		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: 0052696

Facility Name: Aperion Care St Elmo

Address: 221 East Cumberland (Number) St Elmo (City) 62458 (Zip Code)

County: Fayette

Telephone Number: (618) 829-5551 **Fax #** (618) 829-5569

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2014

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 St Elmo # 0052696 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	42	Skilled (SNF)	42	15,372	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,588	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	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	6,242		3,165	9,407	8
9	SNF/PED				0	9
10	ICF	5,057	1,531		6,588	10
11	ICF/DD				0	11
12	SC				0	12
13	DD 16 OR LESS				0	13
14	TOTALS	11,299	1,531	3,165	15,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.84%

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)
Meals on Wheels

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 02/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 2,798

Medicare Intermediary National Government Services

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 St Elmo # 0052696 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	130,632	11,995	0	142,627		142,627	7,241	149,868			1
2	Food Purchase		96,480		96,480	0	96,480	(51)	96,429			2
3	Housekeeping	96,579	31,400	0	127,979		127,979	150	128,129			3
4	Laundry	25,426	3,707	0	29,133	0	29,133	0	29,133			4
5	Heat and Other Utilities			61,071	61,071		61,071	(9,479)	51,592			5
6	Maintenance	49,750	9,414	44,382	103,546		103,546	(11,720)	91,826			6
7	Other (specify):*	0	0	0	0		0	1,017	1,017			7
8	**TOTAL General Services**	302,387	152,996	105,453	560,836	0	560,836	(12,842)	547,994			8
	B. Health Care and Programs											
9	Medical Director	0	0	12,000	12,000		12,000	720	12,720			9
10	Nursing and Medical Records	1,045,446	145,992	75,492	1,266,930		1,266,930	(41,133)	1,225,797			10
10a	Therapy	81,358	1,898	0	83,256		83,256	0	83,256			10a
11	Activities	94,666	1,969	1,466	98,101		98,101	8	98,109			11
12	Social Services	87,139	0	2,593	89,732		89,732	0	89,732			12
13	CNA Training	0	0	0	0		0	0	0			13
14	Program Transportation	0	0	23,874	23,874		23,874	0	23,874			14
15	Other (specify):*	0	0	0	0		0	2,999	2,999			15
16	**TOTAL Health Care and Programs**	1,308,609	149,859	115,425	1,573,893	0	1,573,893	(37,406)	1,536,487			16
	C. General Administration											
17	Administrative	90,775	0	191,441	282,216		282,216	(173,513)	108,703			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			250,331	250,331	0	250,331	(129,741)	120,590			19
20	Dues, Fees, Subscriptions & Promotions			30,451	30,451		30,451	(13,355)	17,096			20
21	Clerical & General Office Expenses	0	0	257,388	257,388		257,388	(177,133)	80,255			21
22	Employee Benefits & Payroll Taxes			257,616	257,616	0	257,616	0	257,616			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			547	547		547	197	744			24
25	Other Admin. Staff Transportation		0	573	573		573	601	1,174			25
26	Insurance-Prop.Liab.Malpractice			33,354	33,354		33,354	245	33,599			26
27	Other (specify):*	0	0	0	0		0	8,954	8,954			27
28	**TOTAL General Administration**	90,775	0	1,021,701	1,112,476	0	1,112,476	(483,744)	628,732			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,701,771	302,855	1,242,579	3,247,205	0	3,247,205	(533,992)	2,713,213			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 St Elmo #0052696 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			50,568	50,568		50,568	18,412	68,980			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			29,447	29,447		29,447	136,403	165,850			32
33	Real Estate Taxes			23,400	23,400	0	23,400	764	24,164			33
34	Rent-Facility & Grounds			234,000	234,000		234,000	(233,818)	182			34
35	Rent-Equipment & Vehicles			5,863	5,863		5,863	982	6,845			35
36	Other (specify):*			3,640	3,640		3,640	(3,640)	0			36
37	TOTAL Ownership			346,918	346,918	0	346,918	(80,895)	266,023			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0		0	0	0			38
39	Ancillary Service Centers	0	100,033	276,811	376,844		376,844	(51,896)	324,948			39
40	Barber and Beauty Shops	0	0	0	0		0	0	0			40
41	Coffee and Gift Shops	0	0	0	0		0	0	0			41
42	Provider Participation Fee	0	0	123,534	123,534		123,534	0	123,534			42
43	Other (specify):*	0	0	5,442	5,442		5,442	(5,442)	0			43
44	TOTAL Special Cost Centers	0	100,033	405,787	505,820	0	505,820	(57,338)	448,482			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,701,771	402,888	1,995,284	4,099,943	0	4,099,943	(672,226)	3,427,717			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 St Elmo # 0052696 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	(9,769)	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	(14,614)	30		9
10	Interest and Other Investment Income	(43)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,144)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(229,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (486,305)		$ 0	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)	(185,920)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (185,920)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (672,225)		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 St Elmo

ID# 0052696

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	Bank Charges	(13,063)	21	2
3	Theft & Damage Loss	(322)	21	3
4	Credit Card Processing	(155)	21	4
5	Advertising/Marketing	(4,020)	43	5
6	Marketing - Food	(243)	43	6
7	Promotional Products	(1,179)	43	7
8	Amortization	(3,640)	36	8
9	Other Unclassified Income	(87)	21	9
10	Additional R&M	2,083	06	10
11	Capitalized R&M	(2,563)	06	11
12	PAC Dues	(4,904)	20	12
13	Bldg Co - Other Professional	(4,923)	19	13
14	Bldg Co - Accounting & Legal Fees	(6,633)	19	14
15	Bldg Co - Amortization	(11,912)	36	15
16	Bldg Co - Bad Debt	(61,594)	21	16
17	Bldg Co - Bank fees	(36)	21	17
18	Bldg Co - Change in SWAP Valuation	(101,071)	36	18
19	Bldg Co - Licenses & Permits	(245)	20	19
20	Bldg Co - State Replacement Tax	(739)	21	20
21	Bldg Co - Bookkeeping	(12,000)	19	21
22	Prior Period Professional Fees	(532)	19	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		0		48
49	**Total**	(229,144)		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 St Elmo

IDH 0052696

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**	0		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 St Elmo # 0052696 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	0	0	0	7,241	0	0	0	0	0	0	0	7,241	1
2	Food Purchase	(91)	0	40	0	0	0	0	0	0	0	0	(51)	2
3	Housekeeping	0	0	14	0	0	136	0	0	0	0	0	150	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(9,769)	0	0	0	0	290	0	0	0	0	0	(9,479)	5
6	Maintenance	(480)	0	720	(12,422)	0	462	0	0	0	0	0	(11,720)	6
7	Other (specify):*	0	0	75	942	0	0	0	0	0	0	0	1,017	7
8	**TOTAL General Services**	(10,340)	0	849	(4,239)	0	888	0	0	0	0	0	(12,842)	8
	B. Health Care and Programs													
9	Medical Director	0	0	720	0	0	0	0	0	0	0	0	720	9
10	Nursing and Medical Records	0	0	1,872	(43,032)	0	27	0	0	0	0	0	(41,133)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	8	0	0	0	0	0	0	0	0	8	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	208	2,791	0	0	0	0	0	0	0	2,999	15
16	**TOTAL Health Care and Programs**	0	0	2,807	(40,241)	0	27	0	0	0	0	0	(37,406)	16
	C. General Administration													
17	Administrative	0	0	(173,513)	0	0	0	0	0	0	0	0	(173,513)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,455)	23,556	(3,504)	1,085	(121,811)	530	(3,501)	0	0	0	(641)	(129,741)	19
20	Fees, Subscriptions & Promotions	(15,649)	245	1,828	13	206	2	0	0	0	0	0	(13,355)	20
21	Clerical & General Office Expenses	(298,140)	62,369	13,692	199	44,324	423	0	0	0	0	0	(177,133)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	111	66	20	0	0	0	0	0	0	197	24
25	Other Admin. Staff Transportation	0	0	596	5	0	0	0	0	0	0	0	601	25
26	Insurance-Prop.Liab.Malpractice	0	0	245	0	0	0	0	0	0	0	0	245	26
27	Other (specify):*	0	0	3,541	0	5,413	0	0	0	0	0	0	8,954	27
28	**TOTAL General Administration**	(339,244)	86,170	(157,003)	1,368	(71,848)	955	(3,501)	0	0	0	(641)	(483,744)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(349,584)	86,170	(153,347)	(43,112)	(71,848)	1,871	(3,501)	0	0	0	(641)	(533,992)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care St Elmo **#** 0052696 **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	(14,614)	28,410	491	85	87	3,953	0	0	0	0	0	18,412	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43)	127,492	7,967	0	0	986	0	0	0	0	0	136,403	32
33	Real Estate Taxes	0	(8)	0	0	0	772	0	0	0	0	0	764	33
34	Rent-Facility & Grounds	0	(204,000)	110	0	0	(29,928)	0	0	0	0	0	(233,818)	34
35	Rent-Equipment & Vehicles	0	0	504	0	117	361	0	0	0	0	0	982	35
36	Other (specify):*	(116,623)	112,983	0	0	0	0	0	0	0	0	0	(3,640)	36
37	**TOTAL Ownership**	(131,280)	64,877	9,073	85	204	(23,855)	0	0	0	0	0	(80,895)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	(41,848)	0	(10,048)	0	(51,896)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,442)	0	0	0	0	0	0	0	0	0	0	(5,442)	43
44	**TOTAL Special Cost Centers**	(5,442)	0	0	0	0	0	0	(41,848)	0	(10,048)	0	(57,338)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(486,305)	151,047	(144,274)	(43,027)	(71,644)	(21,984)	(3,501)	(41,848)	0	(10,048)	(641)	(672,226)	45

Facility Name & ID Number Aperion Care St Elmo # 0052696 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 Income	$ 204,000	221 East Cumberland		$	$ (204,000)	1
2	V	33	Real Estate Tax	23,400	221 East Cumberland		23,392	(8)	2
3	V	19	Other Professional		221 East Cumberland		4,923	4,923	3
4	V	19	Accounting & Legal Fees		221 East Cumberland		6,633	6,633	4
5	V	36	Amortization		221 East Cumberland		11,912	11,912	5
6	V	21	Bad Debt		221 East Cumberland		61,594	61,594	6
7	V	21	Bank fees		221 East Cumberland		36	36	7
8	V	36	Change in SWAP Valuation		221 East Cumberland		101,071	101,071	8
9	V	19	Bookeeping Fees - Aperion		221 East Cumberland		12,000	12,000	9
10	V	20	Licenses & Permits		221 East Cumberland		245	245	10
11	V	32	Interest	4	221 East Cumberland		127,496	127,492	11
12	V	21	State Replacement Tax		221 East Cumberland		739	739	12
13	V	30	Depreciation		221 East Cumberland		28,410	28,410	13
14	Total			$ 227,404			$ 378,451	$ * 151,047	14

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	David Berkowitz Revocable Trust	48.50%	Aperion Care Bradley	Bradley	221 East Cumberland		Building Co.	1
2	Yosef Meystel Declaration of Trust	48.50%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Frederick S. Frankel Trust	1.50%	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Steven Turofsky	1.50%	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5			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 Springfield	Springfield				29
30			Aperion Care Tolleston Park	Gary, IN				30

Facility Name & ID Number Aperion Care St Elmo # 0052696 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 St Elmo # 0052696 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.		$ 40	$ 40	15
16	V	3	Housekeeping		Aperion Care, Inc.		14	14	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		678	678	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		42	42	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		75	75	19
20	V	9	Medical Director		Aperion Care, Inc.		720	720	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		1,872	1,872	21
22	V	11	Activities		Aperion Care, Inc.		8	8	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		208	208	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		17,929	17,929	24
25	V	19	Professional Fees		Aperion Care, Inc.		3,216	3,216	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		1,828	1,828	26
27	V	21	Clerical Salary		Aperion Care, Inc.		13,190	13,190	27
28	V	21	Clerical & General		Aperion Care, Inc.		502	502	28
29	V	24	Seminars		Aperion Care, Inc.		111	111	29
30	V	25	Auto & Travel		Aperion Care, Inc.		596	596	30
31	V	26	Insurance		Aperion Care, Inc.		245	245	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		3,541	3,541	32
33	V	30	Depreciaiton		Aperion Care, Inc.		491	491	33
34	V	32	Interest		Aperion Care, Inc.		7,967	7,967	34
35	V	34	Rent		Aperion Care, Inc.		110	110	35
36	V	35	Auto Lease		Aperion Care, Inc.		504	504	36
37	V	17	Management Fee	191,441	Aperion Care, Inc.			(191,441)	37
38	V	19	Home Office	6,719	Aperion Care, Inc.			(6,719)	38
39	Total			$ 198,161			$ 53,887	$ * (144,274)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 7,241	$ 7,241	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,225	1,225	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		26	26	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		942	942	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		24,650	24,650	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		2,791	2,791	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,085	1,085	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		13	13	22
23	V	21	Clerical & General		Aperion Consulting, LLC		199	199	23
24	V	24	Seminars		Aperion Consulting, LLC		66	66	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		5	5	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC		0	0	26
27	V	30	Depreciation		Aperion Consulting, LLC		85	85	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 81,355			$ 38,328	$ * (43,027)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		1,384	$ 1,384	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		206	206	16
17	V	21	Clerical & General		Aperion Financial, LLC		26,108	26,108	17
18	V	24	Seminars		Aperion Financial, LLC		20	20	18
19	V	25	Auto & Travel		Aperion Financial, LLC		0	0	19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		3,164	3,164	20
21	V	30	Depreciaiton		Aperion Financial, LLC		87	87	21
22	V	32	Interest		Aperion Financial, LLC		0	0	22
23	V	35	Equipment Rental		Aperion Financial, LLC		117	117	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		18,216	18,216	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		2,249	2,249	25
26	V	0					0	0	26
27	V	0					0	0	27
28	V	0					0	0	28
29	V	0					0	0	29
30	V	0					0	0	30
31	V	0					0	0	31
32	V	19	Home Office Expense	123,195	Aperion Financial, LLC			(123,195)	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 123,195			$ 51,551	$ * (71,644)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 290	$ 290	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		462	462	16
17	V	3	Housekeeping		Chase Office, LLC		136	136	17
18	V	10	Medical Supplies		Chase Office, LLC		27	27	18
19	V	19	Professional Fees		Chase Office, LLC		530	530	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		2	2	20
21	V	21	Office Expense		Chase Office, LLC		423	423	21
22	V	30	Depreciation		Chase Office, LLC		3,953	3,953	22
23	V	32	Interest Expense		Chase Office, LLC		986	986	23
24	V	33	Real Estate Taxes		Chase Office, LLC		772	772	24
25	V	35	Equipment Rental		Chase Office, LLC		361	361	25
26	V	34	Rent	30,000	Chase Office, LLC		72	(29,928)	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 30,000			$ 8,016	$ * (21,984)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$ 15,281	ProPay HR		$ 11,780	$ (3,501)	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 15,281			$ 11,780	$ * (3,501)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	39	Therapy Services	$ 274,012	Renewal Rehab LLC		$ 232,164	$ (41,848)	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 274,012			$ 232,164	$ * (41,848)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$ 14,062	Aperion Incorporated Cell		$ 14,062	$ 0	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 14,062			$ 14,062	$ * 0	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	39	Laboratory	$ 17,650	Lifescan Labs of Illinois		$ 7,602	$ (10,048)	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 17,650			$ 7,602	$ * (10,048)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 3,559	$ (641)	15
16	V							0	16
17	V							0	17
18	V							0	18
19	V							0	19
20	V							0	20
21	V							0	21
22	V							0	22
23	V							0	23
24	V							0	24
25	V							0	25
26	V							0	26
27	V							0	27
28	V							0	28
29	V							0	29
30	V							0	30
31	V							0	31
32	V							0	32
33	V							0	33
34	V							0	34
35	V							0	35
36	V							0	36
37	V							0	37
38	V							0	38
39	Total			$ 4,200			$ 3,559	$ * (641)	39

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	0.34	0.84%	Alloc. Salary	$ 2,105	17-7	1
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.34	0.84%	Alloc. Salary	967	17-7	2
3	Fred Frankel	Relative	Administrative	0.00%	See Attached	0.34	0.84%	Alloc. Salary	2,105	17-7	3
4	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.34	0.84%	Alloc. Salary	2,105	17-7	4
5	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.34	0.84%	Alloc. Salary	495	21-7	5
6	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.23	0.84%	Alloc. Salary	261	21-7	6
7											7
8											8
9											9
10									0		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	$ 8,038		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 St Elmo # 0052696 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						$	$		$ 0	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 0	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$	15,995	$ 40	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		15,995	14	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	15,995	678	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		15,995	42	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		15,995	75	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		15,995	720	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	15,995	1,872	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		15,995	8	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		15,995	208	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	15,995	17,929	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		15,995	3,216	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		15,995	1,828	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	15,995	13,190	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		15,995	502	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		15,995	111	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		15,995	596	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		15,995	245	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		15,995	3,541	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		15,995	491	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		15,995	7,967	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		15,995	110	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		15,995	504	22
23									0	23
24									0	24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 53,887	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	15,995	$ 7,241	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	15,995	1,225	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		15,995	26	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		15,995	942	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	15,995	24,650	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		15,995	2,791	6
7	19	Professional Fees	Census	1,488,113	65	100,933		15,995	1,085	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		15,995	13	8
9	21	Clerical & General	Census	1,488,113	65	18,558	0	15,995	199	9
10	24	Seminars	Census	1,488,113	65	6,182		15,995	66	10
11	25	Auto & Travel	Census	1,488,113	65	484		15,995	5	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65	0		15,995	0	12
13	30	Depreciation	Census	1,488,113	46	7,885		15,995	85	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 2,676,688	$ 2,281,729		$ 38,328	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		15,995	1,384	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		15,995	206	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	15,995	26,108	3
4	24	Seminars	Census	1,899,996	65	2,428		15,995	20	4
5	25	Auto & Travel	Census	1,899,996	65	0		15,995	0	5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		15,995	3,164	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		15,995	87	7
8	32	Interest	Census	1,899,996	65	0		15,995	0	8
9	35	Equipment Rental	Census	1,899,996	65	13,849		15,995	117	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	15,995	18,216	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		15,995	2,249	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 5,678,004	$ 4,811,281		$ 51,551	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$	15,995	$ 290	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	64	54,886		15,995	462	2
3	3	Housekeeping	Actual Census	1,899,996	64	16,134		15,995	136	3
4	10	Medical Supplies	Actual Census	1,899,996	64	3,211		15,995	27	4
5	19	Professional Fees	Actual Census	1,899,996	64	62,958		15,995	530	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	64	256		15,995	2	6
7	21	Office Expense	Actual Census	1,899,996	64	50,267		15,995	423	7
8	30	Depreciation	Actual Census	1,899,996	64	469,583		15,995	3,953	8
9	32	Interest Expense	Actual Census	1,899,996	64	117,136		15,995	986	9
10	33	Real Estate Taxes	Actual Census	1,899,996	64	91,748		15,995	772	10
11	35	Equipment Rental	Actual Census	1,899,996	64	8,550		15,995	361	11
12	34	Rent	Actual Census	1,899,996	64	42,922		15,995	72	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 952,148	$ 0		$ 8,016	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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			$	$		$ 11,780	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 11,780	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy Services	Direct		59	$	$		$ 232,164	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 232,164	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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			$	$		$ 14,062	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 14,062	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 7,602	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 7,602	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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			$	$		$ 3,559	1
2									0	2
3									0	3
4									0	4
5									0	5
6									0	6
7									0	7
8									0	8
9									0	9
10									0	10
11									0	11
12									0	12
13									0	13
14									0	14
15									0	15
16									0	16
17									0	17
18									0	18
19									0	19
20									0	20
21									0	21
22									0	22
23									0	23
24									0	24
25	TOTALS					$ 0	$ 0		$ 3,559	25

Facility Name & ID Number Aperion Care St Elmo # 0052696 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	ACI Equities		X	Mortgage			$	$ 2,232,261			$ 127,496	1
2												2
3												3
4												4
5	0						0	0			0	5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				806,153			29,145	6
7	Insurance Policies		X								302	7
8	0						0	0			0	8
9	TOTAL Facility Related						$ 0	$ 3,038,414			$ 156,943	9
	B. Non-Facility Related*											
10	Interest Income		X								(43)	10
11	Interest Income - Bldg Co		X								(4)	11
12	Allocated from Aperion Care, I	X									7,967	12
13	Allocated from Chase Office	X			$0.00		0	0			986	13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 8,906	14
15	TOTALS (line 9+line14)						$ 0	$ 3,038,414			$ 165,849	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 St Elmo # 0052696 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.**	$ 23,400	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.)		$ 24,165	2
3. Under or (over) accrual (line 2 minus line 1).		$ 765	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,400	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.		$ 24,165	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	23,505	8
	2016	24,020	9
	2017	23,080	10
	2018	23,071	11
	2019	23,393	12

2020 Accrual = 2019 Accrual

Allocated from Chase Office $772

	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 St Elmo COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0052696

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.	01-12-27-237-002	Long Term Care Facility	$ 77.16	$ 77.16
2.	01-12-27-237-003	Long Term Care Facility	$ 21,591.48	$ 21,591.48
3.	01-12-27-237-004	Long Term Care Facility	$ 1,723.56	$ 1,723.56
4.	See Attached	Allocated from Chase Office	$ 72,110.55	$ 576.71
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,502.75	$ 23,968.91

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 St Elmo COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0052696

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	$ 0.00	$ 0.00

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 St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,076 B. General Construction Type: Exterior Brick Frame Reinforced Concrete 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 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	Facility	51,830	2014	$ 90,000	1
2	Allocated from Chase Office LLC			497	2
3	TOTALS	51,830		$ 90,497	3

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	60		2014	1968	$ 1,108,000	$ 28,410	39	$ 28,410	$ 0	$ 198,871	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2014	294,271		20	14,073	14,073	100,356	9
10	Various			2015	19,263		20	963	963	5,414	10
11	Various			2016	11,963		20	599	599	2,870	11
12	0			0	0		0	0		0	12
13	0			0	0		0	0		0	13
14	0			0	0		0	0		0	14
15	0			0	0		0	0		0	15
16	0			0	0		0	0		0	16
17	0			0	0		0	0		0	17
18	0			0	0		0	0		0	18
19	0			0	0		0	0		0	19
20	0			0	0		0	0		0	20
21	0			0	0		0	0		0	21
22	0			0	0		0	0		0	22
23	0			0	0		0	0		0	23
24	0			0	0		0	0		0	24
25	0			0	0		0	0		0	25
26	0			0	0		0	0		0	26
27	0			0	0		0	0		0	27
28	0			0	0		0	0		0	28
29	0			0	0		0	0		0	29
30	0			0	0		0	0		0	30
31	0			0	0		0	0		0	31
32	0			0	0		0	0		0	32
33	0			0	0		0	0		0	33
34	0			0	0		0	0		0	34
35	0			0	0		0	0		0	35
36	0			0	0		0	0		0	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 St Elmo # 0052696 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	0	0	$ 0	$		$ 0	$	$ 0	37
38	0	0	0			0		0	38
39	0	0	0			0		0	39
40	0	0	0			0		0	40
41	0	0	0			0		0	41
42	0	0	0			0		0	42
43	0	0	0			0		0	43
44	0	0	0			0		0	44
45	0	0	0			0		0	45
46	0	0	0			0		0	46
47	0	0	0			0		0	47
48	0	0	0			0		0	48
49	0	0	0			0		0	49
50	0	0	0			0		0	50
51	0	0	0			0		0	51
52	0	0	0			0		0	52
53	0	0	0			0		0	53
54	0	0	0			0		0	54
55	0	0	0			0		0	55
56	0	0	0			0		0	56
57	0	0	0			0		0	57
58	0	0	0			0		0	58
59	0	0	0			0		0	59
60	0	0	0			0		0	60
61	0	0	0			0		0	61
62	0	0	0			0		0	62
63	0	0	0			0		0	63
64	0	0	0			0		0	64
65	0	0	0			0		0	65
66	0	0	0			0		0	66
67	Related Building Company (Pages 12F & 12G)		0	0		0		0	67
68	Related Party Allocations (Pages 12H & 12I)		30,893	2,180		1,436	(744)	6,115	68
69	Financial Statement Depreciation			50,568			(50,568)		69
70	TOTAL (lines 4 thru 69)		$ 1,464,390	$ 81,158		$ 45,481	$ (35,677)	$ 313,626	70

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 1,464,390	$ 81,158		$ 45,481	$ (35,677)	$ 313,626	1
2	Dining Room Wall Improvements	2017	6,994		20	350	350	1,399	2
3	Install Drywall On Ceiling	2017	3,020		20	151	151	604	3
4	Ao Smith Commercial Water Heater	2017	3,965		20	198	198	776	4
5	Basement Sump Pump System	2017	13,613		20	681	681	2,610	5
6	4 Ton Heat Pump System	2017	6,572		20	329	329	1,123	6
7	Wall Base & Floor Prep In Dining Room	2017	3,210		20	161	161	549	7
8	Replace A/C System In Kitchen (4,860)	2018	4,763		20	238	238	655	8
9	Replace Existing Dry Valve	2019	7,159		20	358	358	656	9
10	Installation Of Security Cameras	2019	15,148		20	757	757	934	10
11	2 A/C Units With Air Handlers And Coils-East Hallway	2019	10,460		20	523	523	1,528	11
12	Replace Pump/Isolation Valves On Boiler	2019	4,301		20	215	215	430	12
13	New Hot Water Heater (11,695)	2020	11,073		20	554	554	554	13
14	New Board For Generator	2020	2,729		20	136	136	136	14
15	Repair Dry System Leaks	2020	2,563		20	128	128	128	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	1
2						0		0	2
3						0		0	3
4						0		0	4
5						0		0	5
6						0		0	6
7						0		0	7
8						0		0	8
9						0		0	9
10						0		0	10
11						0		0	11
12						0		0	12
13						0		0	13
14						0		0	14
15						0		0	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	1
2						0		0	2
3						0		0	3
4						0		0	4
5						0		0	5
6						0		0	6
7						0		0	7
8						0		0	8
9						0		0	9
10						0		0	10
11						0		0	11
12						0		0	12
13						0		0	13
14						0		0	14
15						0		0	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	1
2						0		0	2
3						0		0	3
4						0		0	4
5						0		0	5
6						0		0	6
7						0		0	7
8						0		0	8
9						0		0	9
10						0		0	10
11						0		0	11
12						0		0	12
13						0		0	13
14						0		0	14
15						0		0	15
16						0		0	16
17						0		0	17
18						0		0	18
19						0		0	19
20						0		0	20
21						0		0	21
22						0		0	22
23						0		0	23
24						0		0	24
25						0		0	25
26						0		0	26
27						0		0	27
28						0		0	28
29						0		0	29
30						0		0	30
31						0		0	31
32						0		0	32
33						0		0	33
34	TOTAL (lines 1 thru 33)		$ 1,559,960	$ 81,158		$ 50,260	$ (30,898)	$ 325,708	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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)		$ 0	$ 0		$ 0	$ 0	$ 0	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 0	$ 0		$ 0	$ 0	$ 0	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)		$ 0	$ 0		$ 0	$ 0	$ 0	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	4,469	115	20	115		506	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	251	40	20	13	(28)	125	9
10	Allocated from Aperion Care	2012	71	5	20	4	(2)	28	10
11	Allocated from Aperion Care	2013	30	4	20	2	(2)	11	11
12									12
13	Allocated from Chase Office LLC	2020	89	0	20	4	4	4	13
14	Allocated from Chase Office LLC	2019	2,276	103	20	114	10	228	14
15	Allocated from Chase Office LLC	2018	20	1	20	1	(0)	3	15
16	Allocated from Chase Office LLC	2017	1,035	253	20	52	(201)	207	16
17	Allocated from Chase Office LLC	2016	22,651	1,658	20	1,133	(526)	5,002	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)		$ 30,893	$ 2,180		$ 1,436	$ (744)	$ 6,115	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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		$ 30,893	$ 2,180		$ 1,436	$ (744)	$ 6,115	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)		$ 30,893	$ 2,180		$ 1,436	$ (744)	$ 6,115	34

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$ 176,787	$ 2,341	$ 17,711	$ 15,370	10	$ 113,084	71
72	Current Year Purchases	6,445	15	646	631	10	646	72
73	Fully Depreciated Assets	5,839	0	0	0	10	5,839	73
74					0			74
75	TOTALS	$ 189,071	$ 2,356	$ 18,357	$ 16,001		$ 119,569	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Aperion Care	2020	$ 1,813	$ 80	$ 363	$ 283	5	$ 908	76
77		0	0	0		0	0	0	0	77
78		0	0	0		0	0	0	0	78
79		0		0	0	0	0		0	79
80	TOTALS			$ 1,813	$ 80	$ 363	$ 283		$ 908	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)	$ 1,841,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,594	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,980	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,614)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 446,185	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		$ 0	$	$	86
87		0			87
88		0			88
89		0			89
90		0			90
91	TOTALS	$ 0	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$ 0	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 St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Aperion Care				110			5
6	Allocated from Chase Office				72			6
7	TOTAL		0		$ 182 **			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: $ 6,341 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		$	$ 504	17
18					18
19					19
20					20
21	TOTAL		$ 0	$ 504	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 St Elmo # 0052696 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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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	39 - 03	hrs	$ 0		$ 104,057	$ 0	0	$ 104,057	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs	0		53,304	0	0	53,304	2
3	Licensed Recreational Therapist	0	hrs	0		0	0	0	0	3
4	Licensed Physical Therapist	39 - 03	hrs	0		116,811	0	0	116,811	4
5	Physician Care	0	visits	0		0	0	0	0	5
6	Dental Care	0	visits	0		0	0	0	0	6
7	Work Related Program	0	hrs	0		0	0	0	0	7
8	Habilitation	0	hrs	0		0	0	0	0	8
9	Pharmacy	39 - 02	# of prescrpts	0		0	89,529	0	89,529	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	0	hrs	0		0	0	0	0	10
11	Academic Education		hrs	0		0	0	0	0	11
12	Other (specify):	0				0	0	0	0	12
13	Other (specify): See Attached			0		2,639	10,504	0 0	13,143	13
14	TOTAL			$ 0		$ 276,811	$ 100,033	0	$ 376,844	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 St Elmo # 0052696 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	$ 362,586	$ 1,099,774	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	839,476	839,476	3
4	Supply Inventory (priced at)	0	0	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	42,406	42,406	6
7	Other Prepaid Expenses	2,000	2,000	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): See Attached	0	12,414	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,246,468	$ 1,996,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	0	90,000	13
14	Buildings, at Historical Cost	0	1,108,000	14
15	Leasehold Improvements, at Historical Cost	425,204	425,204	15
16	Equipment, at Historical Cost	64,921	206,921	16
17	Accumulated Depreciation (book methods)	(274,610)	(611,930)	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	0	0	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0	0	20
21	Restricted Funds	0	0	21
22	Other Long-Term Assets (specify):	0	0	22
23	Other(specify): See Attached	938,056	969,567	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,153,571	$ 2,187,762	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,400,039	$ 4,183,832	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 125,905	$ 125,903	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	806,153	806,153	29
30	Accrued Salaries Payable	85,613	85,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,788	1,788	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	23,400	32
33	Accrued Interest Payable	1,966	141,064	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36		0	0	36
37		0	0	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,021,425	$ 1,183,921	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	2,232,261	40
41	Bonds Payable	0	0	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,268,952	361,937	43
44		0	0	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,268,952	$ 2,594,198	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,290,377	$ 3,778,119	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 109,662	$ 405,713	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,400,039	$ 4,183,832	48

***(See instructions.)**

Facility Name & ID Number Aperion Care St Elmo # 0052696 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**	$ (480,723)	1
2	Restatements (describe):		2
3	Bad Debt	(55,436)	3
4	Rounding	3	4
5		0	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (536,156)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	645,818	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	0	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe)	0	15
16	Other (describe)	0	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 645,818	17
	B. Transfers (Itemize):		
18		0	18
19		0	19
20		0	20
21		0	21
22		0	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 109,662	24 *

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

Facility Name & ID Number Aperion Care St Elmo # 0052696 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	$ 3,349,884	1
2	Discounts and Allowances for all Levels	901,331	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,251,215	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	77,210	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 77,210	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	465	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	9	19
20	Radiology and X-Ray	137	20
21	Other Medical Services	3,129	21
22	Laundry	0	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,740	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	43	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	See Attached	413,553	28
28a		0	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 413,553	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,745,761	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	560,836	31
32	Health Care	1,573,893	32
33	General Administration	1,112,476	33
	B. Capital Expense		
34	Ownership	346,918	34
	C. Ancillary Expense		
35	Special Cost Centers	382,286	35
36	Provider Participation Fee	123,534	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,099,943	40
41	**Income before Income Taxes (line 30 minus line 40)****	645,818	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 645,818	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 690,728	44
45	Private Pay - Net Inpatient Revenue	315,101	45
46	Medicare - Net Inpatient Revenue	1,542,254	46
47	Other-(specify) Insurance	145,077	47
48	Other-(specify) Managed Care	1,558,055	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,251,215	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 St Elmo # 0052696 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	2,006	2,162	$ 84,128	$ 38.91	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,479	3,778	107,317	28.41	3
4	Licensed Practical Nurses	12,326	13,787	320,747	23.26	4
5	CNAs & Orderlies	34,042	37,863	533,254	14.08	5
6	CNA Trainees			0		6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	2,262	2,430	81,358	33.48	8
9	Activity Director	2,171	2,384	31,611	13.26	9
10	Activity Assistants	3,425	3,786	40,175	10.61	10
11	Social Service Workers	3,601	3,949	87,139	22.07	11
12	Dietician			0		12
13	Food Service Supervisor	1,630	1,742	29,430	16.89	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	8,430	9,272	101,202	10.91	15
16	Dishwashers			0		16
17	Maintenance Workers	2,000	2,179	49,750	22.83	17
18	Housekeepers	7,439	8,161	96,579	11.83	18
19	Laundry	1,994	2,258	25,426	11.26	19
20	Administrator	2,032	2,182	90,775	41.60	20
21	Assistant Administrator			0		21
22	Other Administrative			0		22
23	Office Manager			0		23
24	Clerical			0		24
25	Vocational Instruction			0		25
26	Academic Instruction			0		26
27	Medical Director			0		27
28	Qualified MR Prof. (QMRP)			0		28
29	Resident Services Coordinator			0		29
30	Habilitation Aides (DD Homes)			0		30
31	Medical Records			0		31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,547	1,941	22,880	11.79	33
34	TOTAL (lines 1 - 33)	88,384	97,874	$ 1,701,771 *	$ 17.39	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		$ 0	0	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant		0	0	37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	147	7,810	10-03	39
40	Physical Therapy Consultant		0	0	40
41	Occupational Therapy Consultant		0	0	41
42	Respiratory Therapy Consultant		0	0	42
43	Speech Therapy Consultant		0	0	43
44	Activity Consultant	24	1,466	11-03	44
45	Social Service Consultant	43	2,593	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	214	$ 91,551		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	0	50
51	Licensed Practical Nurses		0	0	51
52	Certified Nurse Assistants/Aides		0	0	52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Gelsinger	Administrator	0	$ 90,775
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,775

B. Administrative - Other

Description	Amount
Aperion Care - Management Fee	$ 191,441
	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 191,441

C. Professional Services

Vendor/Payee	Type	Amount
ProPay HR	Payroll Processing	$ 15,281
Marcum LLP	Accounting	19,055
Aperion Care	Home Office Expense	6,719
GCHMO	Liaison Service	8,900
MPAC Healthcare	Telehealth	8,050
Personnel Planners Inc.	Unemployment Consultant	1,000
NRC Health	Data Processing	2,103
Pinnacle Financial Services	Financial Consultant	1,532
Interbuild	Energy Procurement	953
Ability Network	Eligibility Software	7,608
See Attached	Legal	1,731
See Supplemental Schedule		177,398
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 250,330

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,545
Unemployment Compensation Insurance	17,790
FICA Taxes	130,185
Employee Health Insurance	35,775
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	1,872
Employee Physicals	160
Employee Benefits - Other	11,744
Employee Benefit Other - Covid	3,545
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 257,616

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	1,571
Health Care Worker Background Check	
(Indicate # of checks performed 7)	72
Patient Background Checks 118	1,180
Dues & Subscriptions	7,210
Licenses & Fees	1,034
See Supplemental Schedule	2,049
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	547
See Supplemental Schedule	197
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 744

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Aperion Care St Elmo # 0052696 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $9,809**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,378** 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. $ **123,534**
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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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