

		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>0054759</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Marseilles</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>578 W Commercial St</u> <u>Marseilles</u> <u>61341</u>																									
Number City Zip Code																									
County: <u>Lasalle</u>																									
Telephone Number: <u>(815) 795-5121</u> Fax # <u>(815) 795-6213</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>11/1/2017</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: _____																									

#	0054759	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 11/1/2017

YES ☒ Date 11/1/2017 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 103 and days of care provided 4,501

IV. ACCOUNTING BASIS

ACCRUAL	X
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CASH*	
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CASH* ☐

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

Tax Year: 12/31/2020 **Fiscal Year:** 12/31/2020

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

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,062	550	5,605	24,217	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,062	550	5,605	24,217	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **64.24%**

Facility Name & ID Number Aperion Care Marseilles # 0054759 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	198,132	32,818	21,522	252,472		252,472	(10,560)	241,912			1
2	Food Purchase		141,984		141,984		141,984	(802)	141,182			2
3	Housekeeping	94,870	46,710		141,580		141,580	227	141,807			3
4	Laundry	32,314	8,424		40,738		40,738		40,738			4
5	Heat and Other Utilities			107,932	107,932		107,932	(11,247)	96,685			5
6	Maintenance	53,629	25,156	72,941	151,726		151,726	(18,622)	133,104			6
7	Other (specify):*							1,541	1,541			7
8	TOTAL General Services	378,945	255,092	202,395	836,432		836,432	(39,462)	796,970			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	1,090	13,090			9
10	Nursing and Medical Records	1,817,661	167,513	255,641	2,240,815		2,240,815	(48,663)	2,192,152			10
10a	Therapy		1,139	130	1,269		1,269		1,269			10a
11	Activities	117,847	5,261	402	123,510		123,510	12	123,522			11
12	Social Services	37,391		6,164	43,555		43,555		43,555			12
13	CNA Training											13
14	Program Transportation			2,396	2,396		2,396		2,396			14
15	Other (specify):*							4,541	4,541			15
16	TOTAL Health Care and Programs	1,972,899	173,913	276,733	2,423,545		2,423,545	(43,020)	2,380,525			16
	C. General Administration											
17	Administrative	92,033		278,460	370,493		370,493	(251,315)	119,178			17
18	Directors Fees											18
19	Professional Services			292,114	292,114		292,114	(162,666)	129,448			19
20	Dues, Fees, Subscriptions & Promotions			41,140	41,140		41,140	(14,850)	26,290			20
21	Clerical & General Office Expenses	81,685		290,457	372,142		372,142	(156,730)	215,412			21
22	Employee Benefits & Payroll Taxes			345,678	345,678		345,678		345,678			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,161	1,161		1,161	300	1,461			24
25	Other Admin. Staff Transportation			29,167	29,167		29,167	911	30,078			25
26	Insurance-Prop.Liab.Malpractice			72,931	72,931		72,931	371	73,302			26
27	Other (specify):*							13,557	13,557			27
28	TOTAL General Administration	173,718		1,351,108	1,524,826		1,524,826	(570,422)	954,404			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,525,562	429,005	1,830,236	4,784,803		4,784,803	(652,904)	4,131,899			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			40,585	40,585		40,585	(14,286)	26,299			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,589	52,589		52,589	13,404	65,993			32
33	Real Estate Taxes			64,399	64,399		64,399	(17,876)	46,523			33
34	Rent-Facility & Grounds			438,412	438,412		438,412	(11,724)	426,688			34
35	Rent-Equipment & Vehicles			9,779	9,779		9,779	1,487	11,266			35
36	Other (specify):*			1,770	1,770		1,770	(1,770)	(0)			36
37	TOTAL Ownership			607,534	607,534		607,534	(30,765)	576,769			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		350,364	445,943	796,307		796,307	(67,553)	728,754			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,330	178,330		178,330		178,330			42
43	Other (specify):*			13,734	13,734		13,734	(13,734)				43
44	TOTAL Special Cost Centers		350,364	638,007	988,371		988,371	(81,287)	907,084			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,525,562	779,369	3,075,777	6,380,708		6,380,708	(764,956)	5,615,752			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	(730)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,686)	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	(21,275)	30		9
10	Interest and Other Investment Income	(152)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	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	(335)	21		18
19	Entertainment				19
20	Contributions	(9,500)	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	(241,259)	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	(58,917)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (343,886)		\$	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)	(421,070)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (421,070)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (764,956)		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	\$ (2,732)	19	1
2	PAC Dues	(8,180)	20	2
3	Credit Card Processing	(441)	21	3
4	Advertising/Marketing	(12,979)	43	4
5	Marketing-Food	(25)	43	5
6	Promotional Products	(730)	43	6
7	Bank Charges	(3,335)	21	7
8	Theft & Damage Loss	(140)	21	8
9	Amortization	(1,770)	36	9
10	Vending Comission	(100)	02	10
11	Chamber of Commerce Dues	(273)	20	11
12	Additional R&M	(8,634)	06	12
13	Prior Year Professional Fees	(532)	19	13
14	Real Estate Tax	(19,045)	33	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(58,917)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Marseilles# 0054759

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				(10,560)								(10,560)	1
2	Food Purchase	(862)		60									(802)	2
3	Housekeeping			21			206						227	3
4	Laundry													4
5	Heat and Other Utilities	(11,686)					440						(11,247)	5
6	Maintenance	(8,634)		1,091	(11,778)		700						(18,622)	6
7	Other (specify):*			114	1,427								1,541	7
8	TOTAL General Services	(21,182)		1,286	(20,911)		1,345						(39,462)	8
	B. Health Care and Programs													
9	Medical Director			1,090									1,090	9
10	Nursing and Medical Records			2,834	(51,537)		41						(48,663)	10
10a	Therapy													10a
11	Activities			12									12	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			315	4,226								4,541	15
16	TOTAL Health Care and Programs			4,250	(47,311)		41						(43,020)	16
	C. General Administration													
17	Administrative			(251,315)									(251,315)	17
18	Directors Fees													18
19	Professional Services	(3,264)		30,834	1,643	(187,461)	802	(4,581)	(639)				(162,666)	19
20	Fees, Subscriptions & Promotions	(17,953)		2,768	20	312	3						(14,850)	20
21	Clerical & General Office Expenses	(245,510)		20,729	302	67,108	641						(156,730)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			168	101	31							300	24
25	Other Admin. Staff Transportation			903	8								911	25
26	Insurance-Prop.Liab.Malpractice			371									371	26
27	Other (specify):*			5,361		8,196							13,557	27
28	TOTAL General Administration	(266,727)		(190,181)	2,074	(111,814)	1,446	(4,581)	(639)				(570,422)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(287,909)		(184,644)	(66,148)	(111,814)	2,832	(4,581)	(639)				(652,904)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Marseilles # 0054759 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	(21,275)		744	128	132	5,985						(14,286)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(152)		12,063			1,493						13,404	32
33	Real Estate Taxes	(19,045)					1,169						(17,876)	33
34	Rent-Facility & Grounds			167			(11,891)						(11,724)	34
35	Rent-Equipment & Vehicles			763		177	547						1,487	35
36	Other (specify):*	(1,770)											(1,770)	36
37	TOTAL Ownership	(42,243)		13,737	128	309	(2,696)						(30,765)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(67,553)			(67,553)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(13,734)											(13,734)	43
44	TOTAL Special Cost Centers	(13,734)								(67,553)			(81,287)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(343,886)		(170,907)	(66,020)	(111,505)	136	(4,581)	(639)	(67,553)			(764,956)	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

X NO

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

1		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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number

Aperion Care Marseilles

0054759

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Delta Trust	15.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	David Bekowitz Delta Trust	15.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	David A. Berkowitz Revocable Trust	30.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Steven Turofsky	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Frederick S. Frankel Trust	1.50%	Aperion Care Demotte	Demotte,IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Naftali Wilhelm	1.50%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jennifer Spector	1.50%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9	257 Limited Partnership	1.34%	Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10	1219 Limited Partnership	1.33%	Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11	42170 Limited Partnership	1.33%	Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consutling	11
12			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	18
19			Aperion Care Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	19
20			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	20
21			Aperion Care Morton Villa	Morton				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.		\$ 60	\$ 60	15
16	V	3	Housekeeping		Aperion Care, Inc.		21	21	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,027	1,027	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		64	64	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		114	114	19
20	V	9	Medical Director		Aperion Care, Inc.		1,090	1,090	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,834	2,834	21
22	V	11	Activities		Aperion Care, Inc.		12	12	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		315	315	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		27,145	27,145	24
25	V	19	Professional Fees		Aperion Care, Inc.		4,869	4,869	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,768	2,768	26
27	V	21	Clerical Salary		Aperion Care, Inc.		19,970	19,970	27
28	V	21	Clerical & General		Aperion Care, Inc.		760	760	28
29	V	24	Seminars		Aperion Care, Inc.		168	168	29
30	V	25	Auto & Travel		Aperion Care, Inc.		903	903	30
31	V	26	Insurance		Aperion Care, Inc.		371	371	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		5,361	5,361	32
33	V	30	Depreciaiton		Aperion Care, Inc.		744	744	33
34	V	32	Interest		Aperion Care, Inc.		12,063	12,063	34
35	V	34	Rent		Aperion Care, Inc.		167	167	35
36	V	35	Auto Lease		Aperion Care, Inc.		763	763	36
37	V	17	Management Fee	278,460	Aperion Care, Inc.			(278,460)	37
38	V	19	Home Office	(25,965)	Aperion Care, Inc.			25,965	38
39	Total			\$ 252,495			\$ 81,588	\$ * (170,907)	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		\$ 10,962	\$ 10,962	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,855	1,855	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		40	40	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,427	1,427	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		37,321	37,321	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		4,226	4,226	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,643	1,643	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		20	20	22
23	V	21	Clerical & General		Aperion Consulting, LLC		302	302	23
24	V	24	Seminars		Aperion Consulting, LLC		101	101	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		8	8	25
26	V	30	Depreciation		Aperion Consulting, LLC		128	128	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	88,224	Aperion Consulting, LLC			(88,224)	33
34	V	10	Behavioral Health	634	Aperion Consulting, LLC			(634)	34
35	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	35
36	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	36
37	V								37
38	V								38
39	Total			\$ 124,053			\$ 58,033	\$ * (66,020)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		2,095	\$ 2,095	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		312	312	16
17	V	21	Clerical & General		Aperion Financial, LLC		39,528	39,528	17
18	V	24	Seminars		Aperion Financial, LLC		31	31	18
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		4,791	4,791	19
20	V	30	Depreciaton		Aperion Financial, LLC		132	132	20
21	V	35	Equipment Rental		Aperion Financial, LLC		177	177	21
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		27,580	27,580	22
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		3,405	3,405	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	19	Home Office Expense	189,556	Aperion Financial, LLC			(189,556)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 189,556			\$ 78,051	\$ * (111,505)	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		\$ 440	\$ 440	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		700	700	16
17	V	3	Housekeeping		Chase Office, LLC		206	206	17
18	V	10	Medical Supplies		Chase Office, LLC		41	41	18
19	V	19	Professional Fees		Chase Office, LLC		802	802	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		641	641	21
22	V	30	Depreciation		Chase Office, LLC		5,985	5,985	22
23	V	32	Interest Expense		Chase Office, LLC		1,493	1,493	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,169	1,169	24
25	V	35	Equipment Rental		Chase Office, LLC		547	547	25
26	V	34	Rent	12,000	Chase Office, LLC		109	(11,891)	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			\$ 12,000			\$ 12,136	\$ * 136	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	\$ 19,994	ProPay HR LLC		\$ 15,413	\$ (4,581)	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			\$ 19,994			\$ 15,413	\$ * (4,581)	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	Therapy Services	\$ 442,326	Renewal Rehab, LLC		\$ 374,773	\$ (67,553)	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			\$ 442,326			\$ 374,773	\$ * (67,553)	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	\$ 34,042	Aperion Incorporated Cell		\$ 34,042	\$	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			\$ 34,042			\$ 34,042	\$ *	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	Dialysis	\$ 96,770	Concerto Dialysis		\$ 96,770	\$	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			\$ 96,770			\$ 96,770	\$ *	39

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

Facility Name & ID Number Aperion Care Marseilles # 0054759 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		See Attached	0.51	1.27%	Alloc. Salary	\$ 3,186	17-7	1
2	David Berkowitz	Relative	Administrative		See Attached	0.51	1.27%	Alloc. Salary	1,465	17-7	2
3	Jay Meysel	Relative	Clerical		See Attached	0.51	1.27%	Alloc. Salary	750	21-7	3
4	Elisheva Adest	Relative	Clerical		See Attached	0.35	1.27%	Alloc. Salary	395	21-7	4
5	Fred Frankel	Relative	Administrative		See Attached	0.51	1.27%	Alloc. Salary	3,186	17-7	5
6	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.51	1.27%	Alloc. Salary	3,186	17-7	6
7	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.51	1.27%	Alloc. Salary	2,899	21-7	7
8	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.51	1.27%	Alloc. Salary	1,517	21-7	8
9	Dovid Spector	Relative	Clerical		See Attached	0.51	1.27%	Alloc. Salary	1,051	21-7	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	\$ 17,635		13

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

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

Facility Name & ID Number Aperion Care Marseilles# 0054759

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	\$	24,217	\$ 60	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		24,217	21	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	24,217	1,027	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		24,217	64	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		24,217	114	5
6	9	Medical Director	Census/Direct Cost	65	85,500		24,217	1,090	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	24,217	2,834	7
8	11	Activities	Census/Direct Cost	65	912		24,217	12	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		24,217	315	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	24,217	27,145	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		24,217	4,869	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		24,217	2,768	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	24,217	19,970	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		24,217	760	14
15	24	Seminars	Census/Direct Cost	65	13,215		24,217	168	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		24,217	903	16
17	26	Insurance	Census/Direct Cost	65	29,094		24,217	371	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		24,217	5,361	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		24,217	744	19
20	32	Interest	Census/Direct Cost	65	946,429		24,217	12,063	20
21	34	Rent	Census/Direct Cost	65	13,110		24,217	167	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		24,217	763	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 81,588	25

Ending: 12/31/20

()

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

(847) 410-9720

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2							\$		\$			\$	2
3							\$		\$			\$	3
4							\$		\$			\$	4
5							\$		\$			\$	5
	Working Capital												
6	Congressional Bank	X						-				52,144	6
7	Insurance Policies	X						-				445	7
8													8
9	TOTAL Facility Related						\$		\$			\$ 52,588	9
	B. Non-Facility Related*												
10	Interest Income	X										(152)	10
11	Alloc. Aperion Care Inc.	X										12,063	11
12	Alloc. Chase Office LLC	X										1,493	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ 13,404	14
15	TOTALS (line 9+line14)						\$		\$			\$ 65,992	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	49,720	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.)				\$	48,706	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,014)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	47,537	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.				\$	46,523	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	49,606	8		
		2016	49,048	9		
		2017	49,518	10		
		2018	49,720	11		
		2019	47,537	12		
2020 Accrual = 2019 Tax						
Allocated from Chase Office LLC \$1169						

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 Marseilles COUNTY Lasalle
FACILITY IDPH LICENSE NUMBER 0054759
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 Marseilles COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0054759

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:

26,830

B. General Construction Type:

ExteriorBrick

FrameMasonry

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	Allocated from Chase Office			\$752	1
2					2
3	TOTALS			\$752	3

Facility Name & ID Number **Aperion Care Marseilles**

0054759

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Marseilles

0054759

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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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)								67
68	Related Party Allocations (Pages 12H & 12I)		46,773	3,301		2,174	(1,127)	9,258	68
69	Financial Statement Depreciation			40,585			(40,585)		69
70	TOTAL (lines 4 thru 69)		\$ 46,773	\$ 43,886		\$ 2,174	\$ (41,712)	\$ 9,258	70

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

Facility Name & ID Number Aperion Care Marseilles

0054759

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		\$ 46,773	\$ 43,886		\$ 2,174	\$ (41,712)	\$ 9,258	1
2	80 Gallon Bradford & White Water Heater	2018	7,040		20	352	352	1,027	2
3	5 Ton Condensor Unit	2018	4,250		20	213	213	567	3
4	Signs For Front Of Building	2018	4,738		20	237	237	592	4
5	Replaced Sewer From Hallway To Kitchen	2018	8,000		20	400	400	867	5
6	Pipe / Sewer Repair	2018	3,300		20	165	165	358	6
7	Construction Of New Dialysis Room-Walls/Plumbing/Electrical/D	2019	71,100		20	3,555	3,555	7,110	7
8	Replace Sewer Pipes Under Hallway	2019	21,867		20	1,093	1,093	2,186	8
9	Outlets, Receptacles & Wiring From Panel For Parking Lights &	2019	5,965		20	298	298	596	9
10	Replace/Insulate Kitchen Wall, Counter & Backsplash, Floor Tile	2019	17,747		20	887	887	1,774	10
11	4 A/C 25000 Btu	2019	3,069		20	153	153	460	11
12	Hvac Compressor Replacement	2019	3,182		20	159	159	318	12
13	Walk-In Cooler / Freezer (43,900)	2019	41,827		20	2,195	2,195	2,195	13
14	64 Channel Camera Monitor	2020	16,944		20	847	847	847	14
15	Water Heater Replacement (6,628)	2020	6,337		20	331	331	331	15
16	New Water Softener Tank (7,439)	2020	7,065		20	372	372	372	16
17	New Plumbing Mixing Valve For Hot Water Heater (5,596)	2020	4,850		20	280	280	280	17
18	Install Exterior Doors, New Rim, Panic & Lever Trim	2020	15,316		20	766	766	766	18
19	Replace Gutters, Aluminum Fascia, Soffit & Wood - South (7,000)	2020	6,336		20	350	350	350	19
20	New Kitchen Water Heater (8,500)	2020	8,127		20	425	425	425	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)		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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 12C, Carried Forward		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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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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)		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 303,833	\$ 43,886		\$ 15,252	\$ (28,634)	\$ 30,679	34

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

Facility Name & ID Number Aperion Care Marseilles

0054759

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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
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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	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	6,767	174	20	174		766	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Aperion Care	2010	380	61	20	19	(42)	190	9
10 Allocated from Aperion Care	2012	108	8	20	5	(3)	43	10
11 Allocated from Aperion Care	2013	46	6	20	2	(4)	16	11
12								12
13 Allocated from Chase Office LLC	2020	135		20	7	7	7	13
14 Allocated from Chase Office LLC	2019	3,446	156	20	172	16	345	14
15 Allocated from Chase Office LLC	2018	31	2	20	2	(0)	5	15
16 Allocated from Chase Office LLC	2017	1,566	383	20	78	(305)	313	16
17 Allocated from Chase Office LLC	2016	34,295	2,511	20	1,715	(796)	7,573	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)		\$ 46,773	\$ 3,301		\$ 2,174	\$ (1,127)	\$ 9,258	34

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

Facility Name & ID Number Aperion Care Marseilles

0054759

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 46,773	\$ 3,301		\$ 2,174	\$ (1,127)	\$ 9,258	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)		\$ 46,773	\$ 3,301		\$ 2,174	\$ (1,127)	\$ 9,258	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	\$ 64,649	\$ 3,545	\$ 6,515	\$ 2,971	10	\$ 20,479	71
72	Current Year Purchases	12,999	22	1,302	1,279	10	1,302	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 77,648	\$ 3,567	\$ 7,817	\$ 4,250		\$ 21,780	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		2014 Champion Challenger Bus	2019	\$ 13,406	\$	\$ 2,681	\$ 2,681	5	\$ 5,362
77		Alloc from Aperion Care Inc.	2020	2,745	121	549	428	5	1,375
78									
79									
80	TOTALS			\$ 16,151	\$ 121	\$ 3,230	\$ 3,109		\$ 6,737

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)			\$	398,384
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	47,574
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	26,299
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(21,275)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	59,196

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	Furniture/Art/Window Treatm	\$ 3,300
93	Renovation	8,769
94		
95		\$ 12,069

* 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: American Realty Cap Healthcare Trust Inc.

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:	1967	103	11/1/2017	\$ 426,412			3
4	Additions							4
5	Allocated from Chase Office LLC				109			5
6	Allocated from Aperion Care Inc.				167			6
7	TOTAL		103		\$ 426,688			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: \$ 10,503 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc Aperion Care Inc.		\$	\$ 763	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 763	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12. /2021 \$

13. /2022 \$

14. /2023 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 195,137	\$		\$ 195,137	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			29,101			29,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			218,173			218,173	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				225,833		225,833	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					3,532	124,531		128,063	13
14	TOTAL			\$		\$ 445,943	\$ 350,364		\$ 796,307	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	\$ 353,976	\$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,064,590		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,606		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	63,082		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,545,254	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	252,030		15
16	Equipment, at Historical Cost	95,553		16
17	Accumulated Depreciation (book methods)	(71,380)		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): <u>See Attached</u>	91,659		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 367,862	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,913,116	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 280,979	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,086		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,303		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,537		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	656,073		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,215,978	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	840,626		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 840,626	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,056,604	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (143,488)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,913,116	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (819,748)	1
2	Restatements (describe):		2
3	Bad debt	(15,678)	3
4	Rounding	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (835,425)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	691,937	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)	\$ 691,937	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)	\$ (143,488)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Marseilles# 0054759

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	\$ 5,284,699	1
2	Discounts and Allowances for all Levels	1,098,724	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,383,423	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,959	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 139,959	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	730	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,644	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4	19
20	Radiology and X-Ray	3,903	20
21	Other Medical Services	16,400	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,681	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	152	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 152	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	525,430	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 525,430	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,072,645	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	836,432	31
32	Health Care	2,423,545	32
33	General Administration	1,524,826	33
	B. Capital Expense		
34	Ownership	607,534	34
	C. Ancillary Expense		
35	Special Cost Centers	810,041	35
36	Provider Participation Fee	178,330	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,380,708	40
41	Income before Income Taxes (line 30 minus line 40)**	691,937	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 691,937	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 930,622	44
45	Private Pay - Net Inpatient Revenue	120,380	45
46	Medicare - Net Inpatient Revenue	2,550,964	46
47	Other-(specify) <u>Insurance</u>	279,142	47
48	Other-(specify) <u>Managed Care</u>	2,502,315	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,383,423	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	1,015	1,067	\$ 41,061	\$ 38.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,963	18,120	670,152	36.98	3
4	Licensed Practical Nurses	4,633	4,872	152,007	31.20	4
5	CNAs & Orderlies	47,390	50,388	923,884	18.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,959	2,087	39,757	19.05	9
10	Activity Assistants	6,198	6,824	78,090	11.44	10
11	Social Service Workers	1,920	2,072	37,391	18.05	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,083	41,307	19.83	13
14	Head Cook	3,755	4,178	56,966	13.63	14
15	Cook Helpers/Assistants	8,541	9,144	99,859	10.92	15
16	Dishwashers					16
17	Maintenance Workers	1,768	1,800	53,629	29.79	17
18	Housekeepers	7,921	8,416	94,870	11.27	18
19	Laundry	2,192	2,248	32,314	14.37	19
20	Administrator	1,680	1,805	92,033	50.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,968	2,080	42,685	20.52	23
24	Clerical	1,970	2,130	39,000	18.31	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	1,498	1,621	22,876	14.11	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	465	469	7,681	16.38	33
34	TOTAL (lines 1 - 33)	113,771	121,404	\$ 2,525,562 *	\$ 20.80	34

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

** See instructions.

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	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	88,224	10-03	38
39	Pharmacist Consultant	Per Unit	10,841	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	130	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	402	11-03	44
45	Social Service Consultant	94	6,164	12-03	45
46	Other(specify)				46
47	Memory Care/Psych Consultant	Monthly	4,886	10-03	47
48	Behavioral Health Consultant	Monthly	634	10-03	48
49	TOTAL (lines 35 - 48)	94	\$ 144,803		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	856	\$ 87,103	10-03	50
51	Licensed Practical Nurses	50	3,000	10-03	51
52	Certified Nurse Assistants/Aides	1,812	60,953	10-03	52
53	TOTAL (lines 50 - 52)	2,718	\$ 151,056		53

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	
Brandy Cooper	Administrator	0	\$ 17,560	Workers' Compensation Insurance	\$	54,038	IDPH License Fee	\$ 3,980	
Brandi Ann Melton	Administrator	0	58,767	Unemployment Compensation Insurance		11,232	Advertising: Employee Recruitment	3,463	
Carylon Progress	Administrator	0	14,206	FICA Taxes		193,205	Health Care Worker Background Check		
Jennifer Diaz	Admin Training	0	1,500	Employee Health Insurance		61,075	(Indicate # of checks performed 47)	472	
				Employee Meals		3,119	Patient Background Checks	129	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	12,574	
				401K Expense		165	Licenses & Fees	1,408	
				Employee Physicals		1,417			
				Other Employee Benefits		21,427			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									
						</			

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0054759

Report Period Beginning:

01/01/20

Ending: 12/31/20

Page 22

12/31/20

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$16,359
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,822 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 178,330
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,119 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 730
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.