		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0051086

Facility Name: Aperion Care Springfield

Address: 525 South MLK Dr (Number) Springfield (City) 62703 (Zip Code)

County: Sangamon

Telephone Number: (217)789-1680 **Fax #** (217)789-0842

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2010

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,184		26	22,210	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,184		26	22,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.36%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2010 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,436	17,908	21,522	236,866		236,866	(11,468)	225,398			1
2	Food Purchase		121,816		121,816		121,816	5	121,821			2
3	Housekeeping	145,681	40,756		186,437		186,437	208	186,645			3
4	Laundry	30,210	7,592	390	38,192		38,192		38,192			4
5	Heat and Other Utilities			73,787	73,787		73,787	(6,715)	67,072			5
6	Maintenance	52,533	11,116	45,572	109,221		109,221	(8,484)	100,737			6
7	Other (specify):*							1,414	1,414			7
8	**TOTAL General Services**	425,860	199,188	141,271	766,319		766,319	(25,039)	741,280			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800	999	11,799			9
10	Nursing and Medical Records	991,315	90,526	77,087	1,158,928		1,158,928	(30,817)	1,128,111			10
10a	Therapy		228		228		228		228			10a
11	Activities	60,932	1,426	470	62,828		62,828	11	62,839			11
12	Social Services	89,191		6,500	95,691		95,691		95,691			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,164	4,164			15
16	**TOTAL Health Care and Programs**	1,141,438	92,180	94,857	1,328,475		1,328,475	(25,643)	1,302,832			16
	C. General Administration											
17	Administrative	91,228		166,181	257,409		257,409	(141,286)	116,123			17
18	Directors Fees											18
19	Professional Services			199,694	199,694		199,694	(103,036)	96,658			19
20	Dues, Fees, Subscriptions & Promotions			31,736	31,736		31,736	(12,967)	18,769			20
21	Clerical & General Office Expenses	44,792		167,722	212,514		212,514	(65,933)	146,581			21
22	Employee Benefits & Payroll Taxes			246,283	246,283		246,283		246,283			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,128	2,128		2,128	274	2,402			24
25	Other Admin. Staff Transportation			1,716	1,716		1,716	835	2,551			25
26	Insurance-Prop.Liab.Malpractice			33,985	33,985		33,985	340	34,325			26
27	Other (specify):*							12,434	12,434			27
28	**TOTAL General Administration**	136,020		849,445	985,465		985,465	(309,338)	676,127			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,703,318	291,368	1,085,573	3,080,259		3,080,259	(360,021)	2,720,238			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 Springfield #0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,158	30,158		30,158	30,366	60,524			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,343	18,343		18,343	171,781	190,124			32
33	Real Estate Taxes			16,715	16,715		16,715	1,072	17,787			33
34	Rent-Facility & Grounds			279,125	279,125		279,125	(277,747)	1,378			34
35	Rent-Equipment & Vehicles			7,067	7,067		7,067	1,364	8,431			35
36	Other (specify):*			3,479	3,479		3,479	(3,479)				36
37	TOTAL Ownership			354,887	354,887		354,887	(76,643)	278,244			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,447		48,447		48,447		48,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,059	172,059		172,059		172,059			42
43	Other (specify):*			487	487		487	(487)	0			43
44	TOTAL Special Cost Centers		48,447	172,546	220,993		220,993	(487)	220,506			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,703,318	339,815	1,613,006	3,656,139		3,656,139	(437,150)	3,218,989			45

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,118)	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	13,386	30		9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(650)	21		18
19	Entertainment				19
20	Contributions	(10,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,661)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(258,552)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (397,112)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(40,037)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,037)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (437,149)		37

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

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

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

Aperion Care Springfield

ID# 0051086

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (1,368)	19	1
2	Credit Card Processing	(123)	21	2
3	Advertising/Marketing	(470)	43	3
4	Promotional Products	(17)	43	4
5	Bank Charges	(12,921)	21	5
6	Amortization	(3,479)	36	6
7	Vending Commissions	(50)	02	7
8	Additional R&M	1,809	06	8
9	PAC Dues	(5,313)	20	9
10	Prior Year Professional Fees	(532)	19	10
11	Building Company - Professional Fees	(11,550)	19	11
12	Building Company - Amortization	(8,124)	36	12
13	Building Company - Bad Debt	(76,992)	21	13
14	Building Company - Bank Charges	(36)	21	14
15	Building Company - Bookkeeping Fees	(12,000)	19	15
16	Building Company - Change in Swap Valuation	(126,338)	21	16
17	Building Company - Licenses & Fees	(322)	20	17
18	Building Company - Replacement Tax	(727)	21	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**	(258,552)		49

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

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

STATE OF ILLINOIS **Page 5B**

Aperion Care Springfield

IDF 0051086

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(11,468)								(11,468)	1
2	Food Purchase	(50)		55									5	2
3	Housekeeping			19			189						208	3
4	Laundry													4
5	Heat and Other Utilities	(7,118)					403						(6,715)	5
6	Maintenance	1,809		1,001	(11,935)		642						(8,484)	6
7	Other (specify):*			105	1,309								1,414	7
8	**TOTAL General Services**	(5,359)		1,181	(22,094)		1,233						(25,039)	8
	B. Health Care and Programs													
9	Medical Director			999									999	9
10	Nursing and Medical Records			2,599	(33,454)		38						(30,817)	10
10a	Therapy													10a
11	Activities			11									11	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			289	3,875								4,164	15
16	**TOTAL Health Care and Programs**			3,898	(29,579)		38						(25,643)	16
	C. General Administration													
17	Administrative			(141,286)									(141,286)	17
18	Directors Fees													18
19	Professional Services	(25,450)	23,550	(1,699)	1,506	(98,238)	736	(2,801)	(640)				(103,036)	19
20	Fees, Subscriptions & Promotions	(16,135)	322	2,538	19	286	3						(12,967)	20
21	Clerical & General Office Expenses	(351,448)	204,093	19,012	277	61,546	588						(65,933)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			154	92	28							274	24
25	Other Admin. Staff Transportation			828	7								835	25
26	Insurance-Prop.Liab.Malpractice			340									340	26
27	Other (specify):*			4,917		7,517							12,434	27
28	**TOTAL General Administration**	(393,033)	227,965	(115,196)	1,901	(28,861)	1,327	(2,801)	(640)				(309,338)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(398,392)	227,965	(110,117)	(49,772)	(28,861)	2,598	(2,801)	(640)				(360,021)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Springfield **#** 0051086 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,386	10,570	682	118	121	5,489						30,366	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(17)	159,365	11,063			1,369						171,781	32
33	Real Estate Taxes						1,072						1,072	33
34	Rent-Facility & Grounds		(248,000)	153			(29,900)						(277,747)	34
35	Rent-Equipment & Vehicles			700		162	502						1,364	35
36	Other (specify):*	(11,603)	8,124										(3,479)	36
37	**TOTAL Ownership**	1,766	(69,941)	12,599	118	283	(21,467)						(76,643)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(487)											(487)	43
44	**TOTAL Special Cost Centers**	(487)											(487)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(397,113)	158,024	(97,518)	(49,654)	(28,578)	(18,870)	(2,801)	(640)				(437,150)	45

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 248,000	525 South MLK Drive, LLC		$	$ (248,000)	1
2	V	33	Real Estate Tax	16,715	525 South MLK Drive, LLC		16,715		2
3	V	32	Interest	4	525 South MLK Drive, LLC		159,369	159,365	3
4	V	19	Professional Fees		525 South MLK Drive, LLC		11,550	11,550	4
5	V	36	Amortization		525 South MLK Drive, LLC		8,124	8,124	5
6	V	21	Bad Debt		525 South MLK Drive, LLC		76,992	76,992	6
7	V	21	Bank Charges		525 South MLK Drive, LLC		36	36	7
8	V	19	Bookkeeping Fees		525 South MLK Drive, LLC		12,000	12,000	8
9	V	21	Change in Swap Valuation		525 South MLK Drive, LLC		126,338	126,338	9
10	V	30	Depreciation		525 South MLK Drive, LLC		10,570	10,570	10
11	V	20	Licenses & Fees		525 South MLK Drive, LLC		322	322	11
12	V	21	Replacement Tax		525 South MLK Drive, LLC		727	727	12
13	V								13
14	Total			$ 264,719			$ 422,743	$ * 158,024	14

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Declaration of Trust of Yosef Meystel	47.00%	Aperion Care Bradley	Bradley	525 South MLK Drive, LLC	Springfield	Building Co.	1
2	David Berkowitz Revocable Trust	47.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Jay Meystel Trust	4.00%	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	Frederick Frankel Trust	1.00%	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	19
20			Aperion Care 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 Spring Valley	Spring Valley				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	Aperion Care, Inc.		$ 55	$ 55	15
16	V	3	Housekeeping		Aperion Care, Inc.		19	19	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		942	942	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		59	59	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		105	105	19
20	V	9	Medical Director		Aperion Care, Inc.		999	999	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,599	2,599	21
22	V	11	Activities		Aperion Care, Inc.		11	11	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		289	289	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		24,895	24,895	24
25	V	19	Professional Fees		Aperion Care, Inc.		4,465	4,465	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,538	2,538	26
27	V	21	Clerical Salary		Aperion Care, Inc.		18,315	18,315	27
28	V	21	Clerical & General		Aperion Care, Inc.		697	697	28
29	V	24	Seminars		Aperion Care, Inc.		154	154	29
30	V	25	Auto & Travel		Aperion Care, Inc.		828	828	30
31	V	26	Insurance		Aperion Care, Inc.		340	340	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		4,917	4,917	32
33	V	30	Depreciaiton		Aperion Care, Inc.		682	682	33
34	V	32	Interest		Aperion Care, Inc.		11,063	11,063	34
35	V	34	Rent		Aperion Care, Inc.		153	153	35
36	V	35	Auto Lease		Aperion Care, Inc.		700	700	36
37	V	17	Management Fee	166,181	Aperion Care, Inc.			(166,181)	37
38	V	19	Home Office	6,164	Aperion Care, Inc.			(6,164)	38
39	Total			$ 172,345			$ 74,827	$ * (97,518)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	$	Aperion Consulting, LLC		$ 10,054	$ 10,054	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,702	1,702	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		36	36	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,309	1,309	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		34,228	34,228	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		3,875	3,875	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,506	1,506	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		19	19	22
23	V	21	Clerical & General		Aperion Consulting, LLC		277	277	23
24	V	24	Seminars		Aperion Consulting, LLC		92	92	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		7	7	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		118	118	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	34
35	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,877			$ 53,223	$ * (49,654)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		1,922	$ 1,922	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		286	286	16
17	V	21	Clerical & General		Aperion Financial, LLC		36,252	36,252	17
18	V	24	Seminars		Aperion Financial, LLC		28	28	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		4,394	4,394	20
21	V	30	Depreciaiton		Aperion Financial, LLC		121	121	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		162	162	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		25,294	25,294	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		3,123	3,123	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Home Office Expense	100,160	Aperion Financial, LLC			(100,160)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,160			$ 71,582	$ * (28,578)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Chase Office, LLC		$ 403	$ 403	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		642	642	16
17	V	3	Housekeeping		Chase Office, LLC		189	189	17
18	V	10	Medical Supplies		Chase Office, LLC		38	38	18
19	V	19	Professional Fees		Chase Office, LLC		736	736	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		588	588	21
22	V	30	Depreciation		Chase Office, LLC		5,489	5,489	22
23	V	32	Interest Expense		Chase Office, LLC		1,369	1,369	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,072	1,072	24
25	V	35	Equipment Rental		Chase Office, LLC		502	502	25
26	V	34	Rent	30,000	Chase Office, LLC		100	(29,900)	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			$ 11,130	$ * (18,870)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 12,225	ProPay HR LLC		$ 9,424	$ (2,801)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,225			$ 9,424	$ * (2,801)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Data Processing	$ 4,200	EMSA PURCHASING GROUP		$ 3,560	$ (640)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,200			$ 3,560	$ * (640)	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 8,696	Aperion Incorporated Cell		$ 8,696	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,696			$ 8,696	$ *	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.47	1.17%	Alloc Salary	$ 2,922	17-7	1
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.47	1.17%	Alloc Salary	1,343	17-7	2
3	Fred Frankel	Relative	Administrative	0.00%	See Attached	0.47	1.17%	Alloc Salary	2,922	17-7	3
4	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.47	1.17%	Alloc Salary	2,922	17-7	4
5	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.47	1.17%	Alloc Salary	688	21-7	5
6	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.32	1.17%	Alloc Salary	362	21-7	6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 11,159		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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Census/Direct Cost	1,899,996	65	$ 4,717	$	22,210	$ 55	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		22,210	19	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	22,210	942	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		22,210	59	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		22,210	105	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		22,210	999	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	22,210	2,599	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		22,210	11	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		22,210	289	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	22,210	24,895	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		22,210	4,465	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		22,210	2,538	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	22,210	18,315	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		22,210	697	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		22,210	154	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		22,210	828	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		22,210	340	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		22,210	4,917	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		22,210	682	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		22,210	11,063	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		22,210	153	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		22,210	700	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 74,827	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	$ 498,880	$ 498,880	22,210	$ 10,054	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	22,210	1,702	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		22,210	36	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		22,210	1,309	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	22,210	34,228	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		22,210	3,875	6
7	19	Professional Fees	Census	1,488,113	65	100,933		22,210	1,506	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		22,210	19	8
9	21	Clerical & General	Census	1,488,113	65	18,558		22,210	277	9
10	24	Seminars	Census	1,488,113	65	6,182		22,210	92	10
11	25	Auto & Travel	Census	1,488,113	65	484		22,210	7	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65			22,210		12
13	30	Depreciation	Census	1,488,113	46	7,885		22,210	118	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		$ 53,223	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Census	1,899,996	65	164,380		22,210	1,922	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		22,210	286	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	22,210	36,252	3
4	24	Seminars	Census	1,899,996	65	2,428		22,210	28	4
5	25	Auto & Travel	Census	1,899,996	65			22,210		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		22,210	4,394	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		22,210	121	7
8	32	Interest	Census	1,899,996	65			22,210		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		22,210	162	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	22,210	25,294	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		22,210	3,123	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		$ 71,582	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	64	$ 34,497	$	22,210	$ 403	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		22,210	642	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		22,210	189	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		22,210	38	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		22,210	736	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		22,210	3	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		22,210	588	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		22,210	5,489	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		22,210	1,369	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		22,210	1,072	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		22,210	502	11
12	34	Rent	Actual Census	1,899,996	64	42,922		22,210	100	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	$		$ 11,130	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			$	$		$ 9,424	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 9,424	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct			$	$		$ 3,560	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					$	$		$ 3,560	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 8,696	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					$	$		$ 8,696	25

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Midwest Bank		X	Mortgage			$	$ 2,790,326			$ 159,369	1
2	GM Financial		X	Auto			$	$ 7,184			$ 1,190	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				423,100			16,746	6
7	Assurance		X	Insurance Financing				-			407	7
8												8
9	TOTAL Facility Related						$	$ 3,220,610			$ 177,712	9
	B. Non-Facility Related*											
10	Interest Income		X								(17)	10
11	Interest Income - Bldg Co.										(4)	11
12	Alloc from Aperion Care	X									11,063	12
13	Alloc from Chase Office	X									1369	13
14	TOTAL Non-Facility Related						$	$			$ 12,411	14
15	TOTALS (line 9+line14)						$	$ 3,220,610			$ 190,123	15

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 19,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 19,287	2
3. Under or (over) accrual (line 2 minus line 1).		$ (513)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 18,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 17,787	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	18,109	8
	2016	19,004	9
	2017	19,379	10
	2018	19,795	11
	2019	18,215	12

2020 Accrual = 2019 Tax (rounded up)
Allocated from Chase Office $1071

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051086

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-35.0-161-007	Long Term Care Property	$ 115	$ 115
2.	14-35.0-161-008	Long Term Care Property	$ 115	$ 115
3.	14-35.0-157-012	Long Term Care Property	$ 55	$ 55
4.	14-35.0-157-013	Long Term Care Property	$ 646	$ 646
5.	14-35.0-157-019	Long Term Care Property	$ 17,285	$ 17,285
6.	10-27-307-027-0000	Allocated from Chase Office	$ 72,111	$ 801
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 90,325	$ 19,016

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 Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051086

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	525 South MLK Drive, LLC		2011	$ 183,518	1
2	Allocated from Chase Office			690	2
3	TOTALS			$ 184,208	3

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		2011	1972	$ 639,905	$ 10,570	35	$ 18,283	$ 7,713	$ 188,924	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2011	19,082		20	650	650	17,890	9
10	Various			2012	138,607		20	2,966	2,966	106,871	10
11	Various			2013	7,628		20	381	381	2,851	11
12	Various			2014	11,400		20	360	360	6,540	12
13	Various			2015	2,870		20	144	144	850	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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		42,897	3,027		1,994	(1,033)	8,491	68
69	Financial Statement Depreciation			30,158			(30,158)		69
70	TOTAL (lines 4 thru 69)		$ 862,389	$ 43,755		$ 24,778	$ (18,977)	$ 332,417	70

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 862,389	$ 43,755		$ 24,778	$ (18,977)	$ 332,417	1
2	Install Plumbing, Broke Concrete Floor, Replace Floor Drain-Kitc	2017	2,045		20	102	102	498	2
3	Electrical Work - New Feeder Lines	2017	4,000		20	200	200	650	3
4	Office Area-White Panels,Cabinets,Countertop,Flooring,Doors,W	2018	15,187		20	759	759	1,961	4
5	Fire System - Pipe Repair	2019	3,302		20	165	165	330	5
6	New Dry Pendent Sprinkler Heads For Sprinkler System (33,200)	2020	30,940		20	1,660	1,660	1,660	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)		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	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)		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	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)		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	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)		$ 917,863	$ 43,755		$ 27,664	$ (16,091)	$ 337,516	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	6,206	159	20	159		703	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	348	56	20	17	(39)	174	9
10	Allocated from Aperion Care	2012	99	8	20	5	(3)	39	10
11	Allocated from Aperion Care	2013	42	5	20	2	(3)	15	11
12									12
13	Allocated from Chase Office LLC	2020	124		20	6	6	6	13
14	Allocated from Chase Office LLC	2019	3,161	144	20	158	15	316	14
15	Allocated from Chase Office LLC	2018	28	1	20	1	(0)	4	15
16	Allocated from Chase Office LLC	2017	1,437	351	20	72	(279)	287	16
17	Allocated from Chase Office LLC	2016	31,453	2,303	20	1,573	(730)	6,946	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)		$ 42,897	$ 3,027		$ 1,994	$ (1,033)	$ 8,491	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 42,897	$ 3,027		$ 1,994	$ (1,033)	$ 8,491	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)		$ 42,897	$ 3,027		$ 1,994	$ (1,033)	$ 8,491	34

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

Facility Name & ID Number Aperion Care Springfield # 0051086 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	$ 225,827	$ 3,251	$ 22,628	$ 19,377	10	$ 190,960	71
72	Current Year Purchases	303	20	32	11	10	32	72
73	Fully Depreciated Assets	51,660				10	51,660	73
74								74
75	TOTALS	$ 277,791	$ 3,271	$ 22,660	$ 19,389		$ 242,651	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		2010 FORD E350 - Transfer fron	2012	$ 47,641	$	$	$	5	$ 47,641	76
77		2005 DODGE CARAVAN USED	2014	5,626				5	5,626	77
78		GMC Savana Passenger	2017	48,474		9,695	9,695	5	34,740	78
79		See Attached		2,518	111	504	393		1,261	79
80	TOTALS			$ 104,259	$ 111	$ 10,199	$ 10,088		$ 89,268	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,484,120	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 47,137	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 60,523	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,386	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 669,435	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage Rental				1,125			5
6	Alloc from Aperion Care & Chase Office				253			6
7	TOTAL				$ 1,378 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

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

16. Rental Amount for movable equipment: $ 7,731 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		$	$ 700	17
18					18
19					19
20					20
21	TOTAL		$	$ 700	21

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

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				47,557		47,557	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						890		890	13
14	TOTAL			$		$	$ 48,447		$ 48,447	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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 390,120	$ 585,474	1
2	Cash-Patient Deposits	500	500	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	207,557	207,557	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,506	42,506	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,119,256	8
9	Other(specify): See Attached	7,241	27,859	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 647,924	$ 1,983,152	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		185,440	13
14	Buildings, at Historical Cost		350,849	14
15	Leasehold Improvements, at Historical Cost	142,671	166,283	15
16	Equipment, at Historical Cost	317,326	499,621	16
17	Accumulated Depreciation (book methods)	(372,417)	(669,489)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	2,217,481	2,259,928	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,305,061	$ 2,792,632	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,952,985	$ 4,775,784	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,801	$ 75,801	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	430,284	430,284	29
30	Accrued Salaries Payable	147,578	147,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,955	4,955	31
32	Accrued Real Estate Taxes(Sch.IX-B)		18,300	32
33	Accrued Interest Payable	985	15,193	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	509,963	509,963	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,169,566	$ 1,202,074	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,790,326	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	543,212		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 543,212	$ 2,790,326	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,712,778	$ 3,992,400	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,240,207	$ 783,384	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,952,985	$ 4,775,784	48

***(See instructions.)**

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,107,354	1
2	Restatements (describe):		2
3	Bad Debts	(19,569)	3
4	Rounding	(3)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,087,782	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	152,425	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 152,425	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)**	$ 1,240,207	24 *

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

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,583,634	1
2	Discounts and Allowances for all Levels	(1,039,502)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,544,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,550	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,550	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	261,865	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261,865	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,808,564	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	766,319	31
32	Health Care	1,328,475	32
33	General Administration	985,465	33
	B. Capital Expense		
34	Ownership	354,887	34
	C. Ancillary Expense		
35	Special Cost Centers	48,934	35
36	Provider Participation Fee	172,059	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,656,139	40
41	**Income before Income Taxes (line 30 minus line 40)****	152,425	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 152,425	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 596,818	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Insurance	6,566	47
48	Other-(specify) Managed Care	2,940,748	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,544,132	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 Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,102	$ 99,310	$ 47.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,490	4,757	149,520	31.43	3
4	Licensed Practical Nurses	7,839	8,500	230,929	27.17	4
5	CNAs & Orderlies	25,800	29,133	511,556	17.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,216	44,169	19.93	9
10	Activity Assistants	990	1,130	16,763	14.83	10
11	Social Service Workers	3,839	4,071	89,191	21.91	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	45,843	22.04	13
14	Head Cook	5,244	5,869	90,072	15.35	14
15	Cook Helpers/Assistants	3,624	3,875	61,521	15.88	15
16	Dishwashers					16
17	Maintenance Workers	2,356	2,752	52,533	19.09	17
18	Housekeepers	7,545	8,645	145,681	16.85	18
19	Laundry	1,659	1,977	30,210	15.28	19
20	Administrator	1,520	1,672	91,228	54.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,856	2,160	44,792	20.74	23
24	Clerical					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)	72,602	80,939	$ 1,703,318 *	$ 21.04	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,522	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	101	8,140	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	12	470	11-03	44
45	Social Service Consultant	13	500	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	6,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	125	$ 115,114		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,265	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	25	$ 1,265		53

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Liddell	Administrator		$ 60,120
Tanisha McCullough	Administrator		31,108
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,228

B. Administrative - Other

Description	Amount
Aperion Care, Inc. - Management Fees	$ 166,181
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 166,181

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network Inc.	Eligibility Software	$ 4,561
Aperion Care, Inc.	Data Processing	12,153
Creative Technology Solutions	IT Consulting	5,005
EMSA Purchasing Group, LLC	Procurement Solutions	4,200
PointClickCare Technologies Inc.	Data Processing	20,309
Reside Admissions LLC	Data Processing	3,481
Synapse PDI, LLC	Data Processing	550
Aperion Financial	Home Office Expense	100,160
Aperion Care, Inc.	Home Office Expense	6,164
Propay HR	Payroll Processing	12,225
See Attached	Legal	6,131
See Supplemental Schedule		24,755
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 199,694

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,324
Unemployment Compensation Insurance	6,022
FICA Taxes	130,304
Employee Health Insurance	43,536
Employee Meals	771
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	390
Employee Benefits - Other	6,771
Employee Benefits Other - Covid	4,631
Employee Meal - Covid	534
TOTAL (agree to Schedule V, line 22, col.8)	$ 246,283

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,928
Health Care Worker Background Check (Indicate # of checks performed 35)	
Patient Background Checks	350
Dues & Subscriptions	8,925
Licenses & Fees	740
See Supplemental Schedule	2,846
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,769

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,127
See Supplemental Schedule	274
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,402

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care Springfield # 0051086 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $10,626**

(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. $ **211** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **172,059**
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. $ **1,305** Has any meal income been offset against related costs? **No** Indicate the amount. $ ____

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

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

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

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