

		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>0051094</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																				
Facility Name: <u>Aperion Care Jacksonville</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>1021 North Church St</u> <u>Jacksonville</u> <u>62650</u>																																																																																						
Number City Zip Code																																																																																						
County: <u>Morgan</u>																																																																																						
Telephone Number: <u>(217)245-4174</u> Fax # <u>(217)243-5901</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) _____ <u>05/21/2021</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td>& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>9/1/2010</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/21/2021</u>	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>	& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>9/1/2010</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></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 _____					In the event there are further questions about this report, please contact:				Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>		Email Address: _____			
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#	0051094	Report Period Beginning:	01/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

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

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 9/1/2010

YES ☒ Date 9/1/2010 NO ☐

YES ☐ NO ☐ If YES, enter number
of beds certified 113 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	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	25,359	675	2,450	28,484	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,359	675	2,450	28,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **68.87%**

Facility Name & ID Number Aperion Care Jacksonville # 0051094 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	218,494	21,127		239,621		239,621	12,894	252,515			1
2	Food Purchase		168,132		168,132		168,132	31	168,163			2
3	Housekeeping	133,429	54,253		187,682		187,682	267	187,949			3
4	Laundry	74,814	9,037		83,851		83,851		83,851			4
5	Heat and Other Utilities			91,855	91,855		91,855	(16,746)	75,109			5
6	Maintenance	44,288	11,376	61,743	117,407		117,407	(9,685)	107,722			6
7	Other (specify):*							1,812	1,812			7
8	TOTAL General Services	471,025	263,925	153,598	888,548		888,548	(11,428)	877,120			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000	1,282	43,282			9
10	Nursing and Medical Records	1,975,825	201,652	79,412	2,256,889		2,256,889	(20,404)	2,236,485			10
10a	Therapy		1,063		1,063		1,063		1,063			10a
11	Activities	89,410	5,156	3,088	97,654		97,654	14	97,668			11
12	Social Services	156,892		3,364	160,256		160,256		160,256			12
13	CNA Training											13
14	Program Transportation			26,149	26,149		26,149		26,149			14
15	Other (specify):*							5,341	5,341			15
16	TOTAL Health Care and Programs	2,222,127	207,871	154,013	2,584,011		2,584,011	(13,767)	2,570,244			16
	C. General Administration											
17	Administrative	108,425		261,932	370,357		370,357	(230,005)	140,352			17
18	Directors Fees											18
19	Professional Services			320,588	320,588		320,588	(175,261)	145,327			19
20	Dues, Fees, Subscriptions & Promotions			47,519	47,519		47,519	(16,306)	31,213			20
21	Clerical & General Office Expenses	60,543		381,866	442,409		442,409	(251,622)	190,787			21
22	Employee Benefits & Payroll Taxes			412,816	412,816		412,816		412,816			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,181	1,181		1,181	93	1,274			24
25	Other Admin. Staff Transportation			10,767	10,767		10,767	1,071	11,838			25
26	Insurance-Prop.Liab.Malpractice			120,790	120,790		120,790	436	121,226			26
27	Other (specify):*							15,946	15,946			27
28	TOTAL General Administration	168,968		1,557,459	1,726,427		1,726,427	(655,648)	1,070,779			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,862,120	471,796	1,865,070	5,198,986		5,198,986	(680,843)	4,518,143			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			200,796	200,796		200,796	(26,976)	173,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,133	31,133		31,133	186,705	217,838			32
33	Real Estate Taxes			34,441	34,441		34,441	1,375	35,816			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(299,675)	325			34
35	Rent-Equipment & Vehicles			7,980	7,980		7,980	1,749	9,729			35
36	Other (specify):*			4,009	4,009		4,009	(4,009)				36
37	TOTAL Ownership			578,359	578,359		578,359	(140,831)	437,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		162,066	346,701	508,767		508,767	(59,428)	449,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,500	223,500		223,500		223,500			42
43	Other (specify):*			3,065	3,065		3,065	(3,065)				43
44	TOTAL Special Cost Centers		162,066	573,266	735,332		735,332	(62,493)	672,839			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,862,120	633,862	3,016,695	6,512,677		6,512,677	(884,168)	5,628,509			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	(17,263)	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	(48,048)	30		9
10	Interest and Other Investment Income	(240)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	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	(21,109)	21		18
19	Entertainment				19
20	Contributions	(10,500)	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	(320,893)	21		24
25	Fund Raising, Advertising and Promotional	(3,065)	43		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	(34,562)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (455,720)		\$	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)	(428,448)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (428,448)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (884,168)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (1,368)	19	1
2	Supplemental Insurance	(475)	21	2
3	Credit Card Processing	(710)	21	3
4	Bank Charges	(14,216)	21	4
5	Theft & Damage Loss	1,410	21	5
6	Amortization	(4,009)	36	6
7	Other Income	(53)	21	7
8	Additional R&M	2,679	06	8
9	Capitalized R&M	(3,026)	06	9
10	PAC Dues	(9,237)	20	10
11	Chamber of Commerce Dues	(220)	20	11
12	Prior Year Seminar Expense	(259)	24	12
13	Prior Year Professional Fees	(532)	19	13
14	Building Company - Accounting Fees	(3,224)	19	14
15	Building Company - Bank Charges	(144)	21	15
16	Building Company - IL Replacement Tax	(856)	21	16
17	Building Company - Licenses & Fees	(322)	20	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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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	(34,562)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Jacksonville

0051094

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				12,894								12,894	1
2	Food Purchase	(40)		71									31	2
3	Housekeeping			25			242						267	3
4	Laundry													4
5	Heat and Other Utilities	(17,263)					517						(16,746)	5
6	Maintenance	(347)		1,283	(11,444)		823						(9,685)	6
7	Other (specify):*			134	1,678								1,812	7
8	TOTAL General Services	(17,650)		1,513	3,128		1,582						(11,428)	8
	B. Health Care and Programs													
9	Medical Director			1,282									1,282	9
10	Nursing and Medical Records			3,333	(23,785)		48						(20,404)	10
10a	Therapy													10a
11	Activities			14									14	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			371	4,970								5,341	15
16	TOTAL Health Care and Programs			4,999	(18,815)		48						(13,767)	16
	C. General Administration													
17	Administrative			(230,005)									(230,005)	17
18	Directors Fees													18
19	Professional Services	(5,124)	3,224	6,820	1,932	(177,775)	944	(4,644)	(639)				(175,261)	19
20	Fees, Subscriptions & Promotions	(20,279)	322	3,256	24	367	4						(16,306)	20
21	Clerical & General Office Expenses	(357,046)	1,000	24,382	355	78,933	754						(251,622)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(259)		198	118	36							93	24
25	Other Admin. Staff Transportation			1,062	9								1,071	25
26	Insurance-Prop.Liab.Malpractice			436									436	26
27	Other (specify):*			6,306		9,640							15,946	27
28	TOTAL General Administration	(382,708)	4,546	(187,544)	2,438	(88,799)	1,701	(4,644)	(639)				(655,648)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(400,358)	4,546	(181,032)	(13,249)	(88,799)	3,331	(4,644)	(639)				(680,843)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Jacksonville # 0051094 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	(48,048)	12,851	875	151	155	7,040						(26,976)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(240)	171,000	14,188			1,756						186,705	32
33	Real Estate Taxes						1,375						1,375	33
34	Rent-Facility & Grounds		(270,000)	197			(29,872)						(299,675)	34
35	Rent-Equipment & Vehicles			898		208	643						1,749	35
36	Other (specify):*	(4,009)											(4,009)	36
37	TOTAL Ownership	(52,297)	(86,149)	16,158	151	363	(19,057)						(140,831)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(6,618)	(52,810)		(59,428)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,065)											(3,065)	43
44	TOTAL Special Cost Centers	(3,065)								(6,618)	(52,810)		(62,493)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(455,720)	(81,603)	(164,875)	(13,098)	(88,436)	(15,726)	(4,644)	(639)	(6,618)	(52,810)		(884,168)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 270,000	1021 North Church Street, LLC		\$	(270,000)	1
2	V	33	Real Estate Tax	34,441	1021 North Church Street, LLC		34,441		2
3	V	19	Accounting Fees		1021 North Church Street, LLC		3,224	3,224	3
4	V	21	Bank Charges		1021 North Church Street, LLC		144	144	4
5	V	30	Depreciation		1021 North Church Street, LLC		12,851	12,851	5
6	V	21	IL Replacement Tax		1021 North Church Street, LLC		856	856	6
7	V	32	Interest		1021 North Church Street, LLC		171,000	171,000	7
8	V	20	Licenses & Fees		1021 North Church Street, LLC		322	322	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 304,441			\$ 222,838	\$ * (81,603)	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	DAVID BERKOWITZ REVOCABLE TRUST	47.00 %	Aperion Care Bradley	Bradley	1021 North Church Street, LLC	Jacksonville	Building Co.	1
2	DECLARATION OF TRUST OF YOSEF MEYSTEL	47.00 %	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	JAY MEYSTEL TRUST	4.00 %	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	STEVEN TUROFSKY	1.00 %	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	FREDERICK S. FRANKEL TRUST	1.00 %	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 Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	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.		\$ 71	\$ 71	15
16	V	3	Housekeeping		Aperion Care, Inc.		25	25	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,208	1,208	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		75	75	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		134	134	19
20	V	9	Medical Director		Aperion Care, Inc.		1,282	1,282	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		3,333	3,333	21
22	V	11	Activities		Aperion Care, Inc.		14	14	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		371	371	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		31,928	31,928	24
25	V	19	Professional Fees		Aperion Care, Inc.		5,727	5,727	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,256	3,256	26
27	V	21	Clerical Salary		Aperion Care, Inc.		23,488	23,488	27
28	V	21	Clerical & General		Aperion Care, Inc.		894	894	28
29	V	24	Seminars		Aperion Care, Inc.		198	198	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,062	1,062	30
31	V	26	Insurance		Aperion Care, Inc.		436	436	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		6,306	6,306	32
33	V	30	Depreciaiton		Aperion Care, Inc.		875	875	33
34	V	32	Interest		Aperion Care, Inc.		14,188	14,188	34
35	V	34	Rent		Aperion Care, Inc.		197	197	35
36	V	35	Auto Lease		Aperion Care, Inc.		898	898	36
37	V	17	Management Fee	261,932	Aperion Care, Inc.			(261,932)	37
38	V	19	Home Office	(1,094)	Aperion Care, Inc.			1,094	38
39	Total			\$ 260,839			\$ 95,964	\$ * (164,875)	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	1	Dietician Salary - Illinois Only	\$	Aperion Consulting, LLC		\$ 12,894	\$ 12,894	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,182	2,182	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		47	47	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,678	1,678	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		43,897	43,897	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		4,970	4,970	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,932	1,932	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		24	24	22
23	V	21	Clerical & General		Aperion Consulting, LLC		355	355	23
24	V	24	Seminars		Aperion Consulting, LLC		118	118	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		9	9	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		151	151	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 81,355			\$ 68,257	\$ * (13,098)	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		\$ 517	\$ 517	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		823	823	16
17	V	3	Housekeeping		Chase Office, LLC		242	242	17
18	V	10	Medical Supplies		Chase Office, LLC		48	48	18
19	V	19	Professional Fees		Chase Office, LLC		944	944	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		4	4	20
21	V	21	Office Expense		Chase Office, LLC		754	754	21
22	V	30	Depreciation		Chase Office, LLC		7,040	7,040	22
23	V	32	Interest Expense		Chase Office, LLC		1,756	1,756	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,375	1,375	24
25	V	35	Equipment Rental		Chase Office, LLC		643	643	25
26	V	34	Rent	30,000	Chase Office, LLC		128	(29,872)	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			\$ 14,274	\$ * (15,726)	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	\$ 20,268	ProPay HR LLC		\$ 15,624	\$ (4,644)	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			\$ 20,268			\$ 15,624	\$ * (4,644)	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								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,200			\$ 3,561	\$ * (639)	39

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

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	\$ 11,625	Lifescan Labs of Illinois		\$ 5,007	\$ (6,618)	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			\$ 11,625			\$ 5,007	\$ * (6,618)	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	\$ 345,787	Renewal Rehab, LLC		\$ 292,977	\$ (52,810)	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			\$ 345,787			\$ 292,977	\$ * (52,810)	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	\$ 93,393	Aperion Incorporated Cell		\$ 93,393	\$	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			\$ 93,393			\$ 93,393	\$ *	39

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

Facility Name & ID Number Aperion Care Jacksonville # 0051094 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	0.6	1.50%	Alloc. Salary	\$ 3,748	17-7	1
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.6	1.50%	Alloc. Salary	882	21-7	2
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.41	1.50%	Alloc. Salary	465	21-7	3
4	David Berkowitz	Relative	Administrative	0%	See Attached	0.6	1.50%	Alloc. Salary	1,723	17-7	4
5	Fred Frankel	Relative	Administrative	0%	See Attached	0.6	1.50%	Alloc. Salary	3,748	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	0.6	1.50%	Alloc. Salary	3,748	17-7	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	\$ 14,314		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 Jacksonville# 0051094

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	\$	28,484	\$ 71	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		28,484	25	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	28,484	1,208	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		28,484	75	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		28,484	134	5
6	9	Medical Director	Census/Direct Cost	65	85,500		28,484	1,282	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	28,484	3,333	7
8	11	Activities	Census/Direct Cost	65	912		28,484	14	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		28,484	371	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	28,484	31,928	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		28,484	5,727	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		28,484	3,256	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	28,484	23,488	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		28,484	894	14
15	24	Seminars	Census/Direct Cost	65	13,215		28,484	198	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		28,484	1,062	16
17	26	Insurance	Census/Direct Cost	65	29,094		28,484	436	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		28,484	6,306	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		28,484	875	19
20	32	Interest	Census/Direct Cost	65	946,429		28,484	14,188	20
21	34	Rent	Census/Direct Cost	65	13,110		28,484	197	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		28,484	898	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 95,964	25

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

7

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	First Midwest Bank		X	Mortgage			\$	1,425,000			\$	171,000	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	First Midwest Bank		X	Line of Credit				803,122				30,613	6	
7	Insurance Policies		X									520	7	
8													8	
9	TOTAL Facility Related						\$	2,228,122				\$	202,133	9
	B. Non-Facility Related*													
10	Interest Income		X									(240)	10	
11	Alloc from Aperion Care Inc.	X										14,188	11	
12	Alloc from Chase Office LLC	X										1,756	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	15,704	14
15	TOTALS (line 9+line14)						\$	2,228,122				\$	217,837	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.	\$	32,079		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.)	\$	34,635		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	2,556		3
4.	Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	33,260		4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	35,816		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	29,582	8		
	2016	29,947	9		
	2017	31,375	10		
	2018	32,079	11		
	2019	33,260	12		
2020 Accrual = 2019 Real Estate Tax					
Allocated from Chase Office \$1,375					

	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 Jacksonville COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0051094

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 Jacksonville COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0051094

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

24,500

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		2010	\$ 48,177	1
2	Allocated from Chase Office LLC			884	2
3	TOTALS			\$ 49,061	3

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
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		55,014	3,882		2,557	(1,325)	10,889	68
69	Financial Statement Depreciation			200,796			(200,796)		69
70	TOTAL (lines 4 thru 69)		\$ 2,877,926	\$ 217,529		\$ 113,869	\$ (103,660)	\$ 1,034,782	70

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

Facility Name & ID Number Aperion Care Jacksonville

0051094

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		\$ 2,877,926	\$ 217,529		\$ 113,869	\$ (103,660)	\$ 1,034,782	1
2	Roof Top Unit And Compressor (21,062)	2018	20,820		20	1,041	1,041	2,516	2
3	5 Frigidare 7000 Ptac Hp 230Volt 20 Amp	2018	4,172		20	209	209	435	3
4	Replace Natural Gas Water Heater	2018	4,156		20	208	208	502	4
5	Video Surveillance Cameras Throughout Facility	2019	6,915		20	346	346	605	5
6	Vtac Units In Rooms 212, 304, 312	2019	9,648		20	482	482	683	6
7	One New Vtac Unit In Resident Room	2019	3,681		20	184	184	368	7
8	New Hot Water Heaters	2019	34,432		20	1,722	1,722	3,444	8
9	4 Vtac Heating & Cooling Units (12,024)	2020	11,734		20	587	587	587	9
10	Replace Leaking Pipe In Shower Room Floor, Remove/Replace Co	2020	4,346		20	217	217	217	10
11	Two 3-Phase Booster Water Heaters	2020	4,469		20	223	223	223	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)		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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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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)		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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	Totals from Page 12C, Carried Forward		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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 12D, Carried Forward		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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
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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)		\$ 2,982,300	\$ 217,529		\$ 119,088	\$ (98,441)	\$ 1,044,363	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Aperion Care Jacksonville

0051094

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	Related Party		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	7,959	204	20	204		901	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	447	72	20	22	(49)	223	9
10	Allocated from Aperion Care	2012	127	10	20	6	(3)	51	10
11	Allocated from Aperion Care	2013	54	7	20	3	(4)	19	11
12									12
13	Allocated from Chase Office LLC	2020	159		20	8	8	8	13
14	Allocated from Chase Office LLC	2019	4,054	184	20	203	19	405	14
15	Allocated from Chase Office LLC	2018	36	2	20	2	(0)	5	15
16	Allocated from Chase Office LLC	2017	1,842	450	20	92	(358)	368	16
17	Allocated from Chase Office LLC	2016	40,338	2,953	20	2,017	(936)	8,908	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)		\$ 55,014	\$ 3,882		\$ 2,557	\$ (1,325)	\$ 10,889	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		\$ 55,014	\$ 3,882		\$ 2,557	\$ (1,325)	\$ 10,889	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 55,014	\$ 3,882		\$ 2,557	\$ (1,325)	\$ 10,889	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	\$ 554,288	\$ 4,169	\$ 53,286	\$ 49,117	10	\$ 488,767	71
72	Current Year Purchases	7,970	26	799	773	10	799	72
73	Fully Depreciated Assets	155,368				10	155,368	73
74								74
75	TOTALS	\$ 717,625	\$ 4,195	\$ 54,085	\$ 49,890		\$ 644,934	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		2008 DODGE GRAND CARAVA	2014	\$ 7,297	\$	\$	\$	5	\$ 7,297
77		Alloc from Aperion Care	2020	3,229	143	646	503	5	1,617
78									
79									
80	TOTALS			\$ 10,526	\$ 143	\$ 646	\$ 503		\$ 8,914

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)			\$	3,759,512
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	221,868
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	173,819
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(48,048)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,698,211

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	Additional VTAC Units	\$ 900
93		
94		
95		\$ 900

* 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	Allocation from Aperion Care Inc.				197			5
6	Alloc from Chase Office LLC				128			6
7	TOTAL				\$325			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: \$8,831
- 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	Allocation from Aperion Care Inc.		\$	\$898	17
18					18
19					19
20					20
21	TOTAL		\$	\$898	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	\$		\$ 123,969	\$		\$ 123,969	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			62,066			62,066	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			159,460			159,460	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				136,445		136,445	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					1,206	25,621		26,827	13
14	TOTAL			\$		\$ 346,701	\$ 162,066		\$ 508,767	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 446,530	\$ 451,695	1
2	Cash-Patient Deposits	30	30	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	854,964	854,964	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,307	59,307	6
7	Other Prepaid Expenses	2,000	2,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	18,409	18,409	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,381,240	\$ 1,386,405	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		312,840	13
14	Buildings, at Historical Cost		510,132	14
15	Leasehold Improvements, at Historical Cost	1,885,504	1,947,373	15
16	Equipment, at Historical Cost	424,900	791,418	16
17	Accumulated Depreciation (book methods)	(1,594,902)	(2,153,553)	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	998,361	998,361	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,713,863	\$ 2,406,571	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,095,103	\$ 3,792,976	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,431	\$ 151,430	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	803,122	803,122	29
30	Accrued Salaries Payable	98,611	98,611	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,143	3,143	31
32	Accrued Real Estate Taxes(Sch.IX-B)		33,260	32
33	Accrued Interest Payable	2,043	16,293	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	879,347	879,347	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,937,697	\$ 1,985,206	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,425,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	6,782,710	6,637,823	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,782,710	\$ 8,062,823	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,720,407	\$ 10,048,029	46
47	TOTAL EQUITY (page 18, line 24)	\$ (5,625,304)	\$ (6,255,053)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,095,103	\$ 3,792,976	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,526,394)	1
2	Restatements (describe):		2
3	Bad Debt	(91,593)	3
4	Rounding	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,617,989)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,315)	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)	\$ (7,315)	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)	\$ (5,625,304)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Jacksonville# 0051094Report Period Beginning: 01/01/20Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,923,421	1
2	Discounts and Allowances for all Levels	(141,215)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,782,206	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,174	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 178,174	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	3,353	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91	19
20	Radiology and X-Ray		20
21	Other Medical Services	9,776	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 13,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	240	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 240	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	531,522	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 531,522	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,505,362	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	888,548	31
32	Health Care	2,584,011	32
33	General Administration	1,726,427	33
	B. Capital Expense		
34	Ownership	578,359	34
	C. Ancillary Expense		
35	Special Cost Centers	511,832	35
36	Provider Participation Fee	223,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,512,677	40
41	Income before Income Taxes (line 30 minus line 40)**	(7,315)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (7,315)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 993,682	44
45	Private Pay - Net Inpatient Revenue	137,091	45
46	Medicare - Net Inpatient Revenue	919,247	46
47	Other-(specify) <u>Insurance</u>	211,582	47
48	Other-(specify) <u>Managed Care</u>	3,520,604	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,782,206	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	1,488	1,526	\$ 67,040	\$ 43.93	1
2	Assistant Director of Nursing	1,808	2,116	84,238	39.81	2
3	Registered Nurses	6,108	6,689	240,999	36.03	3
4	Licensed Practical Nurses	17,510	18,811	586,060	31.16	4
5	CNAs & Orderlies	49,098	53,899	995,014	18.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	237	257	4,277	16.64	9
10	Activity Assistants	5,902	6,223	85,133	13.68	10
11	Social Service Workers	6,033	6,273	143,566	22.89	11
12	Dietician					12
13	Food Service Supervisor	1,424	1,554	23,115	14.87	13
14	Head Cook	4,892	5,588	88,735	15.88	14
15	Cook Helpers/Assistants	7,265	7,750	106,644	13.76	15
16	Dishwashers					16
17	Maintenance Workers	2,063	2,238	44,288	19.79	17
18	Housekeepers	8,618	9,325	133,429	14.31	18
19	Laundry	4,260	5,094	74,814	14.69	19
20	Administrator	2,120	2,160	108,425	50.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	400	415	8,371	20.17	23
24	Clerical	2,345	2,811	52,172	18.56	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	203	203	2,474	12.19	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	771	821	13,326	16.23	33
34	TOTAL (lines 1 - 33)	122,545	133,753	\$ 2,862,120 *	\$ 21.40	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		\$		35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	130	10,769	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	51	3,088	11-03	44
45	Social Service Consultant	39	2,364	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	1,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	220	\$ 126,903		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4	\$ 243	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	20	718	10-03	52
53	TOTAL (lines 50 - 52)	24	\$ 961		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			
Tanish McCullough (1/1-11/8)	Administrator	0	\$ 92,171	Workers' Compensation Insurance		\$ 85,352	IDPH License Fee	\$ 1,990			
Tim Cooper (11/9-12/31)	Administrator	0	16,254	Unemployment Compensation Insurance		43,124	Advertising: Employee Recruitment	4,446			
				FICA Taxes		218,952	Health Care Worker Background Check	1,105			
				Employee Health Insurance		45,227	(Indicate # of checks performed 111)				
				Employee Meals		2,436	Patient Background Checks	96			
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	17,821			
				Employee Physicals		400	Licenses & Fees	1,240			
				Other Employee Benefits		17,325					
							See Supplemental Schedule	3,651			
							Less: Public Relations Expense	()			
							Non-allowable advertising	()			
							Yellow page advertising	()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$		108,425	TOTAL (agree to Sch. V, line 20, col. 8)		\$		31,213
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description	Amount			
Management Fees - Aperion Care, Inc.			\$ 261,932			\$	Out-of-State Travel	\$			
							In-State Travel				
							Seminar Expense	922			
							See Supplemental Schedule	352			
							Entertainment Expense	()			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			(agree to Sch. V, line 24, col. 8)			TOTAL	
\$ 261,932				\$						\$ 1,274	
C. Professional Services											
Vendor/Payee	Type		Amount								
Marcum LLP	Accounting		\$ 19,055								
Propay HR	Payroll Processing		20,268								
Ability Network	Eligibility Software		6,468								
Aperion Care, Inc.	Data Processing		20,147								
Creative Technology Solutions	IT Consulting		5,110								
EMSA Purchasing Group, LLC	Procurement Solutions		4,200								
PointClickCare Technologies	Data Processing		31,218								
Reside Admissions LLC	Data Processing		3,481								
Synapse PDI, LLC	Patient Data Integration		638								
Z-Core Analytics, LLC	Reimbursement Consulting		2,200								
See Attached	Legal		1,731								
See Supplemental Schedule			206,072								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 320,588							

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

HCCI \$18,473
- (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?

Yes

Yes
- (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?

No

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 9,799

Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 223,500
- (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.

No

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
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.

No
- (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?

\$ 2,436

No

Indicate the amount. \$ N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

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.

No

N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% Ln 14

d.

Have vehicle usage logs been maintained?

No

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

N/A
- (18)

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

Yes
- (19)

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

Yes