

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0048454</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Evanston</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.																							
Address: <u>1300 Oak Avenue</u> <u>Evanston</u> <u>60201</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 869-1300</u> Fax # <u>(847) 869-1378</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>9/1/2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

#	0048454	Report Period Beginning:	01/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 9/8/2006

YES ☒ Date 9/8/2006 NO ☐

YES NO If YES, enter number
of beds certified 57 and days of care provided

IV. ACCOUNTING BASIS

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

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **91.64%**

91.64%

Facility Name & ID Number Aperion Care Evanston # 0048454 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	205,239	12,868	21,522	239,629		239,629	(12,868)	226,761			1
2	Food Purchase		107,608		107,608		107,608	(492)	107,116			2
3	Housekeeping	113,823	39,024		152,847		152,847	179	153,026			3
4	Laundry		4,893	59,272	64,165		64,165		64,165			4
5	Heat and Other Utilities			40,866	40,866		40,866	(708)	40,158			5
6	Maintenance	40,806	13,385	54,719	108,910		108,910	(8,184)	100,726			6
7	Other (specify):*							1,216	1,216			7
8	TOTAL General Services	359,868	177,778	176,379	714,025		714,025	(20,856)	693,169			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000	860	30,860			9
10	Nursing and Medical Records	1,466,271	139,724	76,443	1,682,438		1,682,438	(35,952)	1,646,486			10
10a	Therapy	44,167	757		44,924		44,924		44,924			10a
11	Activities	68,155	4,526		72,681		72,681	9	72,690			11
12	Social Services	59,777		2,616	62,393		62,393		62,393			12
13	CNA Training											13
14	Program Transportation			10,325	10,325		10,325		10,325			14
15	Other (specify):*							3,585	3,585			15
16	TOTAL Health Care and Programs	1,638,370	145,007	119,384	1,902,761		1,902,761	(31,497)	1,871,264			16
	C. General Administration											
17	Administrative	161,884		241,625	403,509		403,509	(220,197)	183,312			17
18	Directors Fees											18
19	Professional Services			355,943	355,943	(68,280)	287,663	(161,800)	125,863			19
20	Dues, Fees, Subscriptions & Promotions			38,663	38,663		38,663	(21,709)	16,954			20
21	Clerical & General Office Expenses	91,910		191,288	283,198		283,198	(92,557)	190,641			21
22	Employee Benefits & Payroll Taxes			399,162	399,162		399,162		399,162			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,696	1,696		1,696	189	1,885			24
25	Other Admin. Staff Transportation			995	995		995	719	1,714			25
26	Insurance-Prop.Liab.Malpractice			42,875	42,875		42,875	293	43,168			26
27	Other (specify):*							10,702	10,702			27
28	TOTAL General Administration	253,794		1,272,247	1,526,041	(68,280)	1,457,761	(484,361)	973,400			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,252,032	322,785	1,568,010	4,142,827	(68,280)	4,074,547	(536,714)	3,537,833			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			159,927	159,927		159,927	(20,703)	139,224			30
31	Amortization of Pre-Op. & Org.			4,248	4,248		4,248	(4,248)				31
32	Interest			45,158	45,158		45,158	408,586	453,744			32
33	Real Estate Taxes			162,586	162,586	68,280	230,866	923	231,789			33
34	Rent-Facility & Grounds			550,000	550,000		550,000	(549,782)	218			34
35	Rent-Equipment & Vehicles			8,687	8,687		8,687	1,173	9,860			35
36	Other (specify):*											36
37	TOTAL Ownership			930,606	930,606	68,280	998,886	(164,051)	834,835			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,228	321,356	458,584		458,584	(54,343)	404,241			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,143	133,143		133,143		133,143			42
43	Other (specify):*			340	340		340	(340)				43
44	TOTAL Special Cost Centers		137,228	454,839	592,067		592,067	(54,683)	537,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,252,032	460,013	2,953,455	5,665,500		5,665,500	(755,449)	4,910,051			45

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

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 Refer- ence	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	(1,055)	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	(46,192)	30		9
10	Interest and Other Investment Income	(535)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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	(19,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(144,460)	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	(574,982)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (786,763)		\$	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)	31,314		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 31,314		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (755,449)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (1,368)	19	1
2	Bank Charges	(15,948)	21	2
3	Theft & Damage Loss	(980)	21	3
4	Credit Card Processing	(1,252)	21	4
5	Marketing Expense	(340)	43	5
6	Amortization	(4,248)	31	6
7	Vending Commisions	(500)	02	7
8	Additional R&M	2,580	06	8
9	PAC Dues	(4,659)	20	9
10	Prior Period Professional Fees	(532)	19	10
11	Prior Period Seminar Expense	(47)	24	11
12	Bldg Co. - Accounting Fees	(6,438)	19	12
13	Bldg Co. - Amortization	(15,456)	36	13
14	Bldg Co. - Bad Debt	(192,481)	21	14
15	Bldg Co. - Bank Charges	(36)	21	15
16	Bldg Co. - Bookkeeping Fees	(12,000)	19	16
17	Bldg Co. - Change in SWAP Valuation	(315,845)	36	17
18	Bldg Co. - Licenses and Permits	(322)	20	18
19	Bldg Co. - Legal Fees	(190)	19	19
20	Bldg Co. - Other Professional	(4,923)	19	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	(574,982)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(12,868)								(12,868)	1
2	Food Purchase	(539)		47									(492)	2
3	Housekeeping			17			162						179	3
4	Laundry													4
5	Heat and Other Utilities	(1,055)					347						(708)	5
6	Maintenance	2,580		861	(12,177)		552						(8,184)	6
7	Other (specify):*			90	1,126								1,216	7
8	TOTAL General Services	986		1,015	(23,919)		1,062						(20,856)	8
	B. Health Care and Programs													
9	Medical Director			860									860	9
10	Nursing and Medical Records			2,237	(38,221)		32						(35,952)	10
10a	Therapy													10a
11	Activities			9									9	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			249	3,336								3,585	15
16	TOTAL Health Care and Programs			3,355	(34,885)		32						(31,497)	16
	C. General Administration													
17	Administrative			(220,197)									(220,197)	17
18	Directors Fees													18
19	Professional Services	(25,449)	23,550	(6,073)	1,297	(151,282)	100		(3,943)				(161,800)	19
20	Fees, Subscriptions & Promotions	(24,481)	322	2,185	16	246	3						(21,709)	20
21	Clerical & General Office Expenses	(355,157)	192,517	16,364	238	52,975	506						(92,557)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(47)		133	79	24							189	24
25	Other Admin. Staff Transportation			713	6								719	25
26	Insurance-Prop.Liab.Malpractice			293									293	26
27	Other (specify):*			4,232		6,470							10,702	27
28	TOTAL General Administration	(405,134)	216,388	(202,350)	1,636	(91,567)	609		(3,943)				(484,361)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(404,148)	216,388	(197,979)	(57,168)	(91,567)	1,703		(3,943)				(536,714)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Evanston # 0048454 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(46,192)	19,972	587	101	104	4,725						(20,703)	30
31	Amortization of Pre-Op. & Org.	(4,248)											(4,248)	31
32	Interest	(535)	398,419	9,523			1,179						408,586	32
33	Real Estate Taxes						923						923	33
34	Rent-Facility & Grounds		(520,000)	132			(29,914)						(549,782)	34
35	Rent-Equipment & Vehicles			602		139	432						1,173	35
36	Other (specify):*	(331,300)	331,300											36
37	TOTAL Ownership	(382,275)	229,692	10,844	101	243	(22,656)						(164,051)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(4,986)	(49,357)		(54,343)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(340)											(340)	43
44	TOTAL Special Cost Centers	(340)								(4,986)	(49,357)		(54,683)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(786,763)	446,080	(187,135)	(57,067)	(91,324)	(20,953)		(3,943)	(4,986)	(49,357)		(755,449)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 520,000	Evanston NRC Realty		\$	(520,000)	1
2	V	33	Real Estate Taxes	162,587	Evanston NRC Realty		162,587		2
3	V	19	Accounting Fees		Evanston NRC Realty		6,438	6,438	3
4	V	36	Amortization Expense		Evanston NRC Realty		15,456	15,456	4
5	V	21	Bad Debt		Evanston NRC Realty		192,481	192,481	5
6	V	21	Bank Charges		Evanston NRC Realty		36	36	6
7	V	19	Bookeeping Fees- Aperion		Evanston NRC Realty		12,000	12,000	7
8	V	36	Change in SWAP Valuation		Evanston NRC Realty		315,845	315,845	8
9	V	20	Licenses and Permits		Evanston NRC Realty		322	322	9
10	V	19	Legal Fees		Evanston NRC Realty		190	190	10
11	V	19	Other Professional		Evanston NRC Realty		4,923	4,923	11
12	V	30	Depreciation Expense		Evanston NRC Realty		19,972	19,972	12
13	V	32	Interest	3	Evanston NRC Realty		398,422	398,419	13
14	Total			\$ 682,590			\$ 1,128,669	\$ * 446,080	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DECLARATION OF TRUST OF YOSEF MEYSTEL	0.10%	Aperion Care Bradley	Bradley	Evanston NRC Realty	Evanston	Building Co.	1
2	NRC INVESTMENT GROUP, LLC	99.90%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3			Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4			Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5			Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Fairfield	Fairfield	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Forest Park	Forest Park	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Glenwood	Glenwood	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Highwood	Highwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care International	Chicago	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care Jacksonville	Jacksonville	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Kokomo	Kokomo, IN	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Litchfield	Litchfield	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Marion	Marion, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marseilles	Marseilles	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Mascoutah	Mascoutah	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Midlothian	Midlothian	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Morton Villa	Morton	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Oak Lawn	Oak Lawn				22
23			Aperion Care Peoria Heights	Peoria Heights				23
24			Aperion Care Peru	Peru, IN				24
25			Aperion Care Plum Grove	Palatine				25
26			Aperion Care Princeton	Princeton				26
27			Aperion Care Spring Valley	Spring Valley				27
28			Aperion Care Springfield	Springfield				28
29			Aperion Care St. Elmo	St. Elmo				29
30			Aperion Care Tolleston Park	Gary, IN				30

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$	Aperion Care, Inc.		\$ 47	\$ 47	15
16	V	3	Housekeeping		Aperion Care, Inc.		17	17	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		811	811	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		50	50	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		90	90	19
20	V	9	Medical Director		Aperion Care, Inc.		860	860	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,237	2,237	21
22	V	11	Activities		Aperion Care, Inc.		9	9	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		249	249	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		21,428	21,428	24
25	V	19	Professional Fees		Aperion Care, Inc.		3,843	3,843	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,185	2,185	26
27	V	21	Clerical Salary		Aperion Care, Inc.		15,764	15,764	27
28	V	21	Clerical & General		Aperion Care, Inc.		600	600	28
29	V	24	Seminars		Aperion Care, Inc.		133	133	29
30	V	25	Auto & Travel		Aperion Care, Inc.		713	713	30
31	V	26	Insurance		Aperion Care, Inc.		293	293	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		4,232	4,232	32
33	V	30	Depreciaiton		Aperion Care, Inc.		587	587	33
34	V	32	Interest		Aperion Care, Inc.		9,523	9,523	34
35	V	34	Rent		Aperion Care, Inc.		132	132	35
36	V	35	Auto Lease		Aperion Care, Inc.		602	602	36
37	V	17	Management Fee	241,625	Aperion Care, Inc.			(241,625)	37
38	V	19	Home Office	9,916	Aperion Care, Inc.			(9,916)	38
39	Total			\$ 251,541			\$ 64,406	\$ * (187,135)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	\$	Aperion Consulting, LLC		\$ 8,654	\$ 8,654	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,465	1,465	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		31	31	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,126	1,126	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		29,461	29,461	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		3,336	3,336	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,297	1,297	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		16	16	22
23	V	21	Clerical & General		Aperion Consulting, LLC		238	238	23
24	V	24	Seminars		Aperion Consulting, LLC		79	79	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		6	6	25
26	V	30	Depreciation		Aperion Consulting, LLC		101	101	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	34
35	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 102,877			\$ 45,810	\$ * (57,067)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		1,654	\$	1,654
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		246		246
17	V	21	Clerical & General		Aperion Financial, LLC		31,203		31,203
18	V	24	Seminars		Aperion Financial, LLC		24		24
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		3,782		3,782
20	V	30	Depreciaton		Aperion Financial, LLC		104		104
21	V	35	Equipment Rental		Aperion Financial, LLC		139		139
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		21,772		21,772
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		2,688		2,688
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V	19	Home Office Expense	152,936	Aperion Financial, LLC				(152,936)
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			\$ 152,936			\$ 61,612	\$ *	(91,324)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Chase Office, LLC		\$ 347	\$ 347	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		552	552	16
17	V	3	Housekeeping		Chase Office, LLC		162	162	17
18	V	10	Medical Supplies		Chase Office, LLC		32	32	18
19	V	19	Professional Fees		Chase Office, LLC		633	633	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		506	506	21
22	V	30	Depreciation		Chase Office, LLC		4,725	4,725	22
23	V	32	Interest Expense		Chase Office, LLC		1,179	1,179	23
24	V	33	Real Estate Taxes		Chase Office, LLC		923	923	24
25	V	35	Equipment Rental		Chase Office, LLC		432	432	25
26	V	34	Rent	30,000	Chase Office, LLC		86	(29,914)	26
27	V								27
28	V								28
29	V								29
30	V	19	Data Processing	3,500	EMSA Purchasing Group		2,967	(533)	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			\$ 33,500			\$ 12,547	\$ * (20,953)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 59,272	EcoBrite Linen		\$ 59,272	\$	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			\$ 59,272			\$ 59,272	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 17,213	ProPay HR LLC		\$ 13,270	\$ (3,943)	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			\$ 17,213			\$ 13,270	\$ * (3,943)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Laboratory	\$ 8,759	Lifescan Labs of Illinois		\$ 3,773	\$ (4,986)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 8,759			\$ 3,773	\$ * (4,986)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 323,183	Renewal Rehab, LLC		\$ 273,826	\$ (49,357)	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			\$ 323,183			\$ 273,826	\$ * (49,357)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	\$ 16,359	Aperion Incorporated Cell		\$ 16,359	\$	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			\$ 16,359			\$ 16,359	\$ *	39

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

Facility Name & ID Number Aperion Care Evanston # 0048454 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.40	1.01%	Alloc Salary	\$ 2,515	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.40	1.01%	Alloc Salary	592	21-7	2
3	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.27	1.01	Alloc Salary	312	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 3,419		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Aperion Care Evanston# 0048454

Report Period Beginning:

01/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Aperion Care, Inc.

Street Address

4655 W. Chase Avenue

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-8300

Fax Number

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1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	2	Food	Census/Direct Cost	65	\$ 4,717	\$	19,117	\$ 47	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		19,117	17	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	19,117	811	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		19,117	50	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		19,117	90	5
6	9	Medical Director	Census/Direct Cost	65	85,500		19,117	860	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	19,117	2,237	7
8	11	Activities	Census/Direct Cost	65	912		19,117	9	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		19,117	249	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	19,117	21,428	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		19,117	3,843	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		19,117	2,185	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	19,117	15,764	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		19,117	600	14
15	24	Seminars	Census/Direct Cost	65	13,215		19,117	133	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		19,117	713	16
17	26	Insurance	Census/Direct Cost	65	29,094		19,117	293	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		19,117	4,232	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		19,117	587	19
20	32	Interest	Census/Direct Cost	65	946,429		19,117	9,523	20
21	34	Rent	Census/Direct Cost	65	13,110		19,117	132	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		19,117	602	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 64,406	25

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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Ending: 12/31/20

(847) 410-9720

Ending: 12/31/20

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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	ACI Equities		X	Note Payable			\$		\$ 6,975,815			\$ 398,422	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	First Midwest Bank		X	Line of Credit					715,979			44,765	6	
7	Insurance Policies		X									393	7	
8													8	
9	TOTAL Facility Related						\$		\$ 7,691,794			\$ 443,580	9	
	B. Non-Facility Related*													
10	Interest Income		X									(535)	10	
11	Interest Income - Bldg Co.		X									(3)	11	
12	Allocated from Aperion Care		X									9,523	12	
13	Allocated from Chase Office		X									1,179	13	
14	TOTAL Non-Facility Related						\$		\$			\$ 10,164	14	
15	TOTALS (line 9+line14)							\$		\$ 7,691,794			\$ 453,744	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	185,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	170,410	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(14,990)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	178,500	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.)			\$	68,280	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 \$ 53,645 For 17/18 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.			\$	231,790	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	133,577	8	
		2016	169,226	9	
		2017	178,419	10	
		2018	183,203	11	
		2019	169,487	12	
2020 Accrual: \$169,487 x 1.05 = \$178,500 (Rounded)					
Allocated from Chase Office - \$923					

		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.

FACILITY NAME Aperion Care Evanston COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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.

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.

FACILITY NAME Aperion Care Evanston COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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.

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

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.

Page 10B

A. Square Feet:

19,800

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1		2		3		4	
	Use		Square Feet		Year Acquired		Cost	
1	Facility				2008		\$ 286,895	
2	Allocated from Chase Office, LLC						594	
3	TOTALS						\$ 287,489	

HFS 3745 (N-4-99)

IL478-2471

[illegible]

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		34,230			1,712	1,712	12,305	67
68	Related Party Allocations (Pages 12H & 12I)		36,923	2,605		1,716	(889)	7,308	68
69	Financial Statement Depreciation			159,927			(159,927)		69
70	TOTAL (lines 4 thru 69)		\$ 2,937,208	\$ 182,505		\$ 102,975	\$ (79,530)	\$ 979,568	70

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,937,208	\$ 182,505		\$ 102,975	\$ (79,530)	\$ 979,568	1
2	Passenger Elevator - Upgrade Wiring	2017	26,000		20	1,300	1,300	5,092	2
3	Nursing Therapy Expansion - Architect Fees	2017	64,510		20	3,225	3,225	12,901	3
4	Ot Rm-Ceiling,Doors,Electrical,Flooring,Handrail,Bumper,Wall S	2017	107,795		20	5,390	5,390	18,415	4
5	Replace Elevator Pump Drive	2018	5,234		20	262	262	764	5
6	Remove Processor Board For Repair, Replace Door Circuit Board	2018	3,850		20	193	193	434	6
7	Replace 3 Grease Traps & Basket Strainers In Kitchen Sink	2019	4,750		20	238	238	416	7
8	1St/2Nd Floors - Floor Replacement, Nurse Station Surface Tops	2019	118,360		20	5,918	5,918	6,824	8
9	Installation Of New Roof And Metal Deck Panel	2019	25,127		20	1,256	1,256	2,512	9
10	Elevator Fire Alarm Repair	2019	4,508		20	225	225	450	10
11	Installation Of Security Cameras (\$4,664)	2020	4,208		20	210	210	210	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)		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	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)		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	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)		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	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
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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)		\$ 3,301,550	\$ 182,505		\$ 121,192	\$ (61,313)	\$ 1,027,587	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2 Steel Doors & Frame	2012	4,450		20	223	223	2,004	9
10	Concrete Patio - Roof & Railing	2012	14,280		20	714	714	6,426	10
11	Monument Sign	2016	15,500		20	775	775	3,875	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)		\$ 34,230	\$		\$ 1,712	\$ 1,712	\$ 12,305	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 34,230	\$		\$ 1,712	\$ 1,712	\$ 12,305	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,230	\$		\$ 1,712	\$ 1,712	\$ 12,305	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	5,342	137	20	137		605	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	300	48	20	15	(33)	150	9
10	Allocated from Aperion Care	2012	85	7	20	4	(2)	34	10
11	Allocated from Aperion Care	2013	36	5	20	2	(3)	13	11
12									12
13	Allocated from Chase Office LLC	2020	107		20	5	5	5	13
14	Allocated from Chase Office LLC	2019	2,721	124	20	136	13	272	14
15	Allocated from Chase Office LLC	2018	24	1	20	1	(0)	4	15
16	Allocated from Chase Office LLC	2017	1,236	302	20	62	(240)	247	16
17	Allocated from Chase Office LLC	2016	27,073	1,982	20	1,354	(628)	5,979	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)		\$ 36,923	\$ 2,605		\$ 1,716	\$ (889)	\$ 7,308	34

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

Facility Name & ID Number Aperion Care Evanston

0048454

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 36,923	\$ 2,605		\$ 1,716	\$ (889)	\$ 7,308	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
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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)		\$ 36,923	\$ 2,605		\$ 1,716	\$ (889)	\$ 7,308	34

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

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	\$ 180,756	\$ 2,798	\$ 17,319	\$ 14,521	10	\$ 111,957	71
72	Current Year Purchases	2,790	18	280	263	10	280	72
73	Fully Depreciated Assets	437,894				10	437,894	73
74								74
75	TOTALS	\$ 621,440	\$ 2,816	\$ 17,600	\$ 14,784		\$ 550,131	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Allocated from Aperion Care, Inc	2020	\$ 2,167	\$ 96	\$ 433	\$ 337	5	\$ 1,085
77									
78									
79									
80	TOTALS			\$ 2,167	\$ 96	\$ 433	\$ 337		\$ 1,085

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	4,212,645
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	185,417
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	139,225
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(46,192)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,578,802

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	Elevator Upgrade	\$ 19,500
93		
94		
95		\$ 19,500

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Aperion Care				132			5
6	Allocated from Chase Office				86			6
7	TOTAL				\$218			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$5,670
- 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	Facility	2018 Honda Accord	\$299	\$3,588	17
18	Allocated from Aperion Care			602	18
19					19
20					20
21	TOTAL		\$299	\$4,190	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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.

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

☒ 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)	\$			

- (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.

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	

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	\$		\$ 119,820	\$		\$ 119,820	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			54,988			54,988	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			146,495			146,495	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				121,424		121,424	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					53	15,804		15,857	13
14	TOTAL			\$		\$ 321,356	\$ 137,228		\$ 458,584	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.

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	\$ 341,557	\$ 450,504	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	666,259	666,259	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,336	51,336	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	15,262	402,649	8
9	Other(specify): See Attached	473	106,066	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,074,887	\$ 1,676,814	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		286,895	13
14	Buildings, at Historical Cost		764,649	14
15	Leasehold Improvements, at Historical Cost	1,552,870	1,587,100	15
16	Equipment, at Historical Cost	441,313	714,251	16
17	Accumulated Depreciation (book methods)	(1,223,035)	(1,748,709)	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	3,400,970	3,456,353	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,172,118	\$ 5,060,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,247,005	\$ 6,737,353	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,320	\$ 376,319	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	715,979	715,979	29
30	Accrued Salaries Payable	198,571	198,571	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,547	6,547	31
32	Accrued Real Estate Taxes(Sch.IX-B)		178,500	32
33	Accrued Interest Payable	1,901	37,420	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	280,693	679,855	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,580,011	\$ 2,193,191	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		6,975,815	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	3,061,234		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,061,234	\$ 6,975,815	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,641,245	\$ 9,169,006	46
47	TOTAL EQUITY (page 18, line 24)	\$ 605,760	\$ (2,431,653)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,247,005	\$ 6,737,353	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 774,753	1
2	Restatements (describe):		2
3	Bad Debt	381	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 775,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	78,138	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	(247,512)	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)	\$ (169,374)	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)	\$ 605,760	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Evanston# 0048454Report Period Beginning: 01/01/20Ending: 12/31/20**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,404,336	1
2	Discounts and Allowances for all Levels	(137,325)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,267,011	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,735	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,735	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,944	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19	19
20	Radiology and X-Ray	74	20
21	Other Medical Services	1,290	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,327	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	535	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 535	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	312,030	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 312,030	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,743,638	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	714,025	31
32	Health Care	1,902,761	32
33	General Administration	1,526,041	33
	B. Capital Expense		
34	Ownership	930,606	34
	C. Ancillary Expense		
35	Special Cost Centers	458,924	35
36	Provider Participation Fee	133,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,665,500	40
41	Income before Income Taxes (line 30 minus line 40)**	78,138	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 78,138	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 658,919	44
45	Private Pay - Net Inpatient Revenue	194,210	45
46	Medicare - Net Inpatient Revenue	1,310,823	46
47	Other-(specify) <u>Insurance</u>	424,079	47
48	Other-(specify) <u>Managed Care/PPHP/ISNP</u>	2,678,980	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,267,011	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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,908	2,037	\$ 100,560	\$ 49.37	1
2	Assistant Director of Nursing	22	22	889	40.41	2
3	Registered Nurses	10,658	11,093	368,893	33.25	3
4	Licensed Practical Nurses	9,511	10,518	346,410	32.93	4
5	CNAs & Orderlies	31,624	34,255	649,519	18.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,952	2,105	44,167	20.98	8
9	Activity Director					9
10	Activity Assistants	3,948	4,247	68,155	16.05	10
11	Social Service Workers	2,278	2,446	59,777	24.44	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,080	51,851	24.93	13
14	Head Cook	5,813	6,540	107,671	16.46	14
15	Cook Helpers/Assistants	2,803	2,931	45,717	15.60	15
16	Dishwashers					16
17	Maintenance Workers	1,832	2,080	40,806	19.62	17
18	Housekeepers	7,125	7,638	113,823	14.90	18
19	Laundry					19
20	Administrator	1,884	2,080	161,884	77.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,544	1,622	43,524	26.83	23
24	Clerical	3,094	3,234	48,386	14.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,868	94,928	\$ 2,252,032 *	\$ 23.72	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	190	7,884	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				44
45	Social Service Consultant	44	2,616	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	233	\$ 129,704		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	10	\$ 877	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10	\$ 877		53

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

** See instructions.

Facility Name & ID Number	Aperion Care Evanston
--------------------------------------	------------------------------

0048454

Report Period Beginning: 01/01/20**Ending: 12/31/20**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$9,318

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,664 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 133,143
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. \$ 830 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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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.