

		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>0048330</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Highwood</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>50 Pleasant Avenue</u> <u>Highwood</u> <u>60040</u>																									
Number City Zip Code																									
County: <u>Lake</u>																									
Telephone Number: <u>(847) 432-9142</u> Fax # <u>(847) 432-4740</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>9/9/2006</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: _____																									

#	0048330	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 09/06/2006

YES ☒ Date 09/06/2006 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 104 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.

	1 Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,205	4,675	5,571	29,451	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,205	4,675	5,571	29,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **77.37%**

Facility Name & ID Number Aperion Care Highwood # 0048330 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	368,457	28,588	21,522	418,567		418,567	(8,190)	410,377			1
2	Food Purchase		194,651		194,651		194,651	(436)	194,215			2
3	Housekeeping	222,270	55,903		278,173		278,173	276	278,449			3
4	Laundry		8,441	110,589	119,030		119,030		119,030			4
5	Heat and Other Utilities			97,824	97,824		97,824	535	98,359			5
6	Maintenance	91,211	8,619	81,024	180,854		180,854	(1,984)	178,870			6
7	Other (specify):*							1,874	1,874			7
8	TOTAL General Services	681,938	296,202	310,959	1,289,099		1,289,099	(7,926)	1,281,173			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000	1,325	37,325			9
10	Nursing and Medical Records	2,701,718	269,825	81,001	3,052,544		3,052,544	(19,385)	3,033,159			10
10a	Therapy	188,660	4,129		192,789		192,789		192,789			10a
11	Activities	137,168	1,419	869	139,456		139,456	14	139,470			11
12	Social Services	275,848		1,430	277,278		277,278		277,278			12
13	CNA Training											13
14	Program Transportation			22,417	22,417		22,417		22,417			14
15	Other (specify):*							5,523	5,523			15
16	TOTAL Health Care and Programs	3,303,394	275,373	141,717	3,720,484		3,720,484	(12,523)	3,707,961			16
	C. General Administration											
17	Administrative	112,811		383,974	496,785		496,785	(350,963)	145,822			17
18	Directors Fees											18
19	Professional Services			439,920	439,920	(10,530)	429,390	(259,890)	169,500			19
20	Dues, Fees, Subscriptions & Promotions			48,112	48,112		48,112	(23,857)	24,255			20
21	Clerical & General Office Expenses	81,104		263,306	344,410		344,410	(120,789)	223,621			21
22	Employee Benefits & Payroll Taxes			655,029	655,029		655,029		655,029			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,221	1,221		1,221	365	1,586			24
25	Other Admin. Staff Transportation			41	41		41	1,108	1,149			25
26	Insurance-Prop.Liab.Malpractice			431,570	431,570		431,570	451	432,021			26
27	Other (specify):*							16,487	16,487			27
28	TOTAL General Administration	193,915		2,223,173	2,417,088	(10,530)	2,406,558	(737,088)	1,669,470			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,179,247	571,575	2,675,849	7,426,671	(10,530)	7,416,141	(757,536)	6,658,605			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			96,995	96,995		96,995	535,602	632,597			30
31	Amortization of Pre-Op. & Org.			5,217	5,217		5,217	(5,217)				31
32	Interest			45,951	45,951		45,951	411,065	457,016			32
33	Real Estate Taxes			176,850	176,850	10,530	187,380	1,422	188,802			33
34	Rent-Facility & Grounds			550,000	550,000		550,000	(549,664)	336			34
35	Rent-Equipment & Vehicles			8,713	8,713		8,713	1,808	10,521			35
36	Other (specify):*							315,845	315,845			36
37	TOTAL Ownership			883,726	883,726	10,530	894,256	710,862	1,605,118			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		166,817	513,823	680,640		680,640	(102,885)	577,755			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,174	222,174		222,174		222,174			42
43	Other (specify):*			6,634	6,634		6,634	(6,634)				43
44	TOTAL Special Cost Centers		166,817	742,631	909,448		909,448	(109,519)	799,929			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,179,247	738,392	4,302,206	9,219,845		9,219,845	(156,193)	9,063,652			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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(168,381)	30		9
10	Interest and Other Investment Income	(3,837)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(309)	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	(201,096)	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	(280,178)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (673,301)		\$	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)	517,108		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 517,108		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (156,193)		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	\$ (7,164)	19	1
2	Bank Charges	(15,961)	21	2
3	Theft & Damage Loss	(8)	21	3
4	Credit Card Processing	(11,692)	21	4
5	Marketing Expense	(6,634)	43	5
6	Amortization	(5,217)	31	6
7	Vending Commissions	(200)	02	7
8	Additional R&M	7,207	06	8
9	PAC Dues	(8,096)	20	9
10	Prior Period Professional Fees	(532)	19	10
11	Bldg Co - Licenses	(322)	20	11
12	Bldg Co - Bad Debt	(192,481)	21	12
13	Bldg Co - Amortization	(15,456)	36	13
14	Bldg Co - Bank Charges	(36)	21	14
15	Bldg Co - Other Prof Fees	(4,923)	19	15
16	Bldg Co - Accounting Fees	(6,438)	19	16
17	ALF Registration	(35)	20	17
18	Bldg Co - Legal	(190)	19	18
19	Bldg Co - Bookkeeping Fees	(12,000)	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	(280,178)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Highwood # 0048330 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				(8,190)								(8,190)	1
2	Food Purchase	(509)		73									(436)	2
3	Housekeeping			26			250						276	3
4	Laundry													4
5	Heat and Other Utilities						535						535	5
6	Maintenance	7,207		1,327	(11,369)		851						(1,984)	6
7	Other (specify):*			139	1,735								1,874	7
8	TOTAL General Services	6,698		1,565	(17,824)		1,636						(7,926)	8
	B. Health Care and Programs													
9	Medical Director			1,325									1,325	9
10	Nursing and Medical Records			3,447	(22,882)		50						(19,385)	10
10a	Therapy													10a
11	Activities			14									14	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			384	5,139								5,523	15
16	TOTAL Health Care and Programs			5,170	(17,743)		50						(12,523)	16
	C. General Administration													
17	Administrative			(350,963)									(350,963)	17
18	Directors Fees													18
19	Professional Services	(31,247)	23,551	(84,032)	1,998	(165,002)	337	(5,495)					(259,890)	19
20	Fees, Subscriptions & Promotions	(27,953)	322	3,366	25	379	4						(23,857)	20
21	Clerical & General Office Expenses	(421,274)	192,517	25,210	367	81,612	779						(120,789)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			205	122	38							365	24
25	Other Admin. Staff Transportation			1,098	10								1,108	25
26	Insurance-Prop.Liab.Malpractice			451								(0)	451	26
27	Other (specify):*			6,520		9,967							16,487	27
28	TOTAL General Administration	(480,474)	216,390	(398,145)	2,522	(73,006)	1,120	(5,495)				(0)	(737,088)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(473,776)	216,390	(391,409)	(33,045)	(73,006)	2,805	(5,495)				(0)	(757,536)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Highwood # 0048330 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	(168,381)	695,484	905	156	160	7,279						535,602	30
31	Amortization of Pre-Op. & Org.	(5,217)											(5,217)	31
32	Interest	(3,837)	398,416	14,670			1,816						411,065	32
33	Real Estate Taxes						1,422						1,422	33
34	Rent-Facility & Grounds		(520,000)	203			(29,867)						(549,664)	34
35	Rent-Equipment & Vehicles			928		215	665						1,808	35
36	Other (specify):*	(15,456)	331,301										315,845	36
37	TOTAL Ownership	(192,891)	905,201	16,706	156	375	(18,686)						710,862	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(78,132)		(24,753)		(102,885)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(6,634)											(6,634)	43
44	TOTAL Special Cost Centers	(6,634)							(78,132)		(24,753)		(109,519)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(673,301)	1,121,591	(374,703)	(32,889)	(72,631)	(15,880)	(5,495)	(78,132)		(24,753)	(0)	(156,193)	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	Rental Income	\$ 520,000	Highland Park NRC Realty		\$	(520,000)	1
2	V	32	Interest Income	6	Highland Park NRC Realty		398,422	398,416	2
3	V	33	Real Estate Taxes	176,850	Highland Park NRC Realty		176,850		3
4	V	20	License & Permits		Highland Park NRC Realty		322	322	4
5	V	19	Legal Fees		Highland Park NRC Realty		190	190	5
6	V	21	Bad Debt		Highland Park NRC Realty		192,481	192,481	6
7	V	19	Bookkeeping		Highland Park NRC Realty		12,000	12,000	7
8	V	36	Change in SWAP Valuations		Highland Park NRC Realty		315,845	315,845	8
9	V	36	Amortization		Highland Park NRC Realty		15,456	15,456	9
10	V	21	Bank Charges		Highland Park NRC Realty		36	36	10
11	V	30	Depreciation		Highland Park NRC Realty		695,484	695,484	11
12	V	19	Other Professional Fees		Highland Park NRC Realty		4,923	4,923	12
13	V	19	Accounting		Highland Park NRC Realty		6,438	6,438	13
14	Total			\$ 696,856			\$ 1,818,447	\$ * 1,121,591	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	Highland Park NRC Realty		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 Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care 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.		\$ 73	\$ 73	15
16	V	3	Housekeeping		Aperion Care, Inc.		26	26	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,249	1,249	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		78	78	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		139	139	19
20	V	9	Medical Director		Aperion Care, Inc.		1,325	1,325	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		3,447	3,447	21
22	V	11	Activities		Aperion Care, Inc.		14	14	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		384	384	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		33,012	33,012	24
25	V	19	Professional Fees		Aperion Care, Inc.		5,921	5,921	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,366	3,366	26
27	V	21	Clerical Salary		Aperion Care, Inc.		24,286	24,286	27
28	V	21	Clerical & General		Aperion Care, Inc.		924	924	28
29	V	24	Seminars		Aperion Care, Inc.		205	205	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,098	1,098	30
31	V	26	Insurance		Aperion Care, Inc.		451	451	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		6,520	6,520	32
33	V	30	Depreciaiton		Aperion Care, Inc.		905	905	33
34	V	32	Interest		Aperion Care, Inc.		14,670	14,670	34
35	V	34	Rent		Aperion Care, Inc.		203	203	35
36	V	35	Auto Lease		Aperion Care, Inc.		928	928	36
37	V	17	Management Fee	383,974	Aperion Care, Inc.			(383,974)	37
38	V	19	Home Office	89,953	Aperion Care, Inc.			(89,953)	38
39	Total			\$ 473,927			\$ 99,224	\$ * (374,703)	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		\$ 13,332	\$ 13,332	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,256	2,256	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		48	48	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,735	1,735	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		45,387	45,387	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		5,139	5,139	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,998	1,998	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		25	25	22
23	V	21	Clerical & General		Aperion Consulting, LLC		367	367	23
24	V	24	Seminars		Aperion Consulting, LLC		122	122	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		10	10	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		156	156	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	68,269	Aperion Consulting, LLC			(68,269)	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			\$ 103,464			\$ 70,575	\$ * (32,889)	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	19	Professional Fees		Aperion Financial, LLC		2,548	\$ 2,548	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		379	379	16
17	V	21	Clerical & General		Aperion Financial, LLC		48,071	48,071	17
18	V	24	Seminars		Aperion Financial, LLC		38	38	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		5,826	5,826	20
21	V	30	Depreciaton		Aperion Financial, LLC		160	160	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		215	215	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		33,541	33,541	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,141	4,141	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Home Office Expense	167,550	Aperion Financial, LLC			(167,550)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 167,550			\$ 94,919	\$ * (72,631)	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	5	Utilities	\$	Chase Office, LLC		\$ 535	\$ 535	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		851	851	16
17	V	3	Housekeeping		Chase Office, LLC		250	250	17
18	V	10	Medical Supplies		Chase Office, LLC		50	50	18
19	V	19	Professional Fees		Chase Office, LLC		976	976	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		4	4	20
21	V	21	Office Expense		Chase Office, LLC		779	779	21
22	V	30	Depreciation		Chase Office, LLC		7,279	7,279	22
23	V	32	Interest Expense		Chase Office, LLC		1,816	1,816	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,422	1,422	24
25	V	35	Equipment Rental		Chase Office, LLC		665	665	25
26	V	34	Rent	30,000	Chase Office, LLC		133	(29,867)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V	19	Data Processing	4,200	EMSA Purchasing Group		3,561	(639)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 34,200			\$ 18,320	\$ * (15,880)	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	\$ 23,985	ProPay HR		\$ 18,490	\$ (5,495)	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			\$ 23,985			\$ 18,490	\$ * (5,495)	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	\$ 511,593	Renewal Rehab LLC		\$ 433,461	\$ (78,132)	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			\$ 511,593			\$ 433,461	\$ * (78,132)	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	\$ 110,589	EcoBrite Linen		\$ 110,589	\$	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			\$ 110,589			\$ 110,589	\$ *	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	39	Laboratory	\$ 43,479	Lifescan Labs of Illinois		\$ 18,726	\$ (24,753)	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			\$ 43,479			\$ 18,726	\$ * (24,753)	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	\$ 397,629	Aperion Incorporated Cell		\$ 397,629	\$ (0)	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			\$ 397,629			\$ 397,629	\$ * (0)	39

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

Facility Name & ID Number Aperion Care Highwood # 0048330 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%	See Attached	0.62	1.55%	Alloc Salary	\$ 3,875	17-7	1
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.62	1.55%	Alloc Salary	912	21-7	2
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.42	1.55%	Alloc Salary	481	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	\$ 5,268		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.

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number Aperion Care Highwood# 0048330

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

(

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	\$	29,451	\$ 73	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		29,451	26	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	29,451	1,249	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		29,451	78	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		29,451	139	5
6	9	Medical Director	Census/Direct Cost	65	85,500		29,451	1,325	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	29,451	3,447	7
8	11	Activities	Census/Direct Cost	65	912		29,451	14	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		29,451	384	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	29,451	33,012	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		29,451	5,921	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		29,451	3,366	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	29,451	24,286	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		29,451	924	14
15	24	Seminars	Census/Direct Cost	65	13,215		29,451	205	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		29,451	1,098	16
17	26	Insurance	Census/Direct Cost	65	29,094		29,451	451	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		29,451	6,520	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		29,451	905	19
20	32	Interest	Census/Direct Cost	65	946,429		29,451	14,670	20
21	34	Rent	Census/Direct Cost	65	13,110		29,451	203	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		29,451	928	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 99,224	25

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

7

NO ☐IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

()

Fax NumberIL478-2471

Ending: 12/31/20

7

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage			\$	6,975,815			\$	398,422	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				1,009,113				45,423	6
7	Insurance Policies		X									528	7
8													8
9	TOTAL Facility Related						\$	7,984,928			\$	444,373	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,837)	10
11	Interest Income - Bldg Co		X									(6)	11
12	Allocated from Aperion Care	X										14,670	12
13	Allocated from Chase Office, L	X										1,816	13
14	TOTAL Non-Facility Related						\$				\$	12,643	14
15	TOTALS (line 9+line14)						\$	7,984,928			\$	457,016	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.			\$	127,862	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.)			\$	153,734	2
3. Under or (over) accrual (line 2 minus line 1).			\$	25,872	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	152,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	10,530	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.			\$	188,802	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	117,602	8	
		2016	120,153	9	
		2017	124,909	10	
		2018	127,862	11	
		2019	152,311	12	
2020 Accrual = \$152,311 x 1.01 = \$152,400 (Rounded)					
Allocated from Chase Office \$1,422					

		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 Highwood COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

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 Highwood COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

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

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.)

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:

26,802

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

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		2006	\$ 627,000	1
2	Allocated from Chase Office LLC			914	2
3	TOTALS			\$ 627,914	3

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Highwood

0048330

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
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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)		9,501,814			475,091	475,091	4,802,076	67
68	Related Party Allocations (Pages 12H & 12I)		56,882	4,014		2,644	(1,370)	11,259	68
69	Financial Statement Depreciation			96,995			(96,995)		69
70	TOTAL (lines 4 thru 69)		\$ 13,807,981	\$ 796,493		\$ 605,872	\$ (190,621)	\$ 6,713,122	70

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

Facility Name & ID Number Aperion Care Highwood

0048330

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,807,981	\$ 796,493		\$ 605,872	\$ (190,621)	\$ 6,713,122	1
2	Custom Signage Board W/Logo	2017	2,693		20	135	135	494	2
3	Fixture Replacement Sconces	2017	3,729		20	186	186	652	3
4	Replace Flue Pipe In Boiler Room	2018	2,518		20	126	126	367	4
5	Skylights Repair	2018	4,000		20	200	200	517	5
6	Water Heater	2019	11,330		20	567	567	803	6
7	New Rooftop Hvac Unit	2019	22,890		20	1,145	1,145	1,145	7
8	Security Camera Installation (7,946)	2020	7,386		20	369	369	369	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)		\$ 13,862,527	\$ 796,493		\$ 608,600	\$ (187,893)	\$ 6,717,469	34

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

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

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

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		\$ 13,862,527	\$ 796,493		\$ 608,600	\$ (187,893)	\$ 6,717,469	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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15									15
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21									21
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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)		\$ 13,862,527	\$ 796,493		\$ 608,600	\$ (187,893)	\$ 6,717,469	34

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

Facility Name & ID Number Aperion Care Highwood

0048330

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		\$ 13,862,527	\$ 796,493		\$ 608,600	\$ (187,893)	\$ 6,717,469	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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15									15
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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)		\$ 13,862,527	\$ 796,493		\$ 608,600	\$ (187,893)	\$ 6,717,469	34

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

Facility Name & ID Number Aperion Care Highwood

0048330

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	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 Building Company		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Chandalier, Wallcovering, Flooring, Tile, Handrails	2010	190,983		20	9,549	9,549	105,040	9
10 Walls, Repair Cracks, Floor Prep	2010	5,634		20	282	282	3,100	10
11 Flooring, Chandalier, Cove Base	2010	90,707		20	4,535	4,535	49,887	11
12 Blinds, Ramp, Flooring, Cornice, Painting	2010	113,000		20	5,650	5,650	62,150	12
13 VCT & Cove Base, Flooring, Cabinetry, Painting	2010	270,481		20	13,524	13,524	148,765	13
14 Elevator Floor, Granite Wall Caps, Floor Prep, Window Treatmen	2010	20,443		20	1,022	1,022	11,243	14
15 Porcelain Tile, Wallcovering, Custom Reception Desk	2010	18,851		20	943	943	10,370	15
16 Sink Cabinet, Flooring	2010	7,862		20	393	393	4,324	16
17 Flooring, Wallcovering, Cove Base, Handrails, Room Signage	2010	101,919		20	5,096	5,096	56,056	17
18 Handrails, VCT, Flooring, Cubicle Tracks/Curtains, Painting	2010	203,450		20	10,173	10,173	111,900	18
19 Vinyl Cove Base, Corner Guards	2011	1,850		20	92	92	923	19
20 Corner Guards, VCT, Flooring, Signage	2011	44,933		20	2,247	2,247	22,468	20
21 Flooring, Bathroom Mirrors, Window Treatments, Cubicle Track	2011	53,302		20	2,665	2,665	26,651	21
22 Wall Sconces	2011	2,391		20	120	120	1,197	22
23 Additional Construction Costs	2011	81,620		20	4,081	4,081	40,810	23
24 General Construction on Building	2011	7,849,388		20	392,469	392,469	3,924,692	24
25 SAS Architect Fees	2011	445,000		20	22,250	22,250	222,500	25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 4,802,076	34

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

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		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 4,802,076	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 4,802,076	34

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

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	8,229	211	20	211		932	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	462	74	20	23	(51)	231	9
10	Allocated from Aperion Care	2012	131	10	20	7	(4)	52	10
11	Allocated from Aperion Care	2013	56	7	20	3	(4)	19	11
12									12
13	Allocated from Chase Office LLC	2020	164		20	8	8	8	13
14	Allocated from Chase Office LLC	2019	4,191	190	20	210	19	419	14
15	Allocated from Chase Office LLC	2018	37	2	20	2	(0)	6	15
16	Allocated from Chase Office LLC	2017	1,905	466	20	95	(370)	381	16
17	Allocated from Chase Office LLC	2016	41,707	3,053	20	2,085	(968)	9,210	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)		\$ 56,882	\$ 4,014		\$ 2,644	\$ (1,370)	\$ 11,259	34

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

Facility Name & ID Number Aperion Care Highwood

0048330

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		\$ 56,882	\$ 4,014		\$ 2,644	\$ (1,370)	\$ 11,259	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 56,882	\$ 4,014		\$ 2,644	\$ (1,370)	\$ 11,259	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	\$ 278,231	\$ 4,311	\$ 22,925	\$ 18,614	10	\$ 172,289	71
72	Current Year Purchases	4,027	27	405	378	10	405	72
73	Fully Depreciated Assets	388,413				10	388,413	73
74								74
75	TOTALS	\$ 670,671	\$ 4,338	\$ 23,329	\$ 18,992		\$ 561,107	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		2009 GMC Savana	2009	\$ 46,762	\$	\$	\$	5	\$ 46,762
77		Allocated from Aperion Care	2020	3,338	148	668	520	5	1,672
78									
79									
80	TOTALS			\$ 50,100	\$ 148	\$ 668	\$ 520		\$ 48,434

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)			\$	15,211,213
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	800,979
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	632,597
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(168,381)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	7,327,010

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		\$
93		
94		
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.

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				203			5
6	Allocated from Chase Office, LLC				133			6
7	TOTAL				\$ 336			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: \$ 9,593
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		\$	\$ 928	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 928	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	\$		\$ 211,640	\$		\$ 211,640	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			100,193			100,193	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			201,520			201,520	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				139,666		139,666	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					470	27,151		27,621	13
14	TOTAL			\$		\$ 513,823	\$ 166,817		\$ 680,640	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 462,052	\$ 583,710	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	961,337	961,337	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,722	84,722	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	8,471	8,471	8
9	Other(specify): See Attached	1,742	35,076	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,518,324	\$ 1,673,316	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,407,107	14
15	Leasehold Improvements, at Historical Cost	985,976	9,284,470	15
16	Equipment, at Historical Cost	627,680	2,676,303	16
17	Accumulated Depreciation (book methods)	(1,431,586)	(8,792,954)	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	4,278,406	264,159	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,460,476	\$ 7,466,085	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,978,800	\$ 9,139,401	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 741,667	\$ 741,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,009,113	1,009,113	29
30	Accrued Salaries Payable	440,747	440,747	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,243	12,243	31
32	Accrued Real Estate Taxes(Sch.IX-B)		152,400	32
33	Accrued Interest Payable	2,618	38,137	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached		399,265	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,206,388	\$ 2,793,573	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,975,815	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,256,411	2,256,411	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,256,411	\$ 9,232,226	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,462,799	\$ 12,025,799	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,516,001	\$ (2,886,398)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,978,800	\$ 9,139,401	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,552,329	1
2	Restatements (describe):		2
3	Bad Debt	(145,458)	3
4	Rounding	(4)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,406,867	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	109,134	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 109,134	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)	\$ 1,516,001	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Highwood**# **0048330**Report Period Beginning: **01/01/20**Ending: **12/31/20****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,948,757	1
2	Discounts and Allowances for all Levels	(653,034)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,295,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,575	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 267,575	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	15,862	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	255	19
20	Radiology and X-Ray	273	20
21	Other Medical Services	10,753	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,143	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,837	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,837	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	734,701	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 734,701	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,328,979	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,289,099	31
32	Health Care	3,720,484	32
33	General Administration	2,417,088	33
	B. Capital Expense		
34	Ownership	883,726	34
	C. Ancillary Expense		
35	Special Cost Centers	687,274	35
36	Provider Participation Fee	222,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,219,845	40
41	Income before Income Taxes (line 30 minus line 40)**	109,134	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 109,134	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,168,361	44
45	Private Pay - Net Inpatient Revenue	1,461,356	45
46	Medicare - Net Inpatient Revenue	2,193,506	46
47	Other-(specify) <u>Insurance</u>	594,979	47
48	Other-(specify) <u>Managed Care</u>	2,877,521	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,295,723	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	2,032	2,080	\$ 139,890	\$ 67.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,104	22,444	866,390	38.60	3
4	Licensed Practical Nurses	11,519	12,463	433,027	34.75	4
5	CNAs & Orderlies	52,279	58,413	1,224,226	20.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,973	7,765	188,660	24.30	8
9	Activity Director	1,984	2,080	50,660	24.36	9
10	Activity Assistants	7,231	7,930	86,508	10.91	10
11	Social Service Workers	7,953	8,921	275,848	30.92	11
12	Dietician					12
13	Food Service Supervisor	2,092	2,284	57,006	24.96	13
14	Head Cook	5,519	6,383	117,438	18.40	14
15	Cook Helpers/Assistants	11,090	12,699	194,013	15.28	15
16	Dishwashers					16
17	Maintenance Workers	3,140	3,428	91,211	26.61	17
18	Housekeepers	12,465	14,081	222,270	15.79	18
19	Laundry					19
20	Administrator	2,032	2,080	112,811	54.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,550	5,088	81,104	15.94	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	2,056	2,120	38,185	18.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,019	170,259	\$ 4,179,247 *	\$ 24.55	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	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	68,269	10-03	38
39	Pharmacist Consultant	Per Unit	12,732	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	14	869	11-03	44
45	Social Service Consultant	23	1,430	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	\$ 140,822		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Katherine Geigel	Administrator	0	\$ 112,811	Workers' Compensation Insurance		\$ 131,914	IDPH License Fee	\$	
				Unemployment Compensation Insurance		12,991	Advertising: Employee Recruitment	1,345	
				FICA Taxes		319,712	Health Care Worker Background Check		
				Employee Health Insurance		147,069	(Indicate # of checks performed 14)	140	
				Employee Meals		1,430	Patient Background Checks	81	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	16,496	
				401K Expense		1,371	Licenses & Fees	1,690	
				Union Pension Fund		27,018			
				Employee Physicals		480			
				Employee Benefits - Other		6,484			
				Employee Benefit Other - Covid		6,560			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 112,811			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount						
Aperion Care - Management Fees			\$ 383,974						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 383,974					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Levin & Perconti	Legal Settlement		\$ 10,000			\$	Out-of-State Travel	\$	
ProPay HR	Payroll Processing		23,985						
Marcum LLP	Accounting		19,055						
National Datacare Corporation	Resident Fund Services		3,022				In-State Travel		
Achieve Accreditation	Accreditation		10,934						
Interbuild	Energy Procurement		953						
GCHMO	Liason Service		5,900						
Personnel Planners	Unemployment Consultant		756				Seminar Expense	1,221	
Skidelsky & Associates	Real Estate Assessment		10,530						
NRC Health	Data Processing		2,103						
See Attached	Legal		7,527						
See Supplemental Schedule			345,156				See Supplemental Schedule	365	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 439,920			TOTAL (agree to Sch. V, line 24, col. 8)		
				TOTAL			\$ 1,586		

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI \$16,192</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>10 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>28,717</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>222,174</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>1,430</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u> </u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% Ln 14</u>
d. Have vehicle usage logs been maintained? <u>N/A</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|---|