

		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>0049858</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Midlothian</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>3249 West 147th St</u> <u>Midlothian</u> <u>60445</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(708) 389-3141</u> Fax # <u>(773) 396-1626</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>1/1/2008</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ 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: _____																									

Facility Name & ID Number

Aperion Care Midlothian

#

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,568	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,738	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,306	7

B. Census-For the entire report period.

	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	348	18	683	1,049	8
9	SNF/PED					9
10	ICF	29,997	428	111	30,536	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,345	446	794	31,585	14

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

94.83%

D. How many bed reserve days during this year were paid by the Department?

None

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

01/01/2008

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

01/01/2008

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

48

and days of care provided

461

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/20

Fiscal Year:

12/31/20

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

Facility Name & ID Number Aperion Care Midlothian # 0049858 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	228,210	18,860	21,522	268,592		268,592	(7,224)	261,368			1
2	Food Purchase		166,958		166,958		166,958	(596)	166,362			2
3	Housekeeping	131,497	54,761		186,258		186,258	296	186,554			3
4	Laundry		7,555	59,134	66,689		66,689	0	66,689			4
5	Heat and Other Utilities			73,666	73,666		73,666	(7,117)	66,549			5
6	Maintenance	45,575	29,344	80,343	155,262		155,262	(5,007)	150,255			6
7	Other (specify):*							2,010	2,010			7
8	TOTAL General Services	405,282	277,478	234,665	917,425		917,425	(17,637)	899,788			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	1,421	13,421			9
10	Nursing and Medical Records	1,569,570	125,870	91,104	1,786,544		1,786,544	(24,636)	1,761,908			10
10a	Therapy	138,888	1,657		140,545		140,545		140,545			10a
11	Activities	62,288	3,801	1,400	67,489		67,489	15	67,504			11
12	Social Services	177,949		15,987	193,936		193,936		193,936			12
13	CNA Training											13
14	Program Transportation			2,388	2,388		2,388		2,388			14
15	Other (specify):*							5,922	5,922			15
16	TOTAL Health Care and Programs	1,948,695	131,328	122,879	2,202,902		2,202,902	(17,278)	2,185,624			16
	C. General Administration											
17	Administrative	115,224		305,559	420,783		420,783	(270,156)	150,627			17
18	Directors Fees											18
19	Professional Services			363,799	363,799	(23,630)	340,169	(204,374)	135,795			19
20	Dues, Fees, Subscriptions & Promotions			49,020	49,020		49,020	(14,552)	34,468			20
21	Clerical & General Office Expenses	48,987		111,511	160,498		160,498	28,422	188,920			21
22	Employee Benefits & Payroll Taxes			451,570	451,570		451,570		451,570			22
23	Inservice Training & Education											23
24	Travel and Seminar			779	779		779	391	1,170			24
25	Other Admin. Staff Transportation			1,010	1,010		1,010	1,187	2,197			25
26	Insurance-Prop.Liab.Malpractice			389,900	389,900		389,900	484	390,384			26
27	Other (specify):*							17,683	17,683			27
28	TOTAL General Administration	164,211		1,673,148	1,837,359	(23,630)	1,813,729	(440,915)	1,372,814			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,518,188	408,806	2,030,692	4,957,686	(23,630)	4,934,056	(475,830)	4,458,226			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			83,927	83,927		83,927	90,571	174,498			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,648	52,648		52,648	274,062	326,710			32
33	Real Estate Taxes			154,251	154,251	23,630	177,881	1,525	179,406			33
34	Rent-Facility & Grounds			406,000	406,000		406,000	(405,640)	360			34
35	Rent-Equipment & Vehicles			14,972	14,972		14,972	1,939	16,911			35
36	Other (specify):*			5,545	5,545		5,545	(5,545)	(0)			36
37	TOTAL Ownership			717,343	717,343	23,630	740,973	(43,088)	697,885			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,116	266,977	295,093		295,093	(59,647)	235,446			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			237,633	237,633		237,633		237,633			42
43	Other (specify):*			308	308		308	(308)				43
44	TOTAL Special Cost Centers		28,116	504,918	533,034		533,034	(59,955)	473,079			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,518,188	436,922	3,252,953	6,208,063		6,208,063	(578,873)	5,629,190			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	(7,690)	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	(22,701)	30		9
10	Interest and Other Investment Income	(4,801)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	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	(1,673)	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	(57,629)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,558)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(408,530)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (525,106)		\$	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)	(53,767)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (53,767)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (578,873)		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	\$ (12,174)	19	1
2	Bank Charges	(14,475)	21	2
3	Theft & Damage Loss	(129)	21	3
4	Supplemental Insurance	(208)	21	4
5	Credit Card Processing	(1,669)	21	5
6	Advertising/Marketing	(308)	43	6
7	Medical Records Income	(22)	10	7
8	Amortization	(5,545)	36	8
9	Other Unclassified Income	(28)	21	9
10	Vending Commissions	(650)	02	10
11	Additional R&M	3,860	06	11
12	PAC Dues	(8,099)	20	12
13	Bldg Co - Accounting & Legal Fees	(6,628)	19	13
14	Bldg Co - Amortization	(11,247)	36	14
15	Bldg Co - Bad Debt	(126,182)	21	15
16	Bldg Co - IL Replacement Tax	(42)	21	16
17	Bldg Co - Licenses & Permits	(475)	20	17
18	Prior Period Professional Fees	(532)	19	18
19	Bldg Co - Other Prof Fees	(4,923)	19	19
20	Bldg Co - SWAP Valuation	(207,054)	36	20
21	Bldg Co - Bookkeeping Fees	(12,000)	19	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	(408,530)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Midlothian # 0049858 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				(7,224)								(7,224)	1
2	Food Purchase	(674)		78									(596)	2
3	Housekeeping			28			268						296	3
4	Laundry									0			0	4
5	Heat and Other Utilities	(7,690)					573						(7,117)	5
6	Maintenance	3,860		1,422	(11,201)		912						(5,007)	6
7	Other (specify):*			149	1,861								2,010	7
8	TOTAL General Services	(4,504)		1,677	(16,564)		1,754			0			(17,637)	8
	B. Health Care and Programs													
9	Medical Director			1,421									1,421	9
10	Nursing and Medical Records	(22)		3,696	(28,364)		53						(24,636)	10
10a	Therapy													10a
11	Activities			15									15	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			411	5,511								5,922	15
16	TOTAL Health Care and Programs	(22)		5,543	(22,853)		53						(17,278)	16
	C. General Administration													
17	Administrative			(270,156)									(270,156)	17
18	Directors Fees													18
19	Professional Services	(36,257)	23,551	(5,214)	2,142	(185,055)	408	(3,949)					(204,374)	19
20	Fees, Subscriptions & Promotions	(19,074)	475	3,610	27	406	4						(14,552)	20
21	Clerical & General Office Expenses	(213,593)	126,224	27,036	394	87,525	836						28,422	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			220	131	40							391	24
25	Other Admin. Staff Transportation			1,177	10								1,187	25
26	Insurance-Prop.Liab.Malpractice			484									484	26
27	Other (specify):*			6,993		10,690							17,683	27
28	TOTAL General Administration	(268,924)	150,250	(235,850)	2,704	(86,394)	1,247	(3,949)					(440,915)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(273,450)	150,250	(228,630)	(36,713)	(86,394)	3,055	(3,949)		0			(475,830)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Midlothian # 0049858 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	(22,701)	104,157	970	167	172	7,806						90,571	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,801)	261,183	15,733			1,947						274,062	32
33	Real Estate Taxes						1,525						1,525	33
34	Rent-Facility & Grounds		(376,000)	218			(29,858)						(405,640)	34
35	Rent-Equipment & Vehicles			995		230	714						1,939	35
36	Other (specify):*	(223,846)	218,301										(5,545)	36
37	TOTAL Ownership	(251,348)	207,640	17,917	167	402	(17,866)						(43,088)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(40,770)		(18,877)		(59,647)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(308)											(308)	43
44	TOTAL Special Cost Centers	(308)							(40,770)		(18,877)		(59,955)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(525,106)	357,890	(210,713)	(36,546)	(85,992)	(14,811)	(3,949)	(40,770)	0	(18,877)		(578,873)	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 376,000	Plaza Nursing Realty LLC		\$	(376,000)	1
2	V	33	Real Estate Taxes	154,250	Plaza Nursing Realty LLC		154,250		2
3	V	19	Other Professional		Plaza Nursing Realty LLC		4,923	4,923	3
4	V	19	Accounting & Legal Fees		Plaza Nursing Realty LLC		6,628	6,628	4
5	V	36	Amortization Expense		Plaza Nursing Realty LLC		11,247	11,247	5
6	V	21	Bad Debt		Plaza Nursing Realty LLC		126,182	126,182	6
7	V	19	Bookeeping Fees - Aperion		Plaza Nursing Realty LLC		12,000	12,000	7
8	V	36	Change in SWAP Valuation		Plaza Nursing Realty LLC		207,054	207,054	8
9	V	30	Depreciation Expense		Plaza Nursing Realty LLC		104,157	104,157	9
10	V	21	IL Replacement Tax		Plaza Nursing Realty LLC		42	42	10
11	V	32	Interest	5	Plaza Nursing Realty LLC		261,188	261,183	11
12	V	20	Licenses & Permits		Plaza Nursing Realty LLC		475	475	12
13	V								13
14	Total			\$ 530,255			\$ 888,145	\$ * 357,890	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 A. Berkowitz Revocable Trust	43.00 %	Aperion Care Bradley	Bradley	Plaza Nursing Realty LLC	Midlothian	Building Co.	1
2	Declaration of Trust of Yosef Meystel	50.00 %	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Rita Lowinger	7.00 %	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4			Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5			Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Mascoutah	Mascoutah	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.		\$ 78	\$ 78	15
16	V	3	Housekeeping		Aperion Care, Inc.		28	28	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,339	1,339	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		83	83	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		149	149	19
20	V	9	Medical Director		Aperion Care, Inc.		1,421	1,421	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		3,696	3,696	21
22	V	11	Activities		Aperion Care, Inc.		15	15	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		411	411	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		35,404	35,404	24
25	V	19	Professional Fees		Aperion Care, Inc.		6,350	6,350	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,610	3,610	26
27	V	21	Clerical Salary		Aperion Care, Inc.		26,045	26,045	27
28	V	21	Clerical & General		Aperion Care, Inc.		991	991	28
29	V	24	Seminars		Aperion Care, Inc.		220	220	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,177	1,177	30
31	V	26	Insurance		Aperion Care, Inc.		484	484	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		6,993	6,993	32
33	V	30	Depreciaiton		Aperion Care, Inc.		970	970	33
34	V	32	Interest		Aperion Care, Inc.		15,733	15,733	34
35	V	34	Rent		Aperion Care, Inc.		218	218	35
36	V	35	Auto Lease		Aperion Care, Inc.		995	995	36
37	V	17	Management Fee	305,559	Aperion Care, Inc.			(305,559)	37
38	V	19	Home Office	11,564	Aperion Care, Inc.			(11,564)	38
39	Total			\$ 317,124			\$ 106,411	\$ * (210,713)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietician Salary - Illinois Only	\$	Aperion Consulting, LLC		\$ 14,298	\$ 14,298	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,420	2,420	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		52	52	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,861	1,861	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		48,676	48,676	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		5,511	5,511	20
21	V	19	Professional Fees		Aperion Consulting, LLC		2,142	2,142	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		27	27	22
23	V	21	Clerical & General		Aperion Consulting, LLC		394	394	23
24	V	24	Seminars		Aperion Consulting, LLC		131	131	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		10	10	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		167	167	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	73,551	Aperion Consulting, LLC			(73,551)	33
34	V	10	Behavioral Health	3,489	Aperion Consulting, LLC			(3,489)	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			\$ 112,235			\$ 75,689	\$ * (36,546)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		2,733	\$	2,733
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		406		406
17	V	21	Clerical & General		Aperion Financial, LLC		51,554		51,554
18	V	24	Seminars		Aperion Financial, LLC		40		40
19	V	25	Auto & Travel		Aperion Financial, LLC				
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		6,248		6,248
21	V	30	Depreciaton		Aperion Financial, LLC		172		172
22	V	32	Interest		Aperion Financial, LLC				
23	V	35	Equipment Rental		Aperion Financial, LLC		230		230
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		35,971		35,971
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,442		4,442
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V	19	Home Office Expense	187,788	Aperion Financial, LLC				(187,788)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 187,788			\$ 101,796	\$ *	(85,992)

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Chase Office, LLC		\$ 573	\$ 573	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		912	912	16
17	V	3	Housekeeping		Chase Office, LLC		268	268	17
18	V	10	Medical Supplies		Chase Office, LLC		53	53	18
19	V	19	Professional Fees		Chase Office, LLC		1,047	1,047	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		4	4	20
21	V	21	Office Expense		Chase Office, LLC		836	836	21
22	V	30	Depreciation		Chase Office, LLC		7,806	7,806	22
23	V	32	Interest Expense		Chase Office, LLC		1,947	1,947	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,525	1,525	24
25	V	35	Equipment Rental		Chase Office, LLC		714	714	25
26	V	34	Rent	30,000	Chase Office, LLC		142	(29,858)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Data Processing	4,200	EMSA PURCHASING GROUP		3,561	(639)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 34,200			\$ 19,389	\$ * (14,811)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 17,237	ProPay HR LLC		\$ 13,288	\$ (3,949)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 17,237			\$ 13,288	\$ * (3,949)	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	\$ 266,951	Renewal Rehab, LLC		\$ 226,181	\$ (40,770)	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			\$ 266,951			\$ 226,181	\$ * (40,770)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 59,134	EcoBrite Linen		\$ 59,134	\$ 0	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 59,134			\$ 59,134	\$ * 0	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	\$ 33,159	Lifescan Labs of Illinois		\$ 14,282	\$ (18,877)	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			\$ 33,159			\$ 14,282	\$ * (18,877)	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	\$ 284,882	Aperion Incorporated Cell		\$ 284,882	\$	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			\$ 284,882			\$ 284,882	\$ *	39

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

Facility Name & ID Number Aperion Care Midlothian # 0049858 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.66	1.66%	Alloc Sal	\$ 4,156	17-7	1
2	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.66	1.66%	Alloc Sal	1,910	17-7	2
3	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.66	1.66%	Alloc Sal	978	21-7	3
4	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.45	1.66%	Alloc Sal	515	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 7,559		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

Facility Name & ID Number Aperion Care Midlothian# 0049858

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	\$	31,585	\$ 78	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		31,585	28	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	31,585	1,339	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		31,585	83	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		31,585	149	5
6	9	Medical Director	Census/Direct Cost	65	85,500		31,585	1,421	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	31,585	3,696	7
8	11	Activities	Census/Direct Cost	65	912		31,585	15	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		31,585	411	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	31,585	35,404	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		31,585	6,350	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		31,585	3,610	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	31,585	26,045	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		31,585	991	14
15	24	Seminars	Census/Direct Cost	65	13,215		31,585	220	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		31,585	1,177	16
17	26	Insurance	Census/Direct Cost	65	29,094		31,585	484	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		31,585	6,993	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		31,585	970	19
20	32	Interest	Census/Direct Cost	65	946,429		31,585	15,733	20
21	34	Rent	Census/Direct Cost	65	13,110		31,585	218	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		31,585	995	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 106,411	25

Ending: 12/31/20

7

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Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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NO ☐

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Actual Census	1,899,996	65	\$ 34,497	\$	31,585	\$ 573	1
2	6	Repairs & Maintenance	Actual Census	1,899,996	65	54,886		31,585	912	2
3	3	Housekeeping	Actual Census	1,899,996	65	16,134		31,585	268	3
4	10	Medical Supplies	Actual Census	1,899,996	65	3,211		31,585	53	4
5	19	Professional Fees	Actual Census	1,899,996	65	62,958		31,585	1,047	5
6	20	Dues & Subscriptions	Actual Census	1,899,996	65	256		31,585	4	6
7	21	Office Expense	Actual Census	1,899,996	65	50,267		31,585	836	7
8	30	Depreciation	Actual Census	1,899,996	65	469,583		31,585	7,806	8
9	32	Interest Expense	Actual Census	1,899,996	65	117,136		31,585	1,947	9
10	33	Real Estate Taxes	Actual Census	1,899,996	65	91,748		31,585	1,525	10
11	35	Equipment Rental	Actual Census	1,899,996	65	8,550		31,585	714	11
12	34	Rent	Actual Census	1,899,996	65	42,922		31,585	142	12
13										13
14										14
15										15
16										16
17										17
18	19	Data Processing	Direct						3,561	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 952,148	\$		\$ 19,389	25

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

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Ending: 12/31/20

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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	ACI Equities		X	Mortgage			\$		\$ 4,573,034			\$ 261,188	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit					920,048			52,081	6
7	Insurance Policies		X									567	7
8													8
9	TOTAL Facility Related						\$		\$ 5,493,082			\$ 313,836	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,801)	10
11	Interest Income - Bldg Co		X									(5)	11
12	Allocated from Aperion Care Ir	X										15,733	12
13	Allocated from Chase Office	X										1,947	13
14	TOTAL Non-Facility Related						\$		\$			\$ 12,874	14
15	TOTALS (line 9+line14)						\$		\$ 5,493,082			\$ 326,710	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # 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.		\$	200,771	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.)				\$	178,946	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(21,825)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	177,600	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.)				\$	23,630	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>52,172</u> For <u>17-18</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	179,405	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	<u>165,106</u>	8		
		2016	<u>168,861</u>	9		
		2017	<u>193,505</u>	10		
		2018	<u>200,771</u>	11		
		2019	<u>177,421</u>	12		
2020 Accrual = 2019 Tax (rounded)						
Allocated from Chase Office \$1,525						

		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 Midlothian COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049858

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 Midlothian COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049858

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

B. **Real Estate Tax Cost Allocations**

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10B

A. Square Feet: **19,780**

B. General Construction Type: Exterior **Brick** Frame 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			\$ 383,883	1
2	Allocated from Chase Office LLC			981	2
3	TOTALS			\$ 384,864	3

[illegible]

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		61,004	4,305		2,835	(1,470)	12,075	68
69	Financial Statement Depreciation			83,927			(83,927)		69
70	TOTAL (lines 4 thru 69)		\$ 4,080,683	\$ 192,388		\$ 127,300	\$ (65,088)	\$ 821,004	70

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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		\$ 4,080,683	\$ 192,388		\$ 127,300	\$ (65,088)	\$ 821,004	1
2	New Pipes, Rewiring, Circuits & Panels Dining Room Area	2017	25,500		20	1,275	1,275	4,675	2
3	Electrical Upgreade In Living Room, Bathrooms, Hallways (15,400)	2017	14,675		20	734	734	2,691	3
4	New Panels In Electric Room (12,900)	2017	12,292		20	615	615	2,356	4
5	New Pipe; Break Concrete	2018	8,308		20	415	415	1,003	5
6	Alarm Repair-New Notifier 640 Panel With Xp6 Zone Monitor Ca	2018	3,500		20	175	175	408	6
7	New Lighting And Electrical	2018	7,610		20	381	381	920	7
8	New Lighting And Electrical - Replace Defective Outlets	2018	4,095		20	205	205	495	8
9	Window Treatments In Residents Rooms, Dining Room, Sunroom	2019	25,250		20	1,263	1,263	2,526	9
10	Replace Roof & Reconstruct Chimney With Flashing & Saddle	2019	2,681		20	134	134	268	10
11	Replace Roof With Ice & Water Shield, Shw Shingle & Lead Flas	2019	2,805		20	140	140	280	11
12	Six Thru The Wall Airconditioners	2019	3,841		20	192	192	384	12
13	Condensing Unit Replacement With Connection Upgrades	2019	3,853		20	193	193	386	13
14	New Fire Sprinkler Accelerator (5,650)	2020	5,277		20	264	264	264	14
15	Cubicle Curtains With Antimicrobial White Mesh (19,110)	2020	11,185		20	559	559	559	15
16	New Cabinets For Nurses Stations (18,750)	2020	10,974		20	549	549	549	16
17	Turret & Dome Security Cameras, With Dvr And Monitors (12,960)	2020	11,973		20	599	599	599	17
18	Paving And Extension Of Parking Lot (66,665)	2020	63,555		20	3,178	3,178	3,178	18
19	New Walk-In Freezer Combo (54,045)	2020	51,308		20	2,565	2,565	2,565	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)		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,349,364	\$ 192,388		\$ 140,736	\$ (51,653)	\$ 845,109	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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
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.

Facility Name & ID Number Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

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

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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	8,825	226	20	226		999	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	495	80	20	25	(55)	248	9
10	Allocated from Aperion Care	2012	140	11	20	7	(4)	56	10
11	Allocated from Aperion Care	2013	60	8	20	3	(5)	21	11
12									12
13	Allocated from Chase Office LLC	2020	176		20	9	9	9	13
14	Allocated from Chase Office LLC	2019	4,495	204	20	225	21	449	14
15	Allocated from Chase Office LLC	2018	40	2	20	2	(0)	6	15
16	Allocated from Chase Office LLC	2017	2,043	499	20	102	(397)	409	16
17	Allocated from Chase Office LLC	2016	44,729	3,275	20	2,236	(1,038)	9,878	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)		\$ 61,004	\$ 4,305		\$ 2,835	\$ (1,470)	\$ 12,075	34

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

Facility Name & ID Number Aperion Care Midlothian

0049858

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		\$ 61,004	\$ 4,305		\$ 2,835	\$ (1,470)	\$ 12,075	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 61,004	\$ 4,305		\$ 2,835	\$ (1,470)	\$ 12,075	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	\$ 329,366	\$ 4,623	\$ 33,000	\$ 28,377	10	\$ 144,679	71
72	Current Year Purchases	431	29	45	16	10	45	72
73	Fully Depreciated Assets	57,655				10	57,655	73
74								74
75	TOTALS	\$ 387,452	\$ 4,652	\$ 33,045	\$ 28,393		\$ 202,379	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		2009 GMC SAVANA	2011	\$ 23,542	\$	\$	\$	5	\$ 23,542
77		Allocated from Aperion Care	2020	3,580	158	716	558	5	1,793
78									
79									
80	TOTALS			\$ 27,122	\$ 158	\$ 716	\$ 558		\$ 25,335

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)			\$	5,148,802
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	197,198
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	174,497
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(22,701)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,072,824

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	Shower & Tubs Renovation	\$ 5,100
93	Construction, plumbing, ceilings	22,568
94		
95		\$ 27,668

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Aperion Care Inc				218			5
6	Allocated from Chase Office				142			6
7	TOTAL				\$360			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: \$15,916
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care Inc		\$	\$995	17
18					18
19					19
20					20
21	TOTAL		\$	\$995	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 114,427	\$		\$ 114,427	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,863			13,863	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			138,687			138,687	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				26,287		26,287	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached						1,829		1,829	13
14	TOTAL			\$		\$ 266,977	\$ 28,116		\$ 295,093	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 443,161	\$ 589,978	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	460,349	460,349	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,827	61,827	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	15,731	15,731	8
9	Other(specify): See Attached	5,917	72,784	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 986,985	\$ 1,200,669	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		575,825	13
14	Buildings, at Historical Cost		3,263,006	14
15	Leasehold Improvements, at Historical Cost	884,203	884,203	15
16	Equipment, at Historical Cost	231,822	457,636	16
17	Accumulated Depreciation (book methods)	(715,833)	(1,184,537)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	4,461,649	4,523,803	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,861,841	\$ 8,519,936	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,848,826	\$ 9,720,605	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 466,295	\$ 466,297	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	920,048	920,048	29
30	Accrued Salaries Payable	155,617	155,617	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,589	6,589	31
32	Accrued Real Estate Taxes(Sch.IX-B)		177,600	32
33	Accrued Interest Payable	2,585	25,870	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	883,294	1,144,967	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,434,428	\$ 2,896,988	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,573,034	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	696,222		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 696,222	\$ 4,573,034	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,130,650	\$ 7,470,022	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,718,176	\$ 2,250,583	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,848,826	\$ 9,720,605	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,884,008	1
2	Restatements (describe):		2
3	Bad Debt	79,681	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,963,689	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	769,487	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	(15,000)	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)	\$ 754,487	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)	\$ 2,718,176	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Midlothian# 0049858Report 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	\$ 7,842,742	1
2	Discounts and Allowances for all Levels	(1,295,996)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,546,746	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,680	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 94,680	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	3,485	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,957	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,442	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,801	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,801	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	325,881	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 325,881	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,977,550	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	917,425	31
32	Health Care	2,202,902	32
33	General Administration	1,837,359	33
	B. Capital Expense		
34	Ownership	717,343	34
	C. Ancillary Expense		
35	Special Cost Centers	295,401	35
36	Provider Participation Fee	237,633	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,208,063	40
41	Income before Income Taxes (line 30 minus line 40)**	769,487	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 769,487	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 748,280	44
45	Private Pay - Net Inpatient Revenue	112,000	45
46	Medicare - Net Inpatient Revenue	283,780	46
47	Other-(specify) <u>Insurance</u>	64,175	47
48	Other-(specify) <u>Managed Care/PPHP/ISNP</u>	5,338,511	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,546,746	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	964	1,040	\$ 47,201	\$ 45.39	1
2	Assistant Director of Nursing	643	696	23,316	33.48	2
3	Registered Nurses	4,435	4,884	182,272	37.32	3
4	Licensed Practical Nurses	17,334	19,562	605,132	30.93	4
5	CNAs & Orderlies	35,090	39,926	678,086	16.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,485	6,037	138,888	23.01	8
9	Activity Director	2,032	2,084	34,856	16.73	9
10	Activity Assistants	1,787	1,831	27,432	14.98	10
11	Social Service Workers	7,380	7,949	177,949	22.39	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,080	44,596	21.44	13
14	Head Cook	5,630	6,046	99,503	16.46	14
15	Cook Helpers/Assistants	5,274	5,657	84,111	14.87	15
16	Dishwashers					16
17	Maintenance Workers	1,816	1,979	45,575	23.03	17
18	Housekeepers	7,893	8,694	131,497	15.13	18
19	Laundry					19
20	Administrator	2,028	2,288	115,224	50.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,436	3,598	48,987	13.62	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	1,800	1,869	33,563	17.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,058	116,220	\$ 2,518,188 *	\$ 21.67	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	73,551	10-03	38
39	Pharmacist Consultant	Monthly	14,064	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	23	1,400	11-03	44
45	Social Service Consultant	66	3,987	12-03	45
46	Other(specify) <u>Psychiatric MD</u>	Monthly	12,000	12-03	46
47	<u>Behavioral Health Consultant</u>	58	3,489	10-03	47
48					48
49	TOTAL (lines 35 - 48)	148	\$ 142,013		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Aperion Care Midlothian

0049858

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Leola Mixon	Administrator	0	\$ 115,224
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,224

B. Administrative - Other

Description	Amount
Aperion Care - Management Fees	\$ 305,559
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 305,559

C. Professional Services

Vendor/Payee	Type	Amount
Aperion Care, Inc.	Legal Settlement	\$ 100
Marcum LLP	Accounting	19,055
Aperion Care, Inc.	Home Office Expense	11,564
ProPay HR	Payroll Processing	17,237
Interbuild	Energy Procurement	954
GCHMO	Liaison Service	3,900
Personnel Planners	Unemployment Consultant	1,290
Skidelsky & Associates	Real Estate Assessment	23,630
Aperion Financial	Home Office Expense	187,788
NRC Health Solutions	Data Processing	2,103
See Attached	Legal	26,637
See Supplemental Schedule		69,541
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 363,799

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 83,860
Unemployment Compensation Insurance	31,293
FICA Taxes	192,641
Employee Health Insurance	81,795
Employee Meals	1,559
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	21,944
Employee Physicals	28,915
Employee Benefits - Other	6,410
Employee Benefit Other - Covid	3,153
TOTAL (agree to Schedule V, line 22, col.8)	\$ 451,570

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	10,150
Health Care Worker Background Check (Indicate # of checks performed 103)	1,034
Patient Background Checks 140	1,401
Dues & Subscriptions	11,451
Licenses & Fees	2,405
See Supplemental Schedule	4,047
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,468

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	779
See Supplemental Schedule	391
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,170

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Aperion Care Midlothian</u>	STATE OF ILLINOIS # <u>0049858</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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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 \$16,198

(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?
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. \$ 8,018 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. \$ 237,633
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. \$ 1,559 Has any meal income been offset against related costs? N/A Indicate the amount. \$

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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 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.