulting, LLC		11	11
26	V	27		Aperion Consulting, LLC			
27	V	30		Aperion Consulting, LLC		175	175
28	V						
29	V						
30	V						
31	V						
32	V						
33	V	10	67,975	Aperion Consulting, LLC			(67,975)
34	V	01	21,522	Aperion Consulting, LLC			(21,522)
35	V	06	13,673	Aperion Consulting, LLC			(13,673)
36	V						
37	V						
38	V						
39	Total		\$ 103,170			\$ 79,310	\$ * (23,860)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Fees		Aperion Financial, LLC		2,863	\$ 2,863
16	V	20 Fees, Subscriptions		Aperion Financial, LLC		426	426
17	V	21 Clerical & General		Aperion Financial, LLC		54,021	54,021
18	V	24 Seminars		Aperion Financial, LLC		42	42
19	V	25 Auto & Travel		Aperion Financial, LLC			
20	V	27 Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		6,547	6,547
21	V	30 Depreciaton		Aperion Financial, LLC		180	180
22	V	32 Interest		Aperion Financial, LLC			
23	V	35 Equipment Rental		Aperion Financial, LLC		241	241
24	V	21 Clerical & General -IL Only		Aperion Financial, LLC		37,692	37,692
25	V	27 Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,654	4,654
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V	19 Home Office Expense	261,964	Aperion Financial, LLC			(261,964)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 261,964			\$ 106,666	\$ * (155,298)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 Utilities	\$	Chase Office, LLC		\$ 601	\$	601	15
16	V	6 Repairs & Maintenance		Chase Office, LLC		956		956	16
17	V	3 Housekeeping		Chase Office, LLC		281		281	17
18	V	10 Medical Supplies		Chase Office, LLC		56		56	18
19	V	19 Professional Fees		Chase Office, LLC		1,097		1,097	19
20	V	20 Dues & Subscriptions		Chase Office, LLC		4		4	20
21	V	21 Office Expense		Chase Office, LLC		876		876	21
22	V	30 Depreciation		Chase Office, LLC		8,180		8,180	22
23	V	32 Interest Expense		Chase Office, LLC		2,040		2,040	23
24	V	33 Real Estate Taxes		Chase Office, LLC		1,598		1,598	24
25	V	35 Equipment Rental		Chase Office, LLC		748		748	25
26	V	34 Rent	30,000	Chase Office, LLC		149		(29,851)	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		\$ 30,000			\$ 16,585	\$ *	(13,415)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 26,027	ProPay HR LLC		\$ 20,064	\$ (5,963)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 26,027			\$ 20,064	\$ * (5,963)

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

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. 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)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,200			\$ 3,561	\$ * (639)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Laboratory	\$ 70,824	Lifescan Labs of Illinois		\$ 30,504	\$ (40,320)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 70,824			\$ 30,504	\$ * (40,320)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 622,553	Renewal Rehab, LLC		\$ 527,475	\$ (95,078)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 622,553			\$ 527,475	\$ * (95,078)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance	\$ 34,240	Aperion Incorporated Cell		\$ 34,240	\$	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		\$ 34,240			\$ 34,240	\$ *	39

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

Facility Name & ID Number Aperion Care Spring Valley # 0053611 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.74%	Alloc Salary	\$ 4,355	17-7	1	
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.7	1.74%	Alloc Salary	2,002	17-7	2	
3	Frederick Frankel	Relative	Administrative	0.00%	See Attached	0.7	1.74%	Alloc Salary	4,355	17-7	3	
4	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.7	1.74%	Alloc Salary	4,355	17-7	4	
5	Michelle Koder	Owner	Nursing	1.00%	See Attached	0.7	1.74%	Alloc Salary	2,366	10-7	5	
6	Michael Rosen	Relative	Administrative	0.00%	See Attached	18.13	45.33%	Alloc Salary	113,321	17-7	6	
7	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.7	1.74%	Alloc Salary	1,025	21-7	7	
8	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.48	1.74%	Alloc Salary	540	21-7	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 132,319		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 Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Census/Direct Cost	1,899,996	65	\$ 4,717	\$ 33,096	\$ 82	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663	33,096	29	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	33,096	1,403	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009	33,096	87	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146	33,096	156	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500	33,096	1,489	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	33,096	3,873	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912	33,096	16	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060	33,096	431	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	33,096	37,097	10
11	17	Management Fees	Census/Direct Cost	1,899,996	65	250,000	33,096	104,852	11
12	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984	33,096	6,654	12
13	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158	33,096	3,783	13
14	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	33,096	27,291	14
15	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611	33,096	1,038	15
16	24	Seminars	Census/Direct Cost	1,899,996	65	13,215	33,096	230	16
17	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828	33,096	1,234	17
18	26	Insurance	Census/Direct Cost	1,899,996	65	29,094	33,096	507	18
19	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479	33,096	7,327	19
20	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358	33,096	1,017	20
21	32	Interest	Census/Direct Cost	1,899,996	65	946,429	33,096	16,486	21
22	34	Rent	Census/Direct Cost	1,899,996	65	13,110	33,096	228	22
23	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876	33,096	1,043	23
24									24
25	TOTALS					\$ 6,943,967	\$ 4,262,818	\$ 216,354	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	\$ 498,880	\$ 498,880	33,096	\$ 14,982	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	33,096	2,536	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		33,096	54	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		33,096	1,950	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	33,096	51,004	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		33,096	5,775	6
7	19	Professional Fees	Census	1,488,113	65	100,933		33,096	2,245	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		33,096	28	8
9	21	Clerical & General	Census	1,488,113	65	18,558		33,096	413	9
10	24	Seminars	Census	1,488,113	65	6,182		33,096	137	10
11	25	Auto & Travel	Census	1,488,113	65	484		33,096	11	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65			33,096		12
13	30	Depreciation	Census	1,488,113	46	7,885		33,096	175	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		\$ 79,310	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380	33,096	2,863	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450	33,096	426	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	54,021	3
4	24	Seminars	Census	1,899,996	65	2,428	33,096	42	4
5	25	Auto & Travel	Census	1,899,996	65		33,096		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858	33,096	6,547	6
7	30	Depreciaton	Census	1,899,996	65	10,323	33,096	180	7
8	32	Interest	Census	1,899,996	65		33,096		8
9	35	Equipment Rental	Census	1,899,996	65	13,849	33,096	241	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	37,692	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211	33,096	4,654	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	\$ 106,666	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Chase Office, LLC

Street Address

4655 W. Chase Ave.

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-3800

Fax Number

()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	\$ 34,497	\$ 33,096	\$ 601	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886	33,096	956	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134	33,096	281	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211	33,096	56	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958	33,096	1,097	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256	33,096	4	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267	33,096	876	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583	33,096	8,180	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136	33,096	2,040	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748	33,096	1,598	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550	33,096	748	11
12	34	Rent	Actual Census	1,899,996	64	42,922	33,096	149	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	\$	\$ 16,585	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 20,064	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				\$	\$		\$ 20,064	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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

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

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

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

LIFESCAN LABS OF ILLINOIS, LLC

Street Address

5255 GOLF RD

City / State / Zip Code

SKOKIE, IL 60077

Phone Number

(847) 663 - 8300

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct		\$	\$		\$ 30,504	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				\$	\$		\$ 30,504	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Renewal Rehab, LLC

Street Address

7358 N. Lincoln Ave., Suite 160

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847) 938-8750

Fax Number

(847) 410-9720

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct	59	\$	\$		\$ 527,475	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				\$	\$		\$ 527,475	25

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Aperion Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

Phone Number

()

Fax Number

()

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation		\$	\$		\$ 34,240	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				\$	\$		\$ 34,240	25

Facility Name & ID Number

Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	GM Financial		X	Auto			\$	\$ 7,377			\$	1,092	1					
2	ACI Equities		X	Note Payable			\$	\$ 6,825,000			\$	362,716	2					
3							\$	\$			\$		3					
4							\$	\$			\$		4					
5							\$	\$			\$		5					
Working Capital																		
6	First Midwest Bank & Trust	X		Line of Credit				938,395				30,136	6					
7	Interest - Insurance Policies							-				363	7					
8													8					
9	TOTAL Facility Related						\$	\$ 7,770,772			\$	394,307	9					
B. Non-Facility Related*																		
10	Interest Income											(1,235)	10					
11	Alloc from Aperion Care											16,486	11					
12	Alloc from Chase Office											2,040	12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	17,291	14					
15	TOTALS (line 9+line14)						\$	\$ 7,770,772			\$	411,598	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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Spring Valley COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0053611

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>18-27-400-011</u>	<u>Long Term Care Property</u>	\$ <u>60,456</u>	\$ <u>60,456</u>
2. <u>10-27-307-027-0000</u>	<u>Allocated from Chase Office</u>	\$ <u>72,111</u>	\$ <u>1,193</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>132,566</u></u>	\$ <u><u>61,649</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Spring Valley COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0053611

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,107 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2019</u>	<u>\$ 233,000</u>	<u>1</u>
2	<u>Allocated from Chase Office LLC</u>			<u>1,027</u>	<u>2</u>
3	TOTALS			\$ 234,027	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		2019	1972	\$ 2,841,000	\$ 137,698	35	\$ 6,764	\$ (130,934)	\$ 13,528	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2015		26,731		20	1,336	1,336	7,351	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 Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)		63,922	4,511		2,971	(1,540)	12,652
69	Financial Statement Depreciation			114,061			(114,061)	
70	TOTAL (lines 4 thru 69)		\$ 2,931,653	\$ 256,270		\$ 11,071	\$ (245,199)	\$ 33,531

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,931,653	\$ 256,270		\$ 11,071	\$ (245,199)	\$ 33,531	1
2	Install Trane Packaged Rooftop Unit	2017	8,250		20	413	413	1,599	2
3	Intake Damper Blade For Hvac Unit	2017	2,800		20	140	140	531	3
4	Cable Installation & Programming For Phones	2017	5,574		20	279	279	987	4
5	Installation Of 6 Foot White Privacy Fence	2017	3,200		20	160	160	560	5
6	Dining Room/Lounge-New Floors, Ceiling, Lighting, Paint	2017	391,065		20	19,553	19,553	59,474	6
7	98 Dry Pendant Sprinkler Heads	2017	19,760		20	988	988	3,088	7
8	Replace Compressor On Walk-In Cooler	2017	2,620		20	131	131	459	8
9	Dining Room Light / Electrical Fixture Replacement (4,973)	2018	4,731		20	237	237	552	9
10	Project Mgmt - Dining Room, Activity Room (2,148)	2018	1,628		20	81	81	210	10
11	Activity-Walls/Electrical/Doors/Floors; Dining-Tile/Millwork/Wal	2018	100,792		20	5,040	5,040	14,559	11
12	Project Mgmt Of Activity Office & Dining Room Renovation	2018	13,102		20	655	655	1,965	12
13	Roofing - Repair Leak Area By Double Doors	2018	3,292		20	165	165	494	13
14	Installation Of White Privacy Fency	2019	3,500		20	175	175	233	14
15	Parking Lot Concrete Work - Repair Inlet	2019	7,890		20	395	395	559	15
16	Install Compressor 5 Ton Rooftop Unit	2019	5,844		20	292	292	389	16
17	Kitchen Electrical Wiring - Replace Circuit Breaker	2019	5,860		20	293	293	391	17
18	Installation Of Concrete Patio	2019	3,297		20	165	165	192	18
19	Therapy Gym/Conference Rm-Flooring,Walls,Electrical,Doors	2019	133,576		20	6,679	6,679	13,358	19
20	100 Gallon Commercial Water Heater	2019	3,821		20	191	191	382	20
21	Installation Of 4 Foot White Picket Fence	2019	4,000		20	200	200	400	21
22	Door Magnet Replacement For Alarm System	2019	3,166		20	158	158	316	22
23	Door Holder/Door Keypad For Alarm System Replacement	2019	3,892		20	195	195	390	23
24	Repair Roof - Flash Kneewall	2020	4,686		20	234	234	234	24
25	Shower/Tub Room Renovation-Construction/Electrical/Flooring/P	2020	49,768		20	2,719	2,719	2,719	25
26	Changed The Mag Locks On North Doors	2020	2,582		20	129	129	129	26
27	Changed The Mag Locks On South Doors	2020	2,901		20	145	145	145	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,723,250	\$ 256,270		\$ 50,883	\$ (205,387)	\$ 137,846	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	9,247	237	20	237		1,047	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	519	83	20	26	(57)	259	9
10	Allocated from Aperion Care	2012	147	11	20	7	(4)	59	10
11	Allocated from Aperion Care	2013	63	8	20	3	(5)	22	11
12									12
13	Allocated from Chase Office LLC	2020	185		20	9	9	9	13
14	Allocated from Chase Office LLC	2019	4,710	214	20	235	22	471	14
15	Allocated from Chase Office LLC	2018	42	2	20	2	(0)	6	15
16	Allocated from Chase Office LLC	2017	2,141	523	20	107	(416)	428	16
17	Allocated from Chase Office LLC	2016	46,869	3,431	20	2,343	(1,088)	10,350	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)		\$ 63,922	\$ 4,511		\$ 2,971	\$ (1,540)	\$ 12,652	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 63,922	\$ 4,511		\$ 2,971	\$ (1,540)	\$ 12,652	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 63,922	\$ 4,511		\$ 2,971	\$ (1,540)	\$ 12,652	34

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

Facility Name & ID Number Aperion Care Spring Valley

0053611

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	\$ 719,360	\$ 4,844	\$ 72,005	\$ 67,160	10	\$ 158,687	71
72	Current Year Purchases	4,167	30	419	388	10	419	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 723,527	\$ 4,875	\$ 72,424	\$ 67,549		\$ 159,106	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		2016 GMC Savana	2016	\$ 57,278	\$	\$ 11,456	\$ 11,456	5	\$ 49,641	76
77		Alloc from Aperion Care	2020	3,752	166	750	584	5	1,879	77
78										78
79										79
80	TOTALS			\$ 61,030	\$ 166	\$ 12,206	\$ 12,040		\$ 51,520	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,741,834 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,310 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,512 83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (125,798) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 348,473 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	Inline Sewer Grinder	\$ 7,450	92
93	Underground Pump	3,900	93
94			94
95		\$ 11,350	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

	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	Alloc from Aperion Care			228			5
6	Alloc from Chase Office			149			6
7	TOTAL			\$ 377			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: _____ *

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: \$ 16,218 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		BMW	\$ 866	\$ 3,465	17
18	Allocated from Aperion Care			1,043	18
19					19
20					20
21	TOTAL		\$ 866	\$ 4,508	21

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 237,046	\$		\$ 237,046	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			108,220			108,220	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			276,754			276,754	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				202,836		202,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					6,521	53,493		60,014	13
14	TOTAL			\$		\$ 628,541	\$ 256,329		\$ 884,870	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 Spring Valley**

0053611

Report Period Beginning: **01/01/20**

Ending:

12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/20**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 884,688	\$ 956,497	1
2	Cash-Patient Deposits	380	380	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,107,134	1,107,134	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,254	61,254	6
7	Other Prepaid Expenses	150	150	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	124,334	124,334	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,177,940	\$ 2,249,749	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		272,938	13
14	Buildings, at Historical Cost		2,743,321	14
15	Leasehold Improvements, at Historical Cost	817,155	817,155	15
16	Equipment, at Historical Cost	187,646	556,481	16
17	Accumulated Depreciation (book methods)	(314,379)	(460,888)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	3,766,415	7,227,944	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,456,837	\$ 11,156,951	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,634,777	\$ 13,406,700	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 371,009	\$ 371,009	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	945,772	1,218,772	29
30	Accrued Salaries Payable	211,441	211,441	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,658	9,658	31
32	Accrued Real Estate Taxes(Sch.IX-B)		60,456	32
33	Accrued Interest Payable		28,740	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	1,618,036	1,618,036	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,155,916	\$ 3,518,112	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,552,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	54,176		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 54,176	\$ 6,552,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,210,092	\$ 10,070,112	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,424,685	\$ 3,336,588	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,634,777	\$ 13,406,700	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,662,963	1
2	Restatements (describe):		2
3	Bad Debt Expense	(6,548)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,656,414	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,181,454	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	(413,183)	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)	\$ 1,768,271	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)	\$ 3,424,685	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Spring Valley# 0053611Report Period Beginning: 01/01/20Ending: 12/31/20**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,842,854	1
2	Discounts and Allowances for all Levels	1,651,632	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,494,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	158,342	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 158,342	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	6,607	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	131	19
20	Radiology and X-Ray	15	20
21	Other Medical Services	3,279	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,032	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,235	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	329,208	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 329,208	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,993,303	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	993,218	31
32	Health Care	2,817,738	32
33	General Administration	2,026,568	33
B. Capital Expense			
34	Ownership	858,880	34
C. Ancillary Expense			
35	Special Cost Centers	897,606	35
36	Provider Participation Fee	217,839	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,811,849	40
41	Income before Income Taxes (line 30 minus line 40)**	2,181,454	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,181,454	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 910,460	44
45	Private Pay - Net Inpatient Revenue	758,238	45
46	Medicare - Net Inpatient Revenue	4,371,812	46
47	Other-(specify) <u>Insurance</u>	368,658	47
48	Other-(specify) <u>Managed Care</u>	3,085,318	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,494,486	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 Spring Valley

0053611

Report Period Beginning: 01/01/20

Ending: 12/31/20

12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,036	2,230	\$ 98,844	\$ 44.32	1
2	Assistant Director of Nursing	505	555	21,483	38.71	2
3	Registered Nurses	9,943	10,850	336,686	31.03	3
4	Licensed Practical Nurses	16,011	17,503	488,582	27.91	4
5	CNAs & Orderlies	66,161	71,547	1,164,949	16.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,027	1,065	35,797	33.61	8
9	Activity Director	1,870	2,080	44,753	21.52	9
10	Activity Assistants	9,379	9,900	116,390	11.76	10
11	Social Service Workers	4,006	4,351	90,890	20.89	11
12	Dietician					12
13	Food Service Supervisor	3,134	3,456	69,952	20.24	13
14	Head Cook	4,561	5,205	65,198	12.53	14
15	Cook Helpers/Assistants	7,141	7,256	80,562	11.10	15
16	Dishwashers					16
17	Maintenance Workers	1,734	2,080	41,656	20.03	17
18	Housekeepers	10,408	10,978	133,682	12.18	18
19	Laundry	5,353	5,675	61,239	10.79	19
20	Administrator	1,852	2,080	116,261	55.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,888	2,080	34,967	16.81	23
24	Clerical	1,833	2,003	38,781	19.36	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)	148,842	160,894	\$ 3,040,672 *	\$ 18.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	58	26,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,975	10-03	38
39	Pharmacist Consultant	135	12,881	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	18	277	11-03	44
45	Social Service Consultant	45	3,162	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 132,517		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	225	\$ 11,863	10-03	50
51	Licensed Practical Nurses	100	6,185	10-03	51
52	Certified Nurse Assistants/Aides	550	27,238	10-03	52
53	TOTAL (lines 50 - 52)	875	\$ 45,286		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jennifer Diaz	Administrator		\$ 116,261	Workers' Compensation Insurance	\$ 98,632	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	17,663	Advertising: Employee Recruitment	2,192		
				FICA Taxes	232,611	Health Care Worker Background Check			
				Employee Health Insurance	81,291	(Indicate # of checks performed <u>141</u>)	1,410		
				Employee Meals	619	Patient Background Checks	780		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,079		
				401K Expense	1,407	Licenses & Fees	1,276		
				Employee Benefits Other	22,759				
				Employee Physicals	24,285				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,261	TOTAL (agree to Schedule V, line 22, col.8)		\$ 479,267	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 17,968
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Aperion Care Inc. - Management Fees			\$ 427,674				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 427,674				In-State Travel		
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount			\$	Seminar Expense	2,688	
Z Core Analytics	Reimbursement Consulting		\$ 2,050				See Supplemental Schedule	409	
Synapse PDI	Data Processing		600				Entertainment Expense	()	
Reside Admission	Data Processing		3,481						
PointClick Care	Data Processing		36,713						
EMSA Purchasing Group	Procurement Solutions		4,200						
Creative Technology Solutions	IT Consulting		5,740						
Aperion Care	Data Processing		12,852						
Ability Network	Eligibility Software		6,716						
Aperion Financial	Home Office Expense		261,964						
Propay	Payroll Processing		26,027						
See Attached	Legal		23,879						
See Supplemental Schedule			78,718						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 462,939						

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$6860
- (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. \$ 9,962 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. \$ 217,839
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. \$ 619 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? No
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.