

		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>0050187</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care International</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>4815 S Western Ave</u> <u>Chicago</u> <u>60609</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 927- 4200</u> Fax # <u>(773) 927-1287</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>10/1/2008</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																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
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: _____																									

#	0050187	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 10/1/2008

YES ☒ Date 10/1/2008 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified **218** and days of care provided

IV. ACCOUNTING BASIS

ACCUAL	☒	MODIFIED	☐	CASH*	☐
CASH*	☐				

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

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

* 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.) **75.24%**

75.24%

Facility Name & ID Number Aperion Care International # 0050187 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	541,323	63,416	21,522	626,261		626,261	5,655	631,916			1
2	Food Purchase		351,889		351,889		351,889	118	352,007			2
3	Housekeeping	444,287	117,993		562,280		562,280	562	562,842			3
4	Laundry	89,020	29,202	212,898	331,120		331,120		331,120			4
5	Heat and Other Utilities			284,003	284,003		284,003	(253)	283,750			5
6	Maintenance	139,057	48,597	154,929	342,583		342,583	(2,252)	340,331			6
7	Other (specify):*							3,820	3,820			7
8	TOTAL General Services	1,213,687	611,097	673,352	2,498,136		2,498,136	7,651	2,505,787			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500	2,702	16,202			9
10	Nursing and Medical Records	5,707,667	558,679	94,507	6,360,853		6,360,853	31,674	6,392,527			10
10a	Therapy	317,918			317,918		317,918		317,918			10a
11	Activities	251,325	14,638	616	266,579		266,579	29	266,608			11
12	Social Services	472,896		1,126	474,022		474,022		474,022			12
13	CNA Training											13
14	Program Transportation			58,189	58,189		58,189		58,189			14
15	Other (specify):*							11,258	11,258			15
16	TOTAL Health Care and Programs	6,749,806	573,317	167,938	7,491,061		7,491,061	45,663	7,536,724			16
	C. General Administration											
17	Administrative	199,225		895,495	1,094,720		1,094,720	(828,201)	266,519			17
18	Directors Fees											18
19	Professional Services			1,124,843	1,124,843	(19,228)	1,105,615	(662,546)	443,069			19
20	Dues, Fees, Subscriptions & Promotions			72,757	72,757		72,757	(18,074)	54,683			20
21	Clerical & General Office Expenses	224,850		1,100,460	1,325,310		1,325,310	(822,115)	503,195			21
22	Employee Benefits & Payroll Taxes			1,276,888	1,276,888		1,276,888		1,276,888			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,573	1,573		1,573	744	2,317			24
25	Other Admin. Staff Transportation			438	438		438	2,258	2,696			25
26	Insurance-Prop.Liab.Malpractice			974,111	974,111		974,111	919	975,030			26
27	Other (specify):*							33,610	33,610			27
28	TOTAL General Administration	424,075		5,446,565	5,870,640	(19,228)	5,851,412	(2,293,404)	3,558,008			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,387,568	1,184,414	6,287,855	15,859,837	(19,228)	15,840,609	(2,240,091)	13,600,518			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			391,832	391,832		391,832	465,692	857,524			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			157,705	157,705		157,705	692,694	850,399			32
33	Real Estate Taxes					19,228	19,228	767,262	786,490			33
34	Rent-Facility & Grounds			2,370,000	2,370,000		2,370,000	(2,369,316)	684			34
35	Rent-Equipment & Vehicles			19,718	19,718		19,718	3,686	23,404			35
36	Other (specify):*			5,179	5,179		5,179	121,774	126,953			36
37	TOTAL Ownership			2,944,434	2,944,434	19,228	2,963,662	(318,207)	2,645,455			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,112,397	1,599,864	2,712,261		2,712,261	(242,154)	2,470,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			366,545	366,545		366,545		366,545			42
43	Other (specify):*			15,945	15,945		15,945	(15,945)				43
44	TOTAL Special Cost Centers		1,112,397	1,982,354	3,094,751		3,094,751	(258,099)	2,836,652			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,387,568	2,296,811	11,214,643	21,899,022		21,899,022	(2,816,397)	19,082,625			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	(1,343)	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	(166,445)	30		9
10	Interest and Other Investment Income	(6,238)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(279)	21		18
19	Entertainment				19
20	Contributions	(5,400)	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	(976,027)	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	(180,940)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,336,703)		\$	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)	(1,479,695)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,479,695)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,816,398)		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	\$ (41,561)	19	1
2	Bank Charges	(21,830)	21	2
3	Theft & Damage Loss	(10,764)	21	3
4	Supplemental Insurance	(31,820)	21	4
5	Credit Card Processing	(1,488)	21	5
6	Advertising/Marketing	(15,945)	43	6
7	Amortization	(5,179)	36	7
8	Additional R&M	15,340	06	8
9	Capitalized R&M	(13,379)	06	9
10	PAC Dues	(20,367)	20	10
11	Bldg Co - Accounting Fees	(11,330)	19	11
12	Bldg Co - Amortization	(7,054)	36	12
13	Bldg Co - IL Replacement Tax	(336)	21	13
14	Bldg Co - Licenses	(245)	20	14
15	Bldg Co - Other Professional	(2,450)	19	15
16	Prior Period Professional Fees	(532)	19	16
17	Bldg Co - Bookkeeping	(12,000)	19	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(180,940)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically. The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS		Page 58	
Apostrophe Care International			
ID#		0050187	
Report Period Beginning:		01/01/20	
Ending:		12/31/20	
NON-ALLOWABLE EXPENSES		Amount	Sch. Y Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

[illegible]

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care International # 0050187 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				5,655								5,655	1
2	Food Purchase	(31)		149									118	2
3	Housekeeping			53			510						562	3
4	Laundry													4
5	Heat and Other Utilities	(1,343)					1,090						(253)	5
6	Maintenance	1,961	324	2,704	(8,975)		1,734						(2,252)	6
7	Other (specify):*			283	3,537								3,820	7
8	TOTAL General Services	587	324	3,189	217		3,334						7,651	8
	B. Health Care and Programs													
9	Medical Director			2,702									2,702	9
10	Nursing and Medical Records			7,026	24,547		101						31,674	10
10a	Therapy													10a
11	Activities			29									29	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			782	10,476								11,258	15
16	TOTAL Health Care and Programs			10,538	35,023		101						45,663	16
	C. General Administration													
17	Administrative			(828,201)									(828,201)	17
18	Directors Fees													18
19	Professional Services	(67,873)	25,780	(48,897)	4,072	(565,552)	1,989	(11,426)				(639)	(662,546)	19
20	Fees, Subscriptions & Promotions	(26,012)	245	6,862	50	773	8						(18,074)	20
21	Clerical & General Office Expenses	(1,042,544)	336	51,390	749	166,366	1,588						(822,115)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			418	249	77							744	24
25	Other Admin. Staff Transportation			2,238	20								2,258	25
26	Insurance-Prop.Liab.Malpractice			919									919	26
27	Other (specify):*			13,292		20,318							33,610	27
28	TOTAL General Administration	(1,136,429)	26,361	(801,979)	5,140	(378,018)	3,586	(11,426)				(639)	(2,293,404)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(1,135,842)	26,685	(788,252)	40,380	(378,018)	7,021	(11,426)				(639)	(2,240,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care International # 0050187 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	(166,445)	614,811	1,844	318	326	14,838						465,692	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,238)	665,326	29,905			3,701						692,694	32
33	Real Estate Taxes		764,363				2,899						767,262	33
34	Rent-Facility & Grounds		(2,340,000)	414			(29,730)						(2,369,316)	34
35	Rent-Equipment & Vehicles			1,892		438	1,356						3,686	35
36	Other (specify):*	(12,233)	134,007										121,774	36
37	TOTAL Ownership	(184,916)	(161,493)	34,055	318	764	(6,935)						(318,207)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(242,154)				(242,154)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(15,945)											(15,945)	43
44	TOTAL Special Cost Centers	(15,945)							(242,154)				(258,099)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,336,703)	(134,809)	(754,196)	40,698	(377,254)	86	(11,426)	(242,154)			(639)	(2,816,397)	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	\$ 2,340,000	4815 S. Western LLC		\$	(2,340,000)	1
2	V	32	Interest	1,190	4815 S. Western LLC		666,516	665,326	2
3	V	06	Supplies & Maintenance		4815 S. Western LLC		324	324	3
4	V	19	Accounting Fees		4815 S. Western LLC		11,330	11,330	4
5	V	36	Amortization		4815 S. Western LLC		7,054	7,054	5
6	V	19	Bookeeping Fee		4815 S. Western LLC		12,000	12,000	6
7	V	30	Depreciation Expense		4815 S. Western LLC		614,811	614,811	7
8	V	21	IL Replacement Tax		4815 S. Western LLC		336	336	8
9	V	36	Insurance Expense - MIP		4815 S. Western LLC		126,953	126,953	9
10	V	20	Licenses and Permits		4815 S. Western LLC		245	245	10
11	V	19	Other Professional		4815 S. Western LLC		2,450	2,450	11
12	V	33	Real Estate Tax		4815 S. Western LLC		764,363	764,363	12
13	V								13
14	Total			\$ 2,341,190			\$ 2,206,381	\$ * (134,809)	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	28.79 %	Aperion Care Bradley	Bradley	4815 S. Western LLC		Building Co.	1
2	David A. Berkowitz Revocable Trust	28.80 %	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Christina Inofre	1.00 %	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	42170 Limited Partnership	1.50 %	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	1219 Limited Partnership	1.50 %	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6	257 Limited Partnership	3.00 %	Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7	Western Avenue Irrevocable Trust	19.47 %	Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8	Highlander Irrevocable Trust	15.94 %	Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care 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.		\$ 149	\$ 149	15
16	V	3	Housekeeping		Aperion Care, Inc.		53	53	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		2,546	2,546	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		158	158	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		283	283	19
20	V	9	Medical Director		Aperion Care, Inc.		2,702	2,702	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		7,026	7,026	21
22	V	11	Activities		Aperion Care, Inc.		29	29	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		782	782	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		67,294	67,294	24
25	V	19	Professional Fees		Aperion Care, Inc.		12,070	12,070	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		6,862	6,862	26
27	V	21	Clerical Salary		Aperion Care, Inc.		49,507	49,507	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,884	1,884	28
29	V	24	Seminars		Aperion Care, Inc.		418	418	29
30	V	25	Auto & Travel		Aperion Care, Inc.		2,238	2,238	30
31	V	26	Insurance		Aperion Care, Inc.		919	919	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		13,292	13,292	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,844	1,844	33
34	V	32	Interest		Aperion Care, Inc.		29,905	29,905	34
35	V	34	Rent		Aperion Care, Inc.		414	414	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,892	1,892	36
37	V	17	Management Fee	895,495	Aperion Care, Inc.			(895,495)	37
38	V	19	Home Office	60,967	Aperion Care, Inc.			(60,967)	38
39	Total			\$ 956,461			\$ 202,265	\$ * (754,196)	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		\$ 27,177	\$ 27,177	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		4,600	4,600	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		98	98	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		3,537	3,537	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		92,522	92,522	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		10,476	10,476	20
21	V	19	Professional Fees		Aperion Consulting, LLC		4,072	4,072	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		50	50	22
23	V	21	Clerical & General		Aperion Consulting, LLC		749	749	23
24	V	24	Seminars		Aperion Consulting, LLC		249	249	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		20	20	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		318	318	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,975	Aperion Consulting, LLC			(67,975)	33
34	V	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			\$ 103,170			\$ 143,868	\$ * 40,698	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		5,194	\$	5,194
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		773		773
17	V	21	Clerical & General		Aperion Financial, LLC		97,993		97,993
18	V	24	Seminars		Aperion Financial, LLC		77		77
19	V	25	Auto & Travel		Aperion Financial, LLC				
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		11,876		11,876
21	V	30	Depreciaton		Aperion Financial, LLC		326		326
22	V	32	Interest		Aperion Financial, LLC				
23	V	35	Equipment Rental		Aperion Financial, LLC		438		438
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		68,373		68,373
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		8,442		8,442
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V	19	Home Office Expense	570,746	Aperion Financial, LLC				(570,746)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 570,746			\$ 193,492	\$ *	(377,254)

* 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		\$ 1,090	\$ 1,090	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,734	1,734	16
17	V	3	Housekeeping		Chase Office, LLC		510	510	17
18	V	10	Medical Supplies		Chase Office, LLC		101	101	18
19	V	19	Professional Fees		Chase Office, LLC		1,989	1,989	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		8	8	20
21	V	21	Office Expense		Chase Office, LLC		1,588	1,588	21
22	V	30	Depreciation		Chase Office, LLC		14,838	14,838	22
23	V	32	Interest Expense		Chase Office, LLC		3,701	3,701	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,899	2,899	24
25	V	35	Equipment Rental		Chase Office, LLC		1,356	1,356	25
26	V	34	Rent	30,000	Chase Office, LLC		270	(29,730)	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			\$ 30,000			\$ 30,086	\$ * 86	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	Payroll Services	\$ 49,875	ProPay HR LLC		\$ 38,449	\$ (11,426)	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			\$ 49,875			\$ 38,449	\$ * (11,426)	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	\$ 1,585,585	Renewal Rehab, LLC		\$ 1,343,431	\$ (242,154)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,585,585			\$ 1,343,431	\$ * (242,154)	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	\$ 212,898	EcoBrite Linen		\$ 212,898	\$	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			\$ 212,898			\$ 212,898	\$ *	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	\$ 940,788	Aperion Incorporated Cell		\$ 940,788	\$	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			\$ 940,788			\$ 940,788	\$ *	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	Data Processing	\$ 4,200	EMSA PURCHASING GROUP		\$ 3,561	\$ (639)	15
16	V								16
17	V								17
18	V								18
19	V	39	Ancillary Services	273,405	Concerto Dialysis		273,405		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			\$ 277,605			\$ 276,966	\$ * (639)	39

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

Facility Name & ID Number Aperion Care International # 0050187 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	1.26	3.16%	Alloc Sal	\$ 7,899	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	1.26	3.16%	Alloc Sal	1,859	21-7	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.26	3.16%	Alloc Sal	3,631	17-7	3
4	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.59	3.97%	Alloc Sal	6,415	10-7	4
5	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.86	3.16%	Alloc Sal	980	21-7	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	\$ 20,784		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 International# 0050187

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	\$	60,036	\$ 149	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		60,036	53	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	60,036	2,546	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		60,036	158	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		60,036	283	5
6	9	Medical Director	Census/Direct Cost	65	85,500		60,036	2,702	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	60,036	7,026	7
8	11	Activities	Census/Direct Cost	65	912		60,036	29	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		60,036	782	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	60,036	67,294	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		60,036	12,070	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		60,036	6,862	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	60,036	49,507	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		60,036	1,884	14
15	24	Seminars	Census/Direct Cost	65	13,215		60,036	418	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		60,036	2,238	16
17	26	Insurance	Census/Direct Cost	65	29,094		60,036	919	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		60,036	13,292	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		60,036	1,844	19
20	32	Interest	Census/Direct Cost	65	946,429		60,036	29,905	20
21	34	Rent	Census/Direct Cost	65	13,110		60,036	414	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		60,036	1,892	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 202,265	25

Ending: 12/31/20

7

7

IL478-2471

Ending: 12/31/20

7

IL478-2471

Ending: 12/31/20

5

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

(847) 410-9720

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Data Processing	Direct			\$	\$		\$ 3,561	1
2										2
3										3
4	39	Ancillary Services	Direct						273,405	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 276,966	25

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	Capital One		X	Mortgage Payable			\$	19,333,661			\$	666,516	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				3,290,743				156,134	6
7	Insurance Policies		X									1,571	7
8													8
9	TOTAL Facility Related						\$	22,624,404			\$	824,221	9
	B. Non-Facility Related*												
10	Interest Income		X									(6,238)	10
11	Interest Income - Bldg Co		X									(1,190)	11
12	Allocated from Aperion Care Ir	X										29,905	12
13	Allocated from Chase Office	X										3,701	13
14	TOTAL Non-Facility Related						\$				\$	26,178	14
15	TOTALS (line 9+line14)						\$	22,624,404			\$	850,399	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 126,953 Line # 36

* 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.			\$	522,000	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.)			\$	630,393	2
3. Under or (over) accrual (line 2 minus line 1).			\$	108,393	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	658,869	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	19,228	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 \$ <u>48,876</u> For <u>2017</u> 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.			\$	786,490	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	<u>448,291</u>	8	
		2016	<u>489,985</u>	9	
		2017	<u>526,635</u>	10	
		2018	<u>521,667</u>	11	
		2019	<u>627,494</u>	12	
2020 Accrual = \$627,494 x 1.05 = \$658,869					
Allocated from Chase Office \$2,899					

		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 International COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050187

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.

B. Real Estate Tax Cost Allocations

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

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

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME Aperion Care International COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050187

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.)

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.

A. Square Feet:

89,132

B. General Construction Type:

Exterior

Brick

Frame

Brick

Number of Stories

3

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		2013	\$ 1,268,120	1
2	Allocated from Chase Office LLC			1,864	2
3	TOTALS			\$ 1,269,984	3

Facility Name & ID Number Aperion Care International

0050187

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	218		2013	2000	\$ 12,080,520	\$ 614,811	35	\$ 345,158	\$ (269,653)	\$ 2,603,006	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2009	23,882		20			23,882	9
10	Various			2010	32,497		20	917	917	26,304	10
11	Various			2011	55,563		20	2,117	2,117	33,665	11
12	Various			2012	748,871		20	36,796	36,796	422,105	12
13	Various			2013	97,463		20	4,087	4,087	51,336	13
14	Various			2014	1,133,232		20	56,661	56,661	369,473	14
15	Various			2015	95,624		20	4,523	4,523	33,140	15
16	Various			2016	180,833		20	9,042	9,042	41,280	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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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)		397,860			19,893	19,893	110,421	67
68	Related Party Allocations (Pages 12H & 12I)		115,954	8,182		5,389	(2,793)	22,951	68
69	Financial Statement Depreciation			391,832			(391,832)		69
70	TOTAL (lines 4 thru 69)		\$ 14,962,300	\$ 1,014,825		\$ 484,583	\$ (530,243)	\$ 3,737,563	70

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

Facility Name & ID Number Aperion Care International

0050187

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		\$ 14,962,300	\$ 1,014,825		\$ 484,583	\$ (530,243)	\$ 3,737,563	1
2	50 Amp 3 Pole Circuit - Activity Room	2017	2,930		20	147	147	574	2
3	Lighting Fixtures - 1St & 2Nd Flr Shower Rooms, Basement Corri	2017	10,575		20	529	529	2,027	3
4	Air Conditioner In Dialysis Room	2017	11,000		20	550	550	1,971	4
5	Ejector Pump Replacement	2017	7,900		20	395	395	1,383	5
6	New Floor / Pipe Repair In Back Of Building	2017	3,200		20	160	160	560	6
7	Cut Masonry, Install Door, Alarms & Concrete Ramp	2017	29,210		20	1,461	1,461	4,991	7
8	Hot Water Coil Replacement	2017	4,775		20	239	239	955	8
9	Installed Electrical Amps / Panels In Basement	2018	10,800		20	540	540	1,485	9
10	Project - Patio Addition	2018	22,212		20	1,111	1,111	3,332	10
11	3Rd Flr-Tile/Floor/Wall/Paint//Windows/Base/Doors/Frames/Fixtu	2018	681,733		20	34,087	34,087	90,898	11
12	Air Conditioner Unit Replacement	2018	3,119		20	156	156	429	12
13	Coil Replacement In Kitchen	2018	2,739		20	137	137	285	13
14	Main Circulating Pump Replacement Kit	2018	3,325		20	166	166	471	14
15	Break Tank System	2019	5,332		20	267	267	489	15
16	Curb&Gutter	2019	3,126		20	156	156	273	16
17	Backflow System Devices	2019	26,046		20	1,302	1,302	2,604	17
18	Replaced Smoke Detectors And System Sensor	2019	5,819		20	291	291	582	18
19	Dome & Terret Cameras With Dvr'S And Hdd'S (15,949)	2020	15,161		20	758	758	758	19
20	Installation Of Water Heater For Kitchen & Laundry (33,250)	2020	31,695		20	1,585	1,585	1,585	20
21	New Circulating Pump	2020	2,958		20	148	148	148	21
22	1St & 3Rd Fl Cubicle Curtains	2020	2,722		20	136	136	136	22
23	10 Wanderguard Pendants	2020	2,530		20	253	253	253	23
24	New Elevator Valve	2020	4,800		20	240	240	240	24
25	Repair Pump	2020	3,327		20	166	166	166	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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 12B, Carried Forward		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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)		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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 12C, Carried Forward		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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)		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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	Totals from Page 12D, Carried Forward		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	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)		\$ 15,859,334	\$ 1,014,825		\$ 529,563	\$ (485,263)	\$ 3,854,158	34

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

Facility Name & ID Number Aperion Care International

0050187

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 Installed canopies/columns/walls/asphalt/paving-North & West Side	2015	300,000		20	15,000	15,000	86,250	9
10 Dialysis Room - new walls, ceiling grids, vinyl flooring,	2016	73,085		20	3,654	3,654	19,216	10
11 electrical work, plumbing (92,000)								11
12 Dialysis Room - new walls, ceiling grids, vinyl flooring,	2017	24,775		20	1,239	1,239	4,955	12
13 electrical work, plumbing (26,000)								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)		\$ 397,860	\$		\$ 19,893	\$ 19,893	\$ 110,421	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		\$ 397,860	\$		\$ 19,893	\$ 19,893	\$ 110,421	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)		\$ 397,860	\$		\$ 19,893	\$ 19,893	\$ 110,421	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	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 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Chase Office LLC	2016	16,775	430	20	430		1,900	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Aperion Care	2010	941	151	20	47	(104)	471	9
10 Allocated from Aperion Care	2012	267	21	20	13	(7)	107	10
11 Allocated from Aperion Care	2013	114	14	20	6	(9)	40	11
12								12
13 Allocated from Chase Office LLC	2020	335		20	17	17	17	13
14 Allocated from Chase Office LLC	2019	8,544	388	20	427	39	854	14
15 Allocated from Chase Office LLC	2018	76	4	20	4	(0)	11	15
16 Allocated from Chase Office LLC	2017	3,883	949	20	194	(755)	777	16
17 Allocated from Chase Office LLC	2016	85,020	6,224	20	4,251	(1,973)	18,775	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)		\$ 115,954	\$ 8,182		\$ 5,389	\$ (2,793)	\$ 22,951	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 12H, Carried Forward		\$ 115,954	\$ 8,182		\$ 5,389	\$ (2,793)	\$ 22,951	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)		\$ 115,954	\$ 8,182		\$ 5,389	\$ (2,793)	\$ 22,951	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	\$ 3,211,499	\$ 8,788	\$ 321,271	\$ 312,484	10	\$ 2,331,731	71
72	Current Year Purchases	53,249	55	5,329	5,274	10	5,329	72
73	Fully Depreciated Assets	441,314				10	441,314	73
74								74
75	TOTALS	\$ 3,706,062	\$ 8,843	\$ 326,600	\$ 317,757		\$ 2,778,374	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		Allocated from Aperion Care	2020	\$ 6,805	\$ 301	\$ 1,361	\$ 1,060	5	\$ 3,408
77									
78									
79									
80	TOTALS			\$ 6,805	\$ 301	\$ 1,361	\$ 1,060		\$ 3,408

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)			\$ 20,842,185	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 1,023,969	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 857,524	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (166,445)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 6,635,940	

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	\$ 800
93		
94		
95		\$ 800

* 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 Inc				414			5
6	Allocated from Chase Office				270			6
7	TOTAL				\$684			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: \$21,511
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care Inc		\$	\$1,892	17
18					18
19					19
20					20
21	TOTAL		\$	\$1,892	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 EndingAnnual 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	\$		\$ 644,954	\$		\$ 644,954	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			220,655			220,655	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			723,840			723,840	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				707,693		707,693	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					10,415	404,704		415,119	13
14	TOTAL			\$		\$ 1,599,864	\$ 1,112,397		\$ 2,712,261	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	\$ 500,141	\$ 863,021	1
2	Cash-Patient Deposits	179	179	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,980,145	2,980,145	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,305	265,750	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	30,593	1,351,912	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,652,363	\$ 5,461,007	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,268,120	13
14	Buildings, at Historical Cost		10,652,215	14
15	Leasehold Improvements, at Historical Cost	3,422,430	5,193,735	15
16	Equipment, at Historical Cost	1,352,748	3,800,108	16
17	Accumulated Depreciation (book methods)	(3,250,571)	(7,649,971)	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	10,595,887	10,737,551	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,120,494	\$ 24,001,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,772,857	\$ 29,462,765	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,321,798	\$ 1,321,801	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,290,743	3,290,743	29
30	Accrued Salaries Payable	485,497	485,497	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,170	20,170	31
32	Accrued Real Estate Taxes(Sch.IX-B)		658,869	32
33	Accrued Interest Payable	8,694	60,250	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	3,600,544	3,600,544	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,727,446	\$ 9,437,874	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,333,661	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 19,333,661	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,727,446	\$ 28,771,535	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,045,411	\$ 691,230	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,772,857	\$ 29,462,765	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,167,735	1
2	Restatements (describe):		2
3	Bad Debts	(295,868)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,871,868	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,173,543	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)	\$ 1,173,543	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)	\$ 7,045,411	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care International**# **0050187**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	\$ 19,845,377	1
2	Discounts and Allowances for all Levels	844,350	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,689,727	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	338,901	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 338,901	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	20,734	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	542	19
20	Radiology and X-Ray	1,215	20
21	Other Medical Services	10,359	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,850	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,238	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,238	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	2,004,849	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,004,849	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 23,072,565	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,498,136	31
32	Health Care	7,491,061	32
33	General Administration	5,870,640	33
	B. Capital Expense		
34	Ownership	2,944,434	34
	C. Ancillary Expense		
35	Special Cost Centers	2,728,206	35
36	Provider Participation Fee	366,545	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,899,022	40
41	Income before Income Taxes (line 30 minus line 40)**	1,173,543	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,173,543	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,059,543	44
45	Private Pay - Net Inpatient Revenue	174,394	45
46	Medicare - Net Inpatient Revenue	9,369,012	46
47	Other-(specify) <u>Insurance</u>	2,306,390	47
48	Other-(specify) <u>Managed Care / PPHP/ISNP</u>	6,780,388	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 20,689,727	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	1,875	2,128	\$ 136,010	\$ 63.91	1
2	Assistant Director of Nursing	1,888	2,249	94,891	42.19	2
3	Registered Nurses	21,440	23,060	912,654	39.58	3
4	Licensed Practical Nurses	54,101	60,690	2,237,945	36.88	4
5	CNAs & Orderlies	108,252	116,105	2,286,977	19.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,304	14,148	317,918	22.47	8
9	Activity Director	2,264	2,492	45,206	18.14	9
10	Activity Assistants	10,941	12,185	206,119	16.92	10
11	Social Service Workers	13,168	14,633	472,896	32.32	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	61,483	29.56	13
14	Head Cook	6,995	7,554	132,641	17.56	14
15	Cook Helpers/Assistants	18,196	20,754	347,199	16.73	15
16	Dishwashers					16
17	Maintenance Workers	5,704	6,240	139,057	22.28	17
18	Housekeepers	23,825	26,543	444,287	16.74	18
19	Laundry	4,432	5,388	89,020	16.52	19
20	Administrator	2,032	2,337	148,542	63.57	20
21	Assistant Administrator	1,961	2,080	50,683	24.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,705	11,335	224,850	19.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,904	2,080	39,190	18.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	302,939	334,081	\$ 8,387,568 *	\$ 25.11	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	13,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,975	10-03	38
39	Pharmacist Consultant	Monthly	26,532	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	11	616	11-03	44
45	Social Service Consultant	18	1,126	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	29	\$ 131,271		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.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Aperion Care International

0050187

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Seidler	Administrator	0	\$ 22,598
David J. Glat	Administrator	0	125,944
Moshe Chayim Silver	Admin in Training	0	50,683
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 199,225

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	\$ 895,495
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 895,495

C. Professional Services

Vendor/Payee	Type	Amount
Hurley McKenna & Mertz	Legal Settlement	\$ 50,000
Marcum LLP	Accounting	19,055
Aperion Care, Inc.	Home Office Expense	60,967
ProPay HR	Payroll Processing	49,875
Achieve Accreditation	Accreditation	10,860
Interbuild	Energy Procurement	954
GCHMO	Liaison Service	3,900
MPAC Healthcare	Telehealth	40,260
Personnel Planners	Unemployment Consultant	1,590
SAS Architects & Planners	Architects	1,225
See Attached	Legal	86,585
See Supplemental Schedule		799,574
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 1,124,844

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 227,228
Unemployment Compensation Insurance	36,369
FICA Taxes	641,649
Employee Health Insurance	274,078
Employee Meals	9,800
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	3,085
Union Pension Fund	59,367
Employee Physicals	2,387
Employee Benefits - Other	17,092
Employee Benefit Other - Covid	5,833
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,276,888

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	2,765
Health Care Worker Background Check (Indicate # of checks performed 69)	691
Patient Background Checks	588 5,885
Dues & Subscriptions	32,247
Licenses & Fees	1,422
See Supplemental Schedule	7,693
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 54,683

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,573
See Supplemental Schedule	744
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,316

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>Yes</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>HCCI \$40,733</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 Years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>45,950</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <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>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>366,545</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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>
(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? 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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?	\$ <u>9,800</u> <u>N/A</u> Indicate the amount. \$
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>N/A</u> <u>N/A</u> <u>100% Ln 14</u> <u>N/A</u> <u>N/A</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(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>
(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. Attach invoices and a summary of services for all architect and appraisal fees.	<u>Yes</u>