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: 0056317

Facility Name: Arcadia of Danville

Address: 1701 North Bowman (Number) Danville (City) 61832 (Zip Code)

County: Vermilion

Telephone Number: (217) 443-2955 **Fax #** (217) 443-0315

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2020

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/20 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	39,530	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	27,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	67,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,033	3,033	8
9	SNF/PED					9
10	ICF	37,239	511	1,468	39,218	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,239	511	4,501	42,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.06%

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 2/1/20

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/20 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 3,033

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	242,111	19,071	12,433	273,615		273,615		273,615			1
2	Food Purchase		259,893		259,893		259,893	(198)	259,695			2
3	Housekeeping	242,510	72,914		315,424		315,424	396	315,820			3
4	Laundry	8,086	11,386		19,472		19,472		19,472			4
5	Heat and Other Utilities			205,864	205,864		205,864	(14,945)	190,919			5
6	Maintenance	70,487	29,890	45,424	145,801		145,801	16,403	162,204			6
7	Other (specify):*							199	199			7
8	TOTAL General Services	563,194	393,154	263,721	1,220,069		1,220,069	1,854	1,221,923			8
	B. Health Care and Programs											
9	Medical Director			35,500	35,500		35,500	1,901	37,401			9
10	Nursing and Medical Records	2,121,900	240,800	90,186	2,452,886		2,452,886	22,716	2,475,602			10
10a	Therapy	22,307	1,506		23,813		23,813		23,813			10a
11	Activities	188,427	6,364	897	195,688		195,688	20	195,708			11
12	Social Services	224,305		34,520	258,825		258,825		258,825			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							16,449	16,449			15
16	TOTAL Health Care and Programs	2,556,939	248,670	161,103	2,966,712		2,966,712	41,087	3,007,799			16
	C. General Administration											
17	Administrative	90,912		408,060	498,972		498,972	(162,551)	336,421			17
18	Directors Fees											18
19	Professional Services			172,672	172,672		172,672	(3,174)	169,498			19
20	Dues, Fees, Subscriptions & Promotions			54,705	54,705		54,705	(6,521)	48,184			20
21	Clerical & General Office Expenses	87,469		267,437	354,906		354,906	(92,413)	262,493			21
22	Employee Benefits & Payroll Taxes			685,503	685,503		685,503		685,503			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,620	1,620		1,620	348	1,968			24
25	Other Admin. Staff Transportation			11,993	11,993		11,993	3,812	15,805			25
26	Insurance-Prop.Liab.Malpractice			251,980	251,980		251,980	710	252,690			26
27	Other (specify):*							23,653	23,653			27
28	TOTAL General Administration	178,381		1,853,970	2,032,351		2,032,351	(236,135)	1,796,216			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,298,514	641,824	2,278,794	6,219,132		6,219,132	(193,194)	6,025,938			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 Arcadia of Danville #0056317 Report Period Beginning: 02/01/20 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			7,888	7,888		7,888	7,970	15,858			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,167	4,167		4,167	15,553	19,720			32
33	Real Estate Taxes			67,416	67,416		67,416	2,040	69,456			33
34	Rent-Facility & Grounds			608,850	608,850		608,850	(157,368)	451,482			34
35	Rent-Equipment & Vehicles			9,028	9,028		9,028	2,594	11,622			35
36	Other (specify):*											36
37	**TOTAL Ownership**			697,349	697,349		697,349	(129,211)	568,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,218	354,810	502,028		502,028	(54,201)	447,827			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			341,395	341,395		341,395		341,395			42
43	Other (specify):*	63,961		67,390	131,351		131,351	(131,351)				43
44	**TOTAL Special Cost Centers**	63,961	147,218	763,595	974,774		974,774	(185,552)	789,222			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,362,475	789,042	3,739,738	7,891,255		7,891,255	(507,957)	7,383,298			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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	(15,712)	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	(4,000)	30		9
10	Interest and Other Investment Income	(8,098)	32		10
11	Discounts, Allowances, Rebates & Refunds	(272)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(11,900)	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	(229,607)	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	(147,079)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (416,699)		$	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)	(91,258)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (91,258)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (507,957)		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

Arcadia of Danville

ID# 0056317

Report Period Beginning: 02/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (4,515)	21	1
2	Theft and Damage Loss	(14)	21	2
3	Credit Card Processing	(10)	21	3
4	Marketing Salaries	(63,961)	43	4
5	Advertising/Marketing	(8,615)	43	5
6	Advertising/Marketing - Covid	(5,014)	43	6
7	Other Income	(10,400)	21	7
8	Additional R&M	17,000	06	8
9	Capitalized R&M	(3,721)	06	9
10	Noncare legal fee	(11,433)	19	10
11	Marketing	(42,000)	43	11
12	Collections	(2,242)	21	12
13	Bldg. Co - License and Permits	(218)	20	13
14	Bldg. Co - Bank Charges	(175)	21	14
15	Nonallowable Expense	(11,761)	43	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**	(147,079)		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**

Arcadia of Danville

IDF 0056317

Report Period Beginning: 02/01/20

Ending: 12/31/20

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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													1
2	Food Purchase	(303)			105								(198)	2
3	Housekeeping				37		359						396	3
4	Laundry													4
5	Heat and Other Utilities	(15,712)					767						(14,945)	5
6	Maintenance	13,279			1,903		1,221						16,403	6
7	Other (specify):*				199								199	7
8	**TOTAL General Services**	(2,736)			2,244		2,346						1,854	8
	B. Health Care and Programs													
9	Medical Director				1,901								1,901	9
10	Nursing and Medical Records			17,701	4,944		71						22,716	10
10a	Therapy													10a
11	Activities				20								20	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			15,899	550								16,449	15
16	**TOTAL Health Care and Programs**			33,600	7,416		71						41,087	16
	C. General Administration													
17	Administrative				(162,551)								(162,551)	17
18	Directors Fees													18
19	Professional Services	(11,433)		360	8,494	3,655	1,400		(5,437)	(213)			(3,174)	19
20	Fees, Subscriptions & Promotions	(12,118)	218		4,829	544	6						(6,521)	20
21	Clerical & General Office Expenses	(246,963)	175	9	36,166	117,082	1,118						(92,413)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar				294	54							348	24
25	Other Admin. Staff Transportation			2,237	1,575								3,812	25
26	Insurance-Prop.Liab.Malpractice			63	647								710	26
27	Other (specify):*				9,354	14,299							23,653	27
28	**TOTAL General Administration**	(270,514)	393	2,669	(101,191)	135,634	2,524		(5,437)	(213)			(236,135)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(273,250)	393	36,269	(91,532)	135,634	4,941		(5,437)	(213)			(193,194)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arcadia of Danville # 0056317 **Report Period Beginning:** 02/01/20 **Ending:** 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,000)			1,298	230	10,442						7,970	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,098)			21,046		2,605						15,553	32
33	Real Estate Taxes						2,040						2,040	33
34	Rent-Facility & Grounds		(157,850)		292		190						(157,368)	34
35	Rent-Equipment & Vehicles				1,331	308	954						2,594	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(12,098)	(157,850)		23,967	538	16,232						(129,211)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(53,220)			(981)		(54,201)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(131,351)											(131,351)	43
44	**TOTAL Special Cost Centers**	(131,351)						(53,220)			(981)		(185,552)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(416,699)	(157,457)	36,269	(67,565)	136,172	21,173	(53,220)	(5,437)	(213)	(981)		(507,957)	45

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	34	Rent Income	$ 608,850	Danville Prop, LLC		$	$ (608,850)	1
2	V	33	Rent Incom - Real Estate Tax	67,416	Danville Prop, LLC			(67,416)	2
3	V	20	License and Permits		Danville Prop, LLC		218	218	3
4	V	21	Bank Service Charges		Danville Prop, LLC		175	175	4
5	V	33	Real Estate Tax Expensse		Danville Prop, LLC		67,416	67,416	5
6	V	34	Rent Expense		Danville Prop, LLC		451,000	451,000	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 676,266			$ 518,809	$ * (157,457)	14

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	BF Danville LLC	50%	Arcadia Care Bloomington	Bloomingdale	Danville Prop, LLC	Lincolnwood	Bldg Co.	1
2	David Seitler	50%	Arcadia Care Clifton	Clifton	Arcadia Care	Lincolnwood	Consulting	2
3			Aperion Care Bradley	Bradley	Management, LLC			3
4			Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	4
5			Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	5
6			Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	6
7			Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	7
8			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	8
9			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	9
10			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	10
11			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	11
12			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	12
13			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	13
14			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	14
15			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	15
16			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	16
17			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	17
18			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	18
19			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	19
20			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	20
21			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	21
22			Aperion Care Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	22
23			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	23
24			Aperion Care Morton Villa	Morton				24
25			Aperion Care Oak Lawn	Oak Lawn				25
26			Aperion Care Peoria Heights	Peoria Heights				26
27			Aperion Care Peru	Peru, IN				27
28			Aperion Care Plum Grove	Palatine				28
29			Aperion Care Princeton	Princeton				29
30								30

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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 Spring Valley	Spring Valley				1
2			Aperion Care Springfield	Springfield				2
3			Aperion Care St. Elmo	St. Elmo				3
4			Aperion Care Tolleston Park	Gary, IN				4
5			Aperion Care Toluca	Toluca				5
6			Aperion Care West Chicago	Springfield				6
7			Aperin Care West Ridge	Chicago				7
8			Aperion Care Wilmington	Wilmington				8
9			Arbors at Michigan City	Michigan City, IN				9
10			Elevate Care Chicago North	Chicago				10
11			Elevate Care Irving Park	Chicago				11
12			Elevate Care Niles	Niles				12
13			Elevate Care North Branch	Niles				13
14			Elevate Care Northbrook	Northbrook				14
15			Elevate Care Riverwoods	Riverwoods				15
16			Elevate Care Waukegan	Waukegan				16
17			Glennon Place	Bolivar, MO				17
18			Hallmark Living Benton Harbor	Benton Harbo, MI				18
19			Legend Healthcare	Tonganoxie, KS				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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	10	Salary Nurse-Illinois	$	Arcadia Care Management		$ 42,601	$ 42,601	15
16	V	15	Emp. Ben HC-Illinois		Arcadia Care Management		15,899	15,899	16
17	V	19	Professional Fees		Arcadia Care Management		360	360	17
18	V	21	Clerical & General		Arcadia Care Management		9	9	18
19	V	25	Auto & Travel		Arcadia Care Management		2,237	2,237	19
20	V	26	Insurance		Arcadia Care Management		63	63	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	10	Consulting Fees	24,900	Arcadia Care Management			(24,900)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,900			$ 61,169	$ * 36,269	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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.		$ 105	$ 105	15
16	V	3	Housekeeping		Aperion Care, Inc.		37	37	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,792	1,792	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		111	111	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		199	199	19
20	V	9	Medical Director		Aperion Care, Inc.		1,901	1,901	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		4,944	4,944	21
22	V	11	Activities		Aperion Care, Inc.		20	20	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		550	550	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		47,359	47,359	24
25	V	19	Professional Fees		Aperion Care, Inc.		8,494	8,494	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		4,829	4,829	26
27	V	21	Clerical Salary		Aperion Care, Inc.		34,841	34,841	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,326	1,326	28
29	V	24	Seminars		Aperion Care, Inc.		294	294	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,575	1,575	30
31	V	26	Insurance		Aperion Care, Inc.		647	647	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		9,354	9,354	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,298	1,298	33
34	V	32	Interest		Aperion Care, Inc.		21,046	21,046	34
35	V	34	Rent		Aperion Care, Inc.		292	292	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,331	1,331	36
37	V	17	Management Fee	209,910	Aperion Care, Inc.			(209,910)	37
38	V								38
39	Total			$ 209,910			$ 142,345	$ * (67,565)	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		3,655	$ 3,655	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		544	544	16
17	V	21	Clerical & General		Aperion Financial, LLC		68,964	68,964	17
18	V	24	Seminars		Aperion Financial, LLC		54	54	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		8,358	8,358	20
21	V	30	Depreciaiton		Aperion Financial, LLC		230	230	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		308	308	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		48,118	48,118	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		5,941	5,941	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			$			$ 136,172	$ * 136,172	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 767	$ 767	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,221	1,221	16
17	V	3	Housekeeping		Chase Office, LLC		359	359	17
18	V	10	Medical Supplies		Chase Office, LLC		71	71	18
19	V	19	Professional Fees		Chase Office, LLC		1,400	1,400	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		6	6	20
21	V	21	Office Expense		Chase Office, LLC		1,118	1,118	21
22	V	30	Depreciation		Chase Office, LLC		10,442	10,442	22
23	V	32	Interest Expense		Chase Office, LLC		2,605	2,605	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,040	2,040	24
25	V	35	Equipment Rental		Chase Office, LLC		954	954	25
26	V	34	Rent		Chase Office, LLC		190	190	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			$			$ 21,173	$ * 21,173	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	$ 348,474	Renewal Rehab, LLC		$ 295,254	$ (53,220)	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			$ 348,474			$ 295,254	$ * (53,220)	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 23,733	ProPay HR, LLC		$ 18,296	$ (5,437)	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			$ 23,733			$ 18,296	$ * (5,437)	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Data Processing	$ 1,400	EMSA Purchasing Group		$ 1,187	$ (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			$ 1,400			$ 1,187	$ * (213)	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	$ 1,724	Lifescan Labs of Illinois		$ 743	$ (981)	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			$ 1,724			$ 743	$ * (981)	39

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Seitler	Owner	Administrative	50.00	See Attached	29.02	79.26%	Mgt Fee	$ 198,149	17-3	1
2	Yosef Meystel	Relative	Administrative	0%	See Attached	0.89	2.22%	Alloc Salary	5,559	17-7	2
3	David Berkowitz	Relative	Administrative	0%	See Attached	0.89	2.22%	Alloc Salary	2,555	17-7	3
4	Jay Meystel	Relative	Clerical	0%	See Attached	0.89	2.22%	Alloc Salary	1,308	21-7	4
5	Elisheva Adest	Relative	Clerical	0%	See Attached	0.61	2.22%	Alloc Salary	689	21-7	5
6	Steve Turofsky	Relative	Administrative	0%	See Attached	0.89	2.22%	Alloc Salary	5,559	17-7	6
7	Fred Frankel	Relative	Administrative	0%	See Attached	0.89	2.22%	Alloc Salary	5,559	17-7	7
8	Jennifer Spector	Relative	Clerical	0%	See Attached	0.89	2.22%	Alloc Salary	2,647	21-7	8
9	Dovid Spector	Relative	Clerical	0%	See Attached	0.89	2.22%	Alloc Salary	1,834	21-7	9
10	Naftali Wilhelm	Relative	Clerical	0%	See Attached	0.89	2.22%	Alloc Salary	5,058	21-7	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	$ 228,917		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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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: Arcadia Care Management
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	10	Salary Nurse-Illinois	Census	53,307	3	$ 53,749	$ 53,749	42,251	$ 42,601	1
2	15	Emp. Ben HC-Illinois	Census	53,307	3	20,060		42,251	15,899	2
3	19	Professional Fees	Census	53,307	3	454		42,251	360	3
4	21	Clerical & General	Census	53,307	3	12		42,251	9	4
5	25	Auto & Travel	Census	53,307	3	2,823		42,251	2,237	5
6	26	Insurance	Census	53,307	3	80		42,251	63	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					$ 77,178	$ 53,749		$ 61,169	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	$	42,251	$ 105	1
2	3	Housekeeping	Census/Direct Cost	1,899,996	65	1,663		42,251	37	2
3	6	Maintenance Salary	Census/Direct Cost	1,899,996	65	64,200	64,200	42,251	1,792	3
4	6	Repairs & Maintenance	Census/Direct Cost	1,899,996	65	5,009		42,251	111	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	1,899,996	65	7,146		42,251	199	5
6	9	Medical Director	Census/Direct Cost	1,899,996	65	85,500		42,251	1,901	6
7	10	Salary - Nurse	Census/Direct Cost	1,899,996	65	386,855	386,855	42,251	4,944	7
8	11	Activities	Census/Direct Cost	1,899,996	65	912		42,251	20	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	1,899,996	65	43,060		42,251	550	9
10	17	Administrative Salaries	Census/Direct Cost	1,899,996	65	2,197,984	2,197,984	42,251	47,359	10
11	19	Professional Fees	Census/Direct Cost	1,899,996	65	381,984		42,251	8,494	11
12	20	Fees, Subscriptions	Census/Direct Cost	1,899,996	65	217,158		42,251	4,829	12
13	21	Clerical Salary	Census/Direct Cost	1,899,996	65	1,613,779	1,613,779	42,251	34,841	13
14	21	Clerical & General	Census/Direct Cost	1,899,996	65	59,611		42,251	1,326	14
15	24	Seminars	Census/Direct Cost	1,899,996	65	13,215		42,251	294	15
16	25	Auto & Travel	Census/Direct Cost	1,899,996	65	70,828		42,251	1,575	16
17	26	Insurance	Census/Direct Cost	1,899,996	65	29,094		42,251	647	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	1,899,996	65	433,479		42,251	9,354	18
19	30	Depreciaiton	Census/Direct Cost	1,899,996	65	58,358		42,251	1,298	19
20	32	Interest	Census/Direct Cost	1,899,996	65	946,429		42,251	21,046	20
21	34	Rent	Census/Direct Cost	1,899,996	65	13,110		42,251	292	21
22	35	Auto Lease	Census/Direct Cost	1,899,996	65	59,876		42,251	1,331	22
23										23
24										24
25	TOTALS					$ 6,693,967	$ 4,262,818		$ 142,345	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		42,251	3,655	1
2	20	Fees, Subscriptions	Census	1,899,996	65	24,450		42,251	544	2
3	21	Clerical & General	Census	1,899,996	65	3,101,245	3,044,021	42,251	68,964	3
4	24	Seminars	Census	1,899,996	65	2,428		42,251	54	4
5	25	Auto & Travel	Census	1,899,996	65			42,251		5
6	27	Emp. Ben. - Gen. Admin.	Census	1,899,996	65	375,858		42,251	8,358	6
7	30	Depreciaiton	Census	1,899,996	65	10,323		42,251	230	7
8	32	Interest	Census	1,899,996	65			42,251		8
9	35	Equipment Rental	Census	1,899,996	65	13,849		42,251	308	9
10	21	Clerical & General -IL Only	Census/Direct Alloc	1,208,651	46	1,767,260	1,767,260	42,251	48,118	10
11	27	Emp. Ben. - Gen. Admin.- IL Only	Census/Direct Alloc	1,208,651	46	218,211		42,251	5,941	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		$ 136,172	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	$	42,251	$ 767	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886		42,251	1,221	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134		42,251	359	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211		42,251	71	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958		42,251	1,400	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256		42,251	6	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267		42,251	1,118	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583		42,251	10,442	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136		42,251	2,605	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748		42,251	2,040	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550		42,251	954	11
12	34	Rent	Actual Census	1,899,996	65	42,922		42,251	190	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	$		$ 21,173	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	$	$		$ 295,254	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					$	$		$ 295,254	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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			$	$		$ 18,296	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					$	$		$ 18,296	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct			$	$		$ 1,187	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					$	$		$ 1,187	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Laboratory	Direct			$	$		$ 743	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					$	$		$ 743	25

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Interest Insurance Policies		X								4,167	6
7	Alloc Aperion Care, Inc.										21,046	7
8	See Supplemental Schedule										2,605	8
9	TOTAL Facility Related						$	$			$ 27,818	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,098)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,098)	14
15	TOTALS (line 9+line14)						$	$			$ 19,720	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* 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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 72,597	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.)		$ 74,637	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,040	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,416	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,456	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	67,231	8
	2016	70,646	9
	2017	69,940	10
	2018	70,043	11
	2019	72,597	12

2019 re tax bill $72,597 * 11/12 estimated = $67,416

Beginning real estate tax adjusted for prior owner tax paid from escrow.

Alloc - Chase Office, LLC $2,040

	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 Arcadia of Danville COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0056317

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.	18-33-200-016-0060	Long-Term Care Property	$ 42,832.38	$ 42,832.38
2.	18-34-100-005-0060	Long-Term Care Property	$ 29,764.86	$ 29,764.86
3.	Alloc - Chase Office, LLC	Home Office Allocation	$ 72,110.55	$ 1,523.37
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 144,707.79	$ 74,120.61

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 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 Arcadia of Danville COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0056317

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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 [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from Chase Office LLC			1,312	1
2					2
3	TOTALS			$ 1,312	3

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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											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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		81,604	5,758		3,793	(1,966)	16,152	68
69	Financial Statement Depreciation			7,888			(7,888)		69
70	TOTAL (lines 4 thru 69)		$ 81,604	$ 13,646		$ 3,793	$ (9,854)	$ 16,152	70

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 81,604	$ 13,646		$ 3,793	$ (9,854)	$ 16,152	1
2	Melamine Nurse Station Installation	2020	9,618		20	481	481	481	2
3	Re-Face Existing Monument Sign Structures	2020	2,672		20	134	134	134	3
4	Install 58 Data Locations Voice Phone Wiring	2020	14,600		20	730	730	730	4
5	7 Thru Wall Amana Ptac Air Conditioners	2020	5,124		20	256	256	256	5
6	Phone System Covid	2020	7,677		20	384	384	384	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,295	$ 13,646		$ 5,777	$ (7,869)	$ 18,137	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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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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)		$	$		$	$	$	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	11,805	303	20	303		1,337	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	662	106	20	33	(73)	331	9
10	Allocated from Aperion Care	2012	188	14	20	9	(5)	75	10
11	Allocated from Aperion Care	2013	80	10	20	4	(6)	28	11
12									12
13	Allocated from Chase Office LLC	2020	236		20	12	12	12	13
14	Allocated from Chase Office LLC	2019	6,013	273	20	301	28	601	14
15	Allocated from Chase Office LLC	2018	54	3	20	3	(0)	8	15
16	Allocated from Chase Office LLC	2017	2,733	668	20	137	(532)	547	16
17	Allocated from Chase Office LLC	2016	59,834	4,381	20	2,992	(1,389)	13,213	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)		$ 81,604	$ 5,758		$ 3,793	$ (1,966)	$ 16,152	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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		$ 81,604	$ 5,758		$ 3,793	$ (1,966)	$ 16,152	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 81,604	$ 5,758		$ 3,793	$ (1,966)	$ 16,152	34

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 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	$ 32,957	$ 5,978	$ 3,380	$ (2,598)	10	$ 14,528	71
72	Current Year Purchases	57,394	21	5,742	5,721	10	5,742	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 90,351	$ 5,999	$ 9,123	$ 3,123		$ 20,270	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc Aperion Care, Inc.	Vehicles - Aperion Care, Inc.	2020	$ 4,789	$ 212	$ 958	$ 746	5	$ 2,398	76
77										77
78										78
79										79
80	TOTALS			$ 4,789	$ 212	$ 958	$ 746		$ 2,398	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)	$ 217,747	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,858	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,858	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,000)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 40,805	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Danville Prop LLC

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:	1974	200	02/01/20	$ 451,000			3
4	Additions	Alloc. - Aperion Care, Inc.			292			4
5		Alloc. - Chase Office, LLC			190			5
6								6
7	TOTAL		200		$ 451,482 **			7

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

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? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,291 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	Alloc. - Aperion Care, Inc.		$	$ 1,331	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,331	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 Arcadia of Danville # 0056317 Report Period Beginning: 02/01/20 Ending: 12/31/20

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 148,187	$		$ 148,187	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			37,785			37,785	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			162,502			162,502	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				108,834		108,834	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					6,336	38,384		44,720	13
14	TOTAL			$		$ 354,810	$ 147,218		$ 502,028	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.

STATE OF ILLINOIS

Facility Name & ID Number Arcadia of Danville **#** 0056317 **Report Period Beginning:** 02/01/20 **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	$ 1,437,066	$ 1,507,023	1
2	Cash-Patient Deposits	1,000	1,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,410,868	1,410,868	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,320	28,320	6
7	Other Prepaid Expenses	3,375	3,375	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	91,650	115,450	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,972,279	$ 3,066,036	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	28,800	28,800	15
16	Equipment, at Historical Cost	81,337	81,337	16
17	Accumulated Depreciation (book methods)	(7,888)	(7,888)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	731,371	1,231,371	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 833,620	$ 1,333,620	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,805,899	$ 4,399,656	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 388,360	$ 388,360	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,313	179,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,564	7,564	31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,416	67,416	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,300,741	1,737,041	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,943,394	$ 2,379,694	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,943,394	$ 2,379,694	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,862,505	$ 2,019,962	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,805,899	$ 4,399,656	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,062,505	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	(200,000)	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)**	$ 1,862,505	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,862,505	24 *

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

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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	$ 10,800,986	1
2	Discounts and Allowances for all Levels	(1,735,968)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,065,018	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,620	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 173,620	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,237	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1	19
20	Radiology and X-Ray	3	20
21	Other Medical Services	203	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,444	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,098	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,098	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	705,580	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 705,580	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,953,760	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,220,069	31
32	Health Care	2,966,712	32
33	General Administration	2,032,351	33
	B. Capital Expense		
34	Ownership	697,349	34
	C. Ancillary Expense		
35	Special Cost Centers	633,379	35
36	Provider Participation Fee	341,395	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,891,255	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,062,505	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,062,505	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,215,069	44
45	Private Pay - Net Inpatient Revenue	143,345	45
46	Medicare - Net Inpatient Revenue	1,891,237	46
47	Other-(specify) Insurance	568,462	47
48	Other-(specify) Managed Care	5,246,905	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,065,018	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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,541	1,664	$ 83,345	$ 50.09	1
2	Assistant Director of Nursing	1,694	1,845	76,020	41.20	2
3	Registered Nurses	11,364	12,207	420,979	34.49	3
4	Licensed Practical Nurses	23,096	24,237	760,349	31.37	4
5	CNAs & Orderlies	48,773	51,999	742,754	14.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,349	1,471	22,307	15.16	8
9	Activity Director	1,666	1,815	30,037	16.55	9
10	Activity Assistants	3,139	3,463	35,314	10.20	10
11	Social Service Workers	7,972	8,612	176,596	20.51	11
12	Dietician					12
13	Food Service Supervisor	3,059	3,281	60,004	18.29	13
14	Head Cook	5,390	5,623	67,004	11.92	14
15	Cook Helpers/Assistants	10,657	11,005	115,103	10.46	15
16	Dishwashers					16
17	Maintenance Workers	3,612	3,781	70,487	18.64	17
18	Housekeepers	20,266	22,158	242,510	10.94	18
19	Laundry	785	810	8,086	9.98	19
20	Administrator	1,852	1,999	90,912	45.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,349	1,396	29,023	20.79	23
24	Clerical	4,111	4,437	58,446	13.17	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	1,848	2,043	38,453	18.82	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	15,801	16,530	234,746	14.20	33
34	TOTAL (lines 1 - 33)	169,324	180,376	$ 3,362,475 *	$ 18.64	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,433	01-03	35
36	Medical Director	Monthly	35,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	64,197	10-03	38
39	Pharmacist Consultant	Per unit	10,437	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	13	897	11-03	44
45	Social Service Consultant	66	4,520	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	30,000		47
48					48
49	TOTAL (lines 35 - 48)	79	$ 157,984		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	99	$ 5,850	10-03	50
51	Licensed Practical Nurses	117	5,739	10-03	51
52	Certified Nurse Assistants/Aides	128	3,963	10-03	52
53	TOTAL (lines 50 - 52)	344	$ 15,552		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paul Gallagher	Administrator		$ 63,464
Leslie Peterson	Administrator		27,448
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,912

B. Administrative - Other

Description	Amount
David Seitler - Management Fees	$ 198,149
Aperion Care, Inc. - Management Fees	209,910
TOTAL (agree to Schedule V, line 17, col. 3)	$ 408,059
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
National Datacare Corp	Resident Trust Fund Svcs	$ 3,452
Ability Network	Eligibility Software	13,399
Aperion Care, Inc.	Data Processing	785
Bequest Payment Systems	Data Processing	316
Creative Technology Solutions	IT Consulting	20,981
Emsa Purchasing Group	Procurement Solutions	1,400
Pax8 Inc	Data Processing	3,090
PointClickCare Technologies	Data Processing	57,567
Solus LLC	Data Processing	11,263
Thomas A Trainor	Data Processing	750
See Attached	Legal	12,006
See Supplemental Schedule		47,663
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 172,672

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,775
Unemployment Compensation Insurance	63,758
FICA Taxes	247,597
Employee Health Insurance	298,367
Employee Meals	5,864
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	1,747
Employee Physicals	5,550
Employee Benefits Other	3,845
TOTAL (agree to Schedule V, line 22, col.8)	$ 685,503

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	38,901
Health Care Worker Background Check	
(Indicate # of checks performed 93)	934
Patient Background Checks 76	760
Dues & Subscriptions	504
Licenses & Fees	1,706
See Supplemental Schedule	5,379
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,184

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,620
See Supplemental Schedule	348
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,968

* Attach copy of IMRF notifications

**See instructions.

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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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,182** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A** 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? **X** YES ____ 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. $ **341,395**
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. $ **5,864** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ ____

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

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

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

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