		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0054817

Facility Name: Aperion Care West Chicago

Address: 201 West North Ave (Number) West Chicago (City) 60185 (Zip Code)

County: Dupage

Telephone Number: (630) 876-8100 **Fax #** (630) 876-8108

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2017

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		

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

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

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 West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	213	Skilled (SNF)	213	77,958	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,958	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	69,964	2,584	2,314	74,862	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,964	2,584	2,314	74,862	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.03%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/1/2017

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2017 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 1,320

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	372,795	40,573	21,522	434,890		434,890	12,366	447,256			1
2	Food Purchase		439,100		439,100		439,100	34	439,134			2
3	Housekeeping	257,920	135,836		393,756		393,756	701	394,457			3
4	Laundry	40	22,969		23,009		23,009		23,009			4
5	Heat and Other Utilities			275,016	275,016		275,016	(12,592)	262,424			5
6	Maintenance	112,666	44,913	135,375	292,954		292,954	(15,683)	277,271			6
7	Other (specify):*							4,764	4,764			7
8	**TOTAL General Services**	743,421	683,391	431,913	1,858,725		1,858,725	(10,409)	1,848,316			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000	3,369	12,369			9
10	Nursing and Medical Records	3,118,744	326,932	97,269	3,542,945		3,542,945	54,696	3,597,641			10
10a	Therapy	203,944	821		204,765		204,765		204,765			10a
11	Activities	216,927	9,529	136	226,592		226,592	36	226,628			11
12	Social Services	609,284		6,314	615,598		615,598		615,598			12
13	CNA Training											13
14	Program Transportation			50	50		50		50			14
15	Other (specify):*							14,038	14,038			15
16	**TOTAL Health Care and Programs**	4,148,899	337,282	112,769	4,598,950		4,598,950	72,139	4,671,089			16
	C. General Administration											
17	Administrative	123,146		665,834	788,980		788,980	(581,921)	207,059			17
18	Directors Fees											18
19	Professional Services			562,487	562,487	(19,140)	543,347	(341,604)	201,743			19
20	Dues, Fees, Subscriptions & Promotions			58,241	58,241		58,241	(14,452)	43,789			20
21	Clerical & General Office Expenses	228,860		151,090	379,950		379,950	167,067	547,017			21
22	Employee Benefits & Payroll Taxes			713,181	713,181		713,181		713,181			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,076	3,076		3,076	928	4,004			24
25	Other Admin. Staff Transportation			253	253		253	2,815	3,068			25
26	Insurance-Prop.Liab.Malpractice			161,694	161,694		161,694	1,146	162,840			26
27	Other (specify):*							41,910	41,910			27
28	**TOTAL General Administration**	352,006		2,315,856	2,667,862	(19,140)	2,648,722	(724,112)	1,924,610			28
29	**TOTAL Operating Expense** (sum of lines 8, 16 & 28)	5,244,326	1,020,673	2,860,538	9,125,537	(19,140)	9,106,397	(662,382)	8,444,015			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 West Chicago #0054817 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			85,410	85,410		85,410	(2,831)	82,579			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,921	35,921		35,921	41,349	77,270			32
33	Real Estate Taxes			289,946	289,946	19,140	309,086	3,615	312,701			33
34	Rent-Facility & Grounds			1,641,969	1,641,969		1,641,969	(11,147)	1,630,822			34
35	Rent-Equipment & Vehicles			18,564	18,564		18,564	4,596	23,160			35
36	Other (specify):*			1,770	1,770		1,770	(1,770)	(0)			36
37	TOTAL Ownership			2,073,580	2,073,580	19,140	2,092,720	33,813	2,126,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,283	323,218	458,501		458,501	(49,356)	409,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			562,890	562,890		562,890		562,890			42
43	Other (specify):*			3,365	3,365		3,365	(3,365)	(0)			43
44	TOTAL Special Cost Centers		135,283	889,473	1,024,756		1,024,756	(52,722)	972,034			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,244,326	1,155,956	5,823,591	12,223,873		12,223,873	(681,291)	11,542,582			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 West Chicago # 0054817 **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	(13,951)	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	(24,436)	30		9
10	Interest and Other Investment Income	(557)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(152)	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	(47)	21		18
19	Entertainment				19
20	Contributions	(4,200)	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	(103,858)	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	(45,333)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (192,533)		$	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)	(488,758)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (488,758)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (681,291)		37

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

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

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

STATE OF ILLINOIS

Aperion Care West Chicago

ID# 0054817

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (2,944)	19	1
2	Credit Card Processing	(643)	21	2
3	Advertising/Marketing	(2,378)	43	3
4	Promotional Products	(987)	43	4
5	Bank Charges	(743)	21	5
6	Theft & Damage Loss	(2,090)	21	6
7	Amortization	(1,770)	36	7
8	Additional R&M	4,435	6	8
9	PAC Dues	(19,844)	20	9
10	Prior Year Professional Fees	(532)	19	10
11	Capitalized R&M	(17,837)	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(45,333)		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 West Chicago

ID# 0054817

Report Period Beginning: 01/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care West Chicago # 0054817 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				12,366								12,366	1
2	Food Purchase	(152)		186									34	2
3	Housekeeping			66			636						701	3
4	Laundry													4
5	Heat and Other Utilities	(13,951)					1,359						(12,592)	5
6	Maintenance	(13,402)		3,372	(7,815)		2,163						(15,683)	6
7	Other (specify):*			353	4,411								4,764	7
8	**TOTAL General Services**	(27,505)		3,976	8,962		4,158						(10,409)	8
	B. Health Care and Programs													
9	Medical Director			3,369									3,369	9
10	Nursing and Medical Records			8,761	45,809		127						54,696	10
10a	Therapy													10a
11	Activities			36									36	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			975	13,063								14,038	15
16	**TOTAL Health Care and Programs**			13,141	58,872		127						72,139	16
	C. General Administration													
17	Administrative			(581,921)									(581,921)	17
18	Directors Fees													18
19	Professional Services	(3,476)		57,473	5,078	(394,345)	2,481	(8,175)		(639)			(341,604)	19
20	Fees, Subscriptions & Promotions	(24,044)		8,556	63	963	10						(14,452)	20
21	Clerical & General Office Expenses	(107,380)		64,081	934	207,451	1,981						167,067	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			521	311	96							928	24
25	Other Admin. Staff Transportation			2,791	24								2,815	25
26	Insurance-Prop.Liab.Malpractice			1,146									1,146	26
27	Other (specify):*			16,574		25,336							41,910	27
28	**TOTAL General Administration**	(134,900)		(430,780)	6,410	(160,499)	4,471	(8,175)		(639)			(724,112)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(162,405)		(413,663)	74,244	(160,499)	8,755	(8,175)		(639)			(662,382)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care West Chicago # 0054817 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 D. Ownership	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)	
30	Depreciation	(24,436)		2,299	397	407	18,502						(2,831)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(557)		37,290			4,615						41,349	32
33	Real Estate Taxes						3,615						3,615	33
34	Rent-Facility & Grounds			517			(11,663)						(11,147)	34
35	Rent-Equipment & Vehicles			2,359		546	1,691						4,596	35
36	Other (specify):*	(1,770)											(1,770)	36
37	**TOTAL Ownership**	(26,763)		42,465	397	953	16,760						33,813	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(49,143)		(213)		(49,356)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,365)											(3,365)	43
44	**TOTAL Special Cost Centers**	(3,365)							(49,143)		(213)		(52,722)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(192,533)		(371,197)	74,641	(159,546)	25,516	(8,175)	(49,143)	(639)	(213)		(681,291)	45

Facility Name & ID Number Aperion Care West Chicago # 0054817 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. [ ] YES [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	Yosef Meystel Delta Trust	15.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	David Berkowitz Delta Trust	15.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	David A. Berkowitz Revocable Trust	30.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Steven Turofsky	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Frederick S Frankel Trust	1.50%	Aperion Care Demotte	Demotte,IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Naftali Wilhelm	1.50%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jennifer Spector	1.50%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9	257 Ltd	1.34%	Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10	1219 Ltd	1.33%	Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11	42170 Ltd	1.33%	Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consutling	11
12			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	18
19			Aperion Care Marseilles	Marseilles	Renewal Rehab, LLC	Lincolnwood	Therapy Services	19
20			Aperion Care Mascoutah	Mascoutah	San Antonio Property, LLC	San Antonio, TX	Building Co.	20
21			Aperion Care Midlothian	Midlothian				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 St. Elmo	St. Elmo				30

Facility Name & ID Number Aperion Care West Chicago # 0054817 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 Tolleston Park	Gary, IN				1
2			Aperion Care Toluca	Toluca				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 West Chicago # 0054817 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.		$ 186	$ 186	15
16	V	3	Housekeeping		Aperion Care, Inc.		66	66	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		3,175	3,175	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		197	197	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		353	353	19
20	V	9	Medical Director		Aperion Care, Inc.		3,369	3,369	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		8,761	8,761	21
22	V	11	Activities		Aperion Care, Inc.		36	36	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		975	975	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		83,913	83,913	24
25	V	19	Professional Fees		Aperion Care, Inc.		15,051	15,051	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		8,556	8,556	26
27	V	21	Clerical Salary		Aperion Care, Inc.		61,732	61,732	27
28	V	21	Clerical & General		Aperion Care, Inc.		2,349	2,349	28
29	V	24	Seminars		Aperion Care, Inc.		521	521	29
30	V	25	Auto & Travel		Aperion Care, Inc.		2,791	2,791	30
31	V	26	Insurance		Aperion Care, Inc.		1,146	1,146	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		16,574	16,574	32
33	V	30	Depreciaiton		Aperion Care, Inc.		2,299	2,299	33
34	V	32	Interest		Aperion Care, Inc.		37,290	37,290	34
35	V	34	Rent		Aperion Care, Inc.		517	517	35
36	V	35	Auto Lease		Aperion Care, Inc.		2,359	2,359	36
37	V	17	Management Fee	665,834	Aperion Care, Inc.			(665,834)	37
38	V	19	Home Office	(42,422)	Aperion Care, Inc.			42,422	38
39	Total			$ 623,412			$ 252,214	$ * (371,197)	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 33,888	$ 33,888	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		5,736	5,736	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		122	122	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		4,411	4,411	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		115,370	115,370	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		13,063	13,063	20
21	V	19	Professional Fees		Aperion Consulting, LLC		5,078	5,078	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		63	63	22
23	V	21	Clerical & General		Aperion Consulting, LLC		934	934	23
24	V	24	Seminars		Aperion Consulting, LLC		311	311	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		24	24	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		397	397	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,975	Aperion Consulting, LLC			(67,975)	33
34	V	10	Behavioral Health	1,586	Aperion Consulting, LLC			(1,586)	34
35	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	35
36	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	36
37	V								37
38	V								38
39	Total			$ 104,756			$ 179,397	$ * 74,641	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		6,477	$ 6,477	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		963	963	16
17	V	21	Clerical & General		Aperion Financial, LLC		122,193	122,193	17
18	V	24	Seminars		Aperion Financial, LLC		96	96	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		14,809	14,809	20
21	V	30	Depreciaiton		Aperion Financial, LLC		407	407	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		546	546	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		85,258	85,258	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		10,527	10,527	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Home Office Expense	400,822	Aperion Financial, LLC			(400,822)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 400,822			$ 241,276	$ * (159,546)	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 1,359	$ 1,359	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		2,163	2,163	16
17	V	3	Housekeeping		Chase Office, LLC		636	636	17
18	V	10	Medical Supplies		Chase Office, LLC		127	127	18
19	V	19	Professional Fees		Chase Office, LLC		2,481	2,481	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		10	10	20
21	V	21	Office Expense		Chase Office, LLC		1,981	1,981	21
22	V	30	Depreciation		Chase Office, LLC		18,502	18,502	22
23	V	32	Interest Expense		Chase Office, LLC		4,615	4,615	23
24	V	33	Real Estate Taxes		Chase Office, LLC		3,615	3,615	24
25	V	35	Equipment Rental		Chase Office, LLC		1,691	1,691	25
26	V	34	Rent	12,000	Chase Office, LLC		337	(11,663)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,000			$ 37,516	$ * 25,516	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 35,684	ProPay HR		$ 27,509	$ (8,175)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 35,684			$ 27,509	$ * (8,175)	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	$ 321,784	Renewal Rehab, LLC		$ 272,641	$ (49,143)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 321,784			$ 272,641	$ * (49,143)	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 375	Lifescan Labs of Illinois		$ 162	$ (213)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 375			$ 162	$ * (213)	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 107,281	Aperion Incorporated Cell		$ 107,281	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 107,281			$ 107,281	$ *	39

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.58	3.94%	Alloc Sal	$ 9,850	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	1.58	3.94%	Alloc Sal	2,318	21-7	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.58	3.94%	Alloc Sal	4,528	17-7	3
4	Fred Frankel	Owner	Administrative	1.50%	See Attached	1.58	3.94%	Alloc Sal	9,850	17-7	4
5	Steve Turofsky	Owner	Administrative	1.50%	See Attached	1.58	3.94%	Alloc Sal	9,850	17-7	5
6	Elisheva Adest	Relative	Clerical	0.00%	See Attached	1.08	3.94%	Alloc Sal	1,222	21-7	6
7	Jennifer Spector	Owner	Clerical	1.50%	See Attached	1.58	3.94%	Alloc Sal	4,691	21-7	7
8	Dovid Spector	Relative	Clerical	0.00%	See Attached	1.58	3.94%	Alloc Sal	3,249	21-7	8
9	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	1.58	3.94%	Alloc Sal	8,962	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 54,520		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 West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	$	74,862	$ 186	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		74,862	66	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	74,862	3,175	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		74,862	197	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		74,862	353	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		74,862	3,369	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	74,862	8,761	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		74,862	36	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		74,862	975	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	74,862	83,913	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		74,862	15,051	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		74,862	8,556	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	74,862	61,732	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		74,862	2,349	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		74,862	521	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		74,862	2,791	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		74,862	1,146	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		74,862	16,574	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		74,862	2,299	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		74,862	37,290	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		74,862	517	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		74,862	2,359	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 252,214	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	74,862	$ 33,888	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	74,862	5,736	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		74,862	122	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		74,862	4,411	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	74,862	115,370	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		74,862	13,063	6
7	19	Professional Fees	Census	1,488,113	65	100,933		74,862	5,078	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		74,862	63	8
9	21	Clerical & General	Census	1,488,113	65	18,558		74,862	934	9
10	24	Seminars	Census	1,488,113	65	6,182		74,862	311	10
11	25	Auto & Travel	Census	1,488,113	65	484		74,862	24	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65			74,862		12
13	30	Depreciation	Census	1,488,113	46	7,885		74,862	397	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,676,688	$ 2,281,729		$ 179,397	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		74,862	6,477	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		74,862	963	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	74,862	122,193	3
4	24	Seminars	Census	1,899,996	65	2,428		74,862	96	4
5	25	Auto & Travel	Census	1,899,996	65			74,862		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		74,862	14,809	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		74,862	407	7
8	32	Interest	Census	1,899,996	65			74,862		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		74,862	546	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	74,862	85,258	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		74,862	10,527	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,678,004	$ 4,811,281		$ 241,276	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	65	$ 34,497	$	74,862	$ 1,359	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886		74,862	2,163	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134		74,862	636	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211		74,862	127	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958		74,862	2,481	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256		74,862	10	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267		74,862	1,981	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583		74,862	18,502	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136		74,862	4,615	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748		74,862	3,615	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550		74,862	1,691	11
12	34	Rent	Actual Census	1,899,996	65	42,922		74,862	337	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 952,148	$		$ 37,516	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 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			$	$		$ 27,509	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 27,509	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	$	$		$ 272,641	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 272,641	25

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	LABS OF ILLINOIS, LLC					$	$		$ 162	1
2	255 GOLF RD									2
3	OKIE, IL 60077									3
4	847) 663 - 8300									4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 162	25

Facility Name & ID Number: Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 107,281	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 107,281	25

Facility Name & ID Number: Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	West Chicago Private Bank		X	Auto Loan			$	$ 32,298			$ 1,464	1
2							$	$			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Interest - Insurance Policies		X					-			682	6
7	Congressional Bank		X	Line of Credit				-			33,775	7
8												8
9	TOTAL Facility Related						$	$ 32,298			$ 35,921	9
	B. Non-Facility Related*											
10	Interest Income		X								(557)	10
11	Allocated from Aperion Care	X									37,290	11
12	Allocated from Chase Office	X									4,615	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 41,348	14
15	TOTALS (line 9+line14)						$	$ 32,298			$ 77,269	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 West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	292,550	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.)	$	287,971	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,579)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	298,140	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.)**	$	19,140	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.	$	312,701	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	350,763	8
2016	348,103	9
2017	347,875	10
2018	352,001	11
2019	284,356	12

2020 Accrual = $284,356 x 1.05 = $298,140

Allocated from Chase Office: $3,615

Beginning Accrual Adjusted

	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 West Chicago COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0054817

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.	01-28-401-085	Long Term Care	$ 284,356	$ 284,356
2.	10-27-307-027-0000	Home Office Allocation	$ 72,111	$ 2,699
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 356,466	$ 287,055

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 West Chicago COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0054817

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: ______ B. General Construction Type: Exterior ______ Frame ______ Number of Stories ______

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2	Allocated from Chase Office LLC			2,324	2
3	TOTALS			$ 2,324	3

Facility Name & ID Number Aperion Care West Chicago # 0054817 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	3,531		20	177	177	177	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		144,590	10,203		6,720	(3,483)	28,619	68
69	Financial Statement Depreciation			85,410			(85,410)		69
70	TOTAL (lines 4 thru 69)		$ 148,121	$ 95,613		$ 6,897	$ (88,716)	$ 28,796	70

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 148,121	$ 95,613		$ 6,897	$ (88,716)	$ 28,796	1
2	Cable And Voice Data	2018	3,995		20	200	200	583	2
3	Lower Front Canopy	2018	7,600		20	380	380	918	3
4	Exhaust Motor	2018	4,897		20	245	245	592	4
5	Door Board And Motor	2018	9,478		20	474	474	1,422	5
6	Tranco Pump/ Proj Mgmt (19,971)	2018	18,688		20	934	934	2,102	6
7	Main Hallway - Interior Drywall (55,011)	2018	54,648		20	2,732	2,732	5,920	7
8	Replace Outdoor Arc Lighting	2018	12,925		20	646	646	1,400	8
9	Installation Wireless Radio (6,641)	2018	6,036		20	302	302	704	9
10	Repaired Electrical Circuit In Undergroup Piping	2018	2,850		20	143	143	381	10
11	Vent Pipe Repair In Basement	2019	6,300		20	315	315	630	11
12	Mixing Valve	2019	4,428		20	221	221	406	12
13	Walk In Freezer Door Replacement	2019	4,838		20	242	242	423	13
14	Removed Old Clay, Backfilled W/Gravel, Replaced 6" Cast Iron I	2019	9,200		20	460	460	805	14
15	High Density Urethane Monument Sign On Facility Entrance	2019	8,093		20	405	405	607	15
16	Install New Exhausts,Motors,Wiring,Pulleys For Roof Top Units	2019	5,948		20	297	297	421	16
17	3Rd Floor Bathroom/Lobby/Entrance - Fire Rated Doors	2019	25,493		20	1,275	1,275	1,806	17
18	Replaced Condenser Fan Motor And Contactor	2019	2,669		20	133	133	166	18
19	1St And 2Nd Floor Drywall/Cast Iron/Pipes	2019	13,104		20	655	655	1,310	19
20	Lobby/1St-3Rd Fl Dining/Shower Rooms-Electrical/Flooring/Plun	2019	148,579		20	7,429	7,429	14,858	20
21	Repaired Corroded Copper Pipes Feeding Boilers	2019	2,700		20	135	135	270	21
22	Fire Alarm Repair	2019	2,773		20	139	139	278	22
23	Hydralic Pit Work	2019	7,854		20	393	393	786	23
24	Repaired Collapsed Storm Drain Pipe	2019	12,536		20	627	627	1,254	24
25	Pothole Filling	2019	10,092		20	505	505	1,010	25
26	Installation Of New Nurse Call System On 3Rd Floor (22,520)	2019	20,737		20	1,126	1,126	1,126	26
27	Cut Concrete, Excavate & Replace 4" Cast Iron Pipe	2019	5,778		20	289	289	289	27
28	Install Cabinets For 1St, 2Nd, 3Rd Floor Nursing Stations And M	2020	15,139		20	815	815	815	28
29	Multiple Common Room Signs & Message Display Boards	2020	15,350		20	768	768	768	29
30	18 Dome Cameras & 5 Turret Cameras With Power Supply (5,400	2020	5,027		20	270	270	270	30
31	Installed New Oil Valve In Elevator (7,456)	2020	7,166		20	373	373	373	31
32	122 Indoor Lighting Fittings For Lower Level Offices (13,513)	2020	12,891		20	676	676	676	32
33	New Fence (16,150)	2020	15,528		20	808	808	808	33
34	TOTAL (lines 1 thru 33)		$ 631,460	$ 95,613		$ 31,307	$ (64,306)	$ 72,971	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 631,460	$ 95,613		$ 31,307	$ (64,306)	$ 72,971	1
2	Elevator Repairs	2020	6,756		20	338	338	338	2
3	Repaired 2 Taco Pumps	2020	5,361		20	268	268	268	3
4	Repaired Fire Dampers On 1St-3Rd Floors	2020	5,720		20	286	286	286	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 649,297	$ 95,613		$ 32,199	$ (63,414)	$ 73,863	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 649,297	$ 95,613		$ 32,199	$ (63,414)	$ 73,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 649,297	$ 95,613		$ 32,199	$ (63,414)	$ 73,863	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 649,297	$ 95,613		$ 32,199	$ (63,414)	$ 73,863	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 649,297	$ 95,613		$ 32,199	$ (63,414)	$ 73,863	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	20,917	536	20	536		2,369	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	1,174	189	20	59	(130)	587	9
10	Allocated from Aperion Care	2012	333	26	20	17	(9)	133	10
11	Allocated from Aperion Care	2013	142	18	20	7	(11)	50	11
12									12
13	Allocated from Chase Office LLC	2020	417		20	21	21	21	13
14	Allocated from Chase Office LLC	2019	10,654	484	20	533	49	1,065	14
15	Allocated from Chase Office LLC	2018	95	5	20	5	(0)	14	15
16	Allocated from Chase Office LLC	2017	4,842	1,184	20	242	(942)	968	16
17	Allocated from Chase Office LLC	2016	106,016	7,762	20	5,301	(2,461)	23,412	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)		$ 144,590	$ 10,203		$ 6,720	$ (3,483)	$ 28,619	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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		$ 144,590	$ 10,203		$ 6,720	$ (3,483)	$ 28,619	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 144,590	$ 10,203		$ 6,720	$ (3,483)	$ 28,619	34

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	$ 238,291	$ 10,958	$ 23,979	$ 13,021	10	$ 66,158	71
72	Current Year Purchases	101,507	69	16,664	16,595	10	16,664	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 339,798	$ 11,027	$ 40,643	$ 29,617		$ 82,822	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		2015 GMC Savana	2019	$ 40,193	$	$ 8,039	$ 8,039	5	$ 16,078	76
77		Allocated from Aperion Care	2020	8,496	375	1,697	1,322	5	4,250	77
78										78
79										79
80	TOTALS			$ 48,689	$ 375	$ 9,736	$ 9,361		$ 20,328	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)	$ 1,040,108	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 107,014	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,578	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,436)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 177,013	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Fire Alarm System	$ 22,300	92
93	2nd Fl Shower Rm Renovation	71,427	93
94	Call Light System for 3rd Fl	64,374	94
95		$ 158,101	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 West Chicago # 0054817 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: American Realty Cap Healthcare Trust Inc
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. [X] 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:				$ 1,629,969			3
4	Additions							4
5	Allocated from Aperion Care Inc				517			5
6	Allocated from Chase Office				337			6
7	TOTAL				$ 1,630,823 **			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: $ 20,801 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 Inc		$	$ 2,359	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,359	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 West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 131,537	$		$ 131,537	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			31,608			31,608	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			158,595			158,595	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				124,713		124,713	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					1,478	10,570		12,048	13
14	TOTAL			$		$ 323,218	$ 135,283		$ 458,501	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 West Chicago | # 0054817 | 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	$ 1,669,719	$	1
2	Cash-Patient Deposits	7,276		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,250,982		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,027		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	5,747		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,021,751	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	566,350		15
16	Equipment, at Historical Cost	302,308		16
17	Accumulated Depreciation (book methods)	(142,094)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	5,905,465		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,632,029	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,653,780	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 368,088	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	463,529		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,595		31
32	Accrued Real Estate Taxes(Sch.IX-B)	298,140		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,883,731		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,031,083	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,298		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		2,006,144		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,038,442	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,069,525	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,584,255	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,653,780	$	48

*(See instructions.)

Facility Name & ID Number Aperion Care West Chicago # 0054817 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**	$ 3,857,183	1
2	Restatements (describe):		2
3	Bad Debt	3,578	3
4	Rent Subsidy Obligation	(1,653,196)	4
5	Rounding	(1)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,207,564	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,676,691	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(300,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,376,691	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,584,255	24 *

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 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	$ 15,674,791	1
2	Discounts and Allowances for all Levels	(1,614,561)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,060,230	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	265,144	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,144	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	126	19
20	Radiology and X-Ray	1,083	20
21	Other Medical Services	5,412	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 21,605	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	557	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 557	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		553,028	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 553,028	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,900,564	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,858,725	31
32	Health Care	4,598,950	32
33	General Administration	2,667,862	33
	B. Capital Expense		
34	Ownership	2,073,580	34
	C. Ancillary Expense		
35	Special Cost Centers	461,866	35
36	Provider Participation Fee	562,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,223,873	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,676,691	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,676,691	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,283,911	44
45	Private Pay - Net Inpatient Revenue	521,129	45
46	Medicare - Net Inpatient Revenue	837,294	46
47	Other-(specify) Insurance	235,264	47
48	Other-(specify) Managed Care	11,182,632	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,060,230	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 West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,108	$ 125,404	$ 59.49	1
2	Assistant Director of Nursing	1,904	2,088	88,728	42.49	2
3	Registered Nurses	21,739	23,545	872,060	37.04	3
4	Licensed Practical Nurses	30,173	32,824	999,173	30.44	4
5	CNAs & Orderlies	49,134	54,584	994,359	18.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,572	8,290	203,944	24.60	8
9	Activity Director	1,984	2,080	53,296	25.62	9
10	Activity Assistants	12,975	13,669	163,631	11.97	10
11	Social Service Workers	31,877	33,673	609,284	18.09	11
12	Dietician					12
13	Food Service Supervisor	1,856	2,080	93,300	44.86	13
14	Head Cook	10,691	11,346	139,989	12.34	14
15	Cook Helpers/Assistants	11,983	13,160	139,506	10.60	15
16	Dishwashers					16
17	Maintenance Workers	5,173	5,545	112,666	20.32	17
18	Housekeepers	19,905	22,231	257,920	11.60	18
19	Laundry	4	4	40	10.00	19
20	Administrator	1,960	2,062	123,146	59.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,623	11,535	228,860	19.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,653	2,050	27,634	13.48	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	720	785	11,386	14.50	33
34	TOTAL (lines 1 - 33)	223,805	243,659	$ 5,244,326 *	$ 21.52	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,522	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,975	10-03	38
39	Pharmacist Consultant	420	27,708	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	2	136	11-03	44
45	Social Service Consultant	96	6,314	12-03	45
46	Other(specify)				46
47	Behavorial Health Consultant	Monthly	1,586	10-03	47
48					48
49	TOTAL (lines 35 - 48)	518	$ 134,241		49

C. CONTRACT NURSES

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

Facility Name & ID Number Aperion Care West Chicago # 0054817 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina M. McCarthy	Administrator		$ 123,146
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 123,146

B. Administrative - Other

Description	Amount
Management Fees - Aperion Care	$ 665,834
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 665,834

C. Professional Services

Vendor/Payee	Type	Amount
PointClickCare Technologies	Data Processing	$ 55,882
Creative Technology Solutions	IT Consulting	10,850
National Datacare Corporation	Resident Trust Fund Services	4,820
DGTell LLC	Telecommunications Service	4,841
EMSA Purchasing Group	Procurement Solutions	4,200
Reside Admissions LLC	Data Processing	3,199
Aperion Care	Data Processing	25,971
Synapse PDI	Patient Data Integrations	550
Personnel Planners	Unemployment Tax Consult	1,800
Z-Core Technologies	Data Processing	2,900
See Attached	Legal	7,707
See Supplemental Schedule		439,767
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 562,487

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,438
Unemployment Compensation Insurance	18,642
FICA Taxes	401,191
Employee Health Insurance	95,488
Employee Meals	3,949
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	3,249
Employee Benefits-Others	30,378
Employee Physicals	42,846
TOTAL (agree to Schedule V, line 22, col.8)	$ 713,181

* Attach copy of IMRF notifications

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	$
Advertising: Employee Recruitment	2,584
Health Care Worker Background Check	
(Indicate # of checks performed 162)	1,620
Patient Background Checks 58	580
Dues & Subscriptions	27,440
Licenses & Fees	1,973
See Supplemental Schedule	9,592
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,076
See Supplemental Schedule	928
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,003

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $39,687**

(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. $ **11,567** 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. $ **562,890**
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. $ **3,949** 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.