

		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: 0050500

Facility Name: Aperion Care Oak Lawn

Address: 9401 S Ridgeland Ave Oak Lawn 60453
Number City Zip Code

County: Cook

Telephone Number: (708) 449-9090 Fax # (708) 449-7070

HFS ID Number:

Date of Initial License for Current Owners: 11/23/2010

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
* Subject to the attached Accountants' Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

#	0050500	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 11/23/210

YES ☒ Date 11/23/10 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 134 and days of care provided

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED	☐	CASH*	☐
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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.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **84.79%**

84.79%

Facility Name & ID Number Aperion Care Oak Lawn # 0050500 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	312,569	34,534	21,522	368,625		368,625	(2,697)	365,928			1
2	Food Purchase		228,835		228,835		228,835	(1,170)	227,665			2
3	Housekeeping	184,038	76,456		260,494		260,494	390	260,884			3
4	Laundry	40,338	13,189	119,238	172,765		172,765		172,765			4
5	Heat and Other Utilities			129,181	129,181		129,181	(6,173)	123,008			5
6	Maintenance	43,006	17,294	88,759	149,059		149,059	(7,771)	141,288			6
7	Other (specify):*							2,646	2,646			7
8	TOTAL General Services	579,951	370,308	358,700	1,308,959		1,308,959	(14,775)	1,294,184			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000	1,871	37,871			9
10	Nursing and Medical Records	2,955,420	334,138	111,367	3,400,925		3,400,925	(25,525)	3,375,400			10
10a	Therapy	159,662	2,521	3,195	165,378		165,378		165,378			10a
11	Activities	138,654	5,802	2,618	147,074		147,074	20	147,094			11
12	Social Services	207,256		2,460	209,716		209,716		209,716			12
13	CNA Training											13
14	Program Transportation			5,305	5,305		5,305		5,305			14
15	Other (specify):*							7,798	7,798			15
16	TOTAL Health Care and Programs	3,460,992	342,461	160,945	3,964,398		3,964,398	(15,836)	3,948,562			16
	C. General Administration											
17	Administrative	84,491		493,853	578,344		578,344	(447,240)	131,104			17
18	Directors Fees											18
19	Professional Services			309,054	309,054	(8,500)	300,554	(108,218)	192,336			19
20	Dues, Fees, Subscriptions & Promotions			50,615	50,615		50,615	(16,124)	34,491			20
21	Clerical & General Office Expenses	212,999		264,183	477,182		477,182	(65,599)	411,583			21
22	Employee Benefits & Payroll Taxes			710,252	710,252		710,252		710,252			22
23	Inservice Training & Education											23
24	Travel and Seminar			695	695		695	515	1,210			24
25	Other Admin. Staff Transportation			652	652		652	1,564	2,216			25
26	Insurance-Prop.Liab.Malpractice			480,506	480,506		480,506	637	481,143			26
27	Other (specify):*							23,282	23,282			27
28	TOTAL General Administration	297,490		2,309,810	2,607,300	(8,500)	2,598,800	(611,183)	1,987,617			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,338,433	712,769	2,829,455	7,880,657	(8,500)	7,872,157	(641,794)	7,230,363			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			159,368	159,368		159,368	381,872	541,240			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,061	84,061		84,061	766,916	850,977			32
33	Real Estate Taxes			482,295	482,295	8,500	490,795	2,008	492,803			33
34	Rent-Facility & Grounds			1,010,000	1,010,000		1,010,000	(1,009,526)	474			34
35	Rent-Equipment & Vehicles			16,533	16,533		16,533	2,553	19,086			35
36	Other (specify):*			8,305	8,305		8,305	(8,305)	(0)			36
37	TOTAL Ownership			1,760,562	1,760,562	8,500	1,769,062	135,518	1,904,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		257,829	483,492	741,321		741,321	(85,639)	655,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			298,222	298,222		298,222		298,222			42
43	Other (specify):*			5,326	5,326		5,326	(5,326)	0			43
44	TOTAL Special Cost Centers		257,829	787,040	1,044,869		1,044,869	(90,965)	953,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,338,433	970,598	5,377,057	10,686,088		10,686,088	(597,240)	10,088,848			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	(6,928)	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	246,624	30		9
10	Interest and Other Investment Income	(13,354)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73)	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	(1,996)	21		18
19	Entertainment	(22)	21		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	(191,061)	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	(1,129,377)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,106,687)		\$	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)	509,447		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 509,447		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (597,240)		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			Sch. V Line	
	Amount	Reference		
1	Non-Allowable Legal	\$ (5,915)	19	1
2	Bank Charges	(17,519)	21	2
3	Theft & Damage Loss	(1,676)	21	3
4	Veterans Expense	(25,941)	10	4
5	Supplemental Insurance	(2,276)	21	5
6	Credit Card Processing	(1,616)	21	6
7	Marketing Expense	(3,078)	43	7
8	Promotional Products	(2,248)	43	8
9	Amortization	(8,305)	36	9
10	Other Unclassified Income	(26)	21	10
11	Vending Commissions	(1,200)	02	11
12	State Replacement Tax	(1,863)	21	12
13	Additional R&M	2,276	06	13
14	Capitalized R&M	(2,702)	06	14
15	PAC Dues	(10,953)	20	15
16	Prior Year Professional Fees	(1,282)	19	16
17	Bldg Co. - Accounting Fees	(6,438)	19	17
18	Bldg Co. - Amortization	(26,452)	36	18
19	Bldg Co. - Bad Debts	(365,714)	21	19
20	Bldg Co. - Bank Service Charges	(72)	21	20
21	Bldg Co. - Bookkeeping Fee	(12,000)	19	21
22	Bldg Co. - Change in SWAP Valuation	(600,105)	36	22
23	Bldg Co. - Legal Fees	(190)	19	23
24	Bldg Co. - Licenses and Fees	(475)	20	24
25	Bldg Co. - Loan Cost Expense	(28,686)	21	25
26	Bldg Co. - Other Professional	(4,923)	19	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	(1,129,377)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Oak Lawn # 0050500 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				(2,697)								(2,697)	1
2	Food Purchase	(1,273)		103									(1,170)	2
3	Housekeeping			36			353						390	3
4	Laundry													4
5	Heat and Other Utilities	(6,928)					755						(6,173)	5
6	Maintenance	(426)		1,873	(10,419)		1,201						(7,771)	6
7	Other (specify):*			196	2,450								2,646	7
8	TOTAL General Services	(8,627)		2,209	(10,666)		2,310						(14,775)	8
	B. Health Care and Programs													
9	Medical Director			1,871									1,871	9
10	Nursing and Medical Records	(25,941)		4,867	(4,522)		70						(25,525)	10
10a	Therapy													10a
11	Activities			20									20	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			542	7,256								7,798	15
16	TOTAL Health Care and Programs	(25,941)		7,300	2,734		70						(15,836)	16
	C. General Administration													
17	Administrative			(447,240)									(447,240)	17
18	Directors Fees													18
19	Professional Services	(30,747)	23,550	(107,372)	2,821	9,781	845		(7,095)				(108,218)	19
20	Fees, Subscriptions & Promotions	(21,928)	475	4,753	35	535	6						(16,124)	20
21	Clerical & General Office Expenses	(612,526)	394,472	35,597	519	115,239	1,100						(65,599)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			289	173	53							515	24
25	Other Admin. Staff Transportation			1,550	14								1,564	25
26	Insurance-Prop.Liab.Malpractice			637									637	26
27	Other (specify):*			9,207		14,075							23,282	27
28	TOTAL General Administration	(665,201)	418,497	(502,579)	3,562	139,683	1,951		(7,095)				(611,183)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(699,769)	418,497	(493,070)	(4,370)	139,683	4,331		(7,095)				(641,794)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Oak Lawn # 0050500 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	246,624	123,247	1,277	220	226	10,278						381,872	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,354)	756,991	20,715			2,564						766,916	32
33	Real Estate Taxes						2,008						2,008	33
34	Rent-Facility & Grounds		(980,000)	287			(29,813)						(1,009,526)	34
35	Rent-Equipment & Vehicles			1,311		303	939						2,553	35
36	Other (specify):*	(634,862)	626,557										(8,305)	36
37	TOTAL Ownership	(401,592)	526,796	23,590	220	529	(14,024)						135,518	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(11,674)	(73,965)		(85,639)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,326)											(5,326)	43
44	TOTAL Special Cost Centers	(5,326)								(11,674)	(73,965)		(90,965)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,106,687)	945,292	(469,480)	(4,150)	140,212	(9,693)		(7,095)	(11,674)	(73,965)		(597,240)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 980,000	CNR Realty		\$	(980,000)	1
2	V	33	Real Estate Taxes	482,295	CNR Realty		482,295		2
3	V	19	Accounting Fees		CNR Realty		6,438	6,438	3
4	V	36	Amortization		CNR Realty		26,452	26,452	4
5	V	21	Bank Charges		CNR Realty		72	72	5
6	V	30	Depreciation		CNR Realty		123,247	123,247	6
7	V	32	Interest	12	CNR Realty		757,003	756,991	7
8	V	20	Licenses and Fees		CNR Realty		475	475	8
9	V	21	Bad Debt		CNR Realty		365,714	365,714	9
10	V	19	Bookkeeping Fees		CNR Realty		12,000	12,000	10
11	V	19	Legal/Other Professional		CNR Realty		5,112	5,112	11
12	V	36	Change in SWAP Valuation		CNR Realty		600,105	600,105	12
13	V	21	Loan Cost Expense		CNR Realty		28,686	28,686	13
14	Total			\$ 1,462,307			\$ 2,407,599	\$ * 945,292	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DECLARATION OF TRUST OF YOSEF MEYSTEL	11.00 %	Legend Healthcare	Tonganoxie, KS	CNR Realty	Oak Lawn	Building Co.	1
2	DAVID BERKOWITZ REVOCABLE TRUST	23.50 %	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	2
3	JAY MEYSTEL TRUST	12.50 %	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	257 LIMITED PARTNERSHIP	4.00 %	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	1219 LIMITED PARTNERSHIP	2.00 %	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	5
6	42170 LIMITED PARTNERSHIP	2.00 %	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7	CONCORD SNF EQUITY PARTNERS, LLC	45.00 %	Aperion Care Demotte	Demotte,IN	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Marseilles	Marseilles	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Mascoutah	Mascoutah	San Antonio Property, LLC	San Antonio, TX	Building Co.	21
22			Aperion Care Midlothian	Midlothian				22
23			Aperion Care Morton Villa	Morton				23
24			Aperion Care Peoria Heights	Peoria Heights				24
25			Aperion Care Peru	Peru, IN				25
26			Aperion Care Plum Grove	Palatine				26
27			Aperion Care Princeton	Princeton				27
28			Aperion Care Spring Valley	Spring Valley				28
29			Aperion Care Springfield	Springfield				29
30			Aperion Care St. Elmo	St. Elmo				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 Tolleston Park	Gary, IN				1
2			Aperion Care Toluca	Toluca				2
3			Aperion Care West Chicago	Springfield				3
4			Aperin Care West Ridge	Chicago				4
5			Aperion Care Wilmington	Wilmington				5
6			Arbors at Michigan City	Michigan City, IN				6
7			Elevate Care Chicago North	Chicago				7
8			Elevate Care Irving Park	Chicago				8
9			Elevate Care Niles	Niles				9
10			Elevate Care North Branch	Niles				10
11			Elevate Care Northbrook	Northbrook				11
12			Elevate Care Riverwoods	Riverwoods				12
13			Elevate Care Waukegan	Waukegan				13
14			Arcadia of Bloomington	Bloomington				14
15			Arcadia of Danville	Danville				15
16			Arcadia of Clifton	Clifton				16
17			Glennon Place	Bolivar, MO				17
18			Hallmark Living Benton Harbor	Benton Harbo, MI				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.		\$ 103	\$ 103	15
16	V	3	Housekeeping		Aperion Care, Inc.		36	36	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,763	1,763	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		110	110	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		196	196	19
20	V	9	Medical Director		Aperion Care, Inc.		1,871	1,871	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		4,867	4,867	21
22	V	11	Activities		Aperion Care, Inc.		20	20	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		542	542	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		46,614	46,614	24
25	V	19	Professional Fees		Aperion Care, Inc.		8,361	8,361	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		4,753	4,753	26
27	V	21	Clerical Salary		Aperion Care, Inc.		34,292	34,292	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,305	1,305	28
29	V	24	Seminars		Aperion Care, Inc.		289	289	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,550	1,550	30
31	V	26	Insurance		Aperion Care, Inc.		637	637	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		9,207	9,207	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,277	1,277	33
34	V	32	Interest		Aperion Care, Inc.		20,715	20,715	34
35	V	34	Rent		Aperion Care, Inc.		287	287	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,311	1,311	36
37	V	17	Management Fee	493,853	Aperion Care, Inc.			(493,853)	37
38	V	19	Home Office	115,733	Aperion Care, Inc.			(115,733)	38
39	Total			\$ 609,586			\$ 140,106	\$ * (469,480)	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		\$ 18,825	\$ 18,825	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		3,186	3,186	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		68	68	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		2,450	2,450	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		64,088	64,088	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		7,256	7,256	20
21	V	19	Professional Fees		Aperion Consulting, LLC		2,821	2,821	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		35	35	22
23	V	21	Clerical & General		Aperion Consulting, LLC		519	519	23
24	V	24	Seminars		Aperion Consulting, LLC		173	173	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		14	14	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		220	220	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,975	Aperion Consulting, LLC			(67,975)	33
34	V	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			\$ 103,805			\$ 99,655	\$ * (4,150)	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		3,598	\$	3,598
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		535		535
17	V	21	Clerical & General		Aperion Financial, LLC		67,878		67,878
18	V	24	Seminars		Aperion Financial, LLC		53		53
19	V	25	Auto & Travel		Aperion Financial, LLC				
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		8,227		8,227
21	V	30	Depreciaton		Aperion Financial, LLC		226		226
22	V	32	Interest		Aperion Financial, LLC				
23	V	35	Equipment Rental		Aperion Financial, LLC		303		303
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		47,361		47,361
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		5,848		5,848
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V	19	Home Office Expense	(6,183)	Aperion Financial, LLC				6,183
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ (6,183)			\$ 134,029	\$ *	140,212

* 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		\$ 755	\$ 755	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,201	1,201	16
17	V	3	Housekeeping		Chase Office, LLC		353	353	17
18	V	10	Medical Supplies		Chase Office, LLC		70	70	18
19	V	19	Professional Fees		Chase Office, LLC		1,378	1,378	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		6	6	20
21	V	21	Office Expense		Chase Office, LLC		1,100	1,100	21
22	V	30	Depreciation		Chase Office, LLC		10,278	10,278	22
23	V	32	Interest Expense		Chase Office, LLC		2,564	2,564	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,008	2,008	24
25	V	35	Equipment Rental		Chase Office, LLC		939	939	25
26	V	34	Rent	30,000	Chase Office, LLC		187	(29,813)	26
27	V								27
28	V								28
29	V								29
30	V	19	Data Processing	3,500	EMSA Purchasing Group		2,967	(533)	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			\$ 33,500			\$ 23,807	\$ * (9,693)	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	04	Laundry Services	\$ 119,238	EcoBrite Linen		\$ 119,238	\$	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			\$ 119,238			\$ 119,238	\$ *	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	\$ 30,967	ProPay HR LLC		\$ 23,872	\$ (7,095)	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			\$ 30,967			\$ 23,872	\$ * (7,095)	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	\$ 20,506	Lifescan Labs of Illinois		\$ 8,832	\$ (11,674)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 20,506			\$ 8,832	\$ * (11,674)	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	\$ 484,312	Renewal Rehab, LLC		\$ 410,347	\$ (73,965)	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			\$ 484,312			\$ 410,347	\$ * (73,965)	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	\$ 431,814	Aperion Incorporated Cell		\$ 431,814	\$	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			\$ 431,814			\$ 431,814	\$ *	39

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

Facility Name & ID Number Aperion Care Oak Lawn # 0050500 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0%	See Attached	0.88	2.19%	Alloc Salary	\$ 5,472	17-7	1
2	David Berkowitz	Relative	Administrative	0%	See Attached	0.88	2.19%	Alloc Salary	2,515	17-7	2
3	Jay Meystel	Relative	Clerical	0%	See Attached	0.88	2.19%	Alloc Salary	1,287	21-7	3
4	Elisheva Adest	Relative	Clerical	0%	See Attached	0.6	2.19%	Alloc Salary	679	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	\$ 9,953		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 Oak Lawn# 0050500

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	\$	41,586	\$ 103	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		41,586	36	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	41,586	1,763	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		41,586	110	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		41,586	196	5
6	9	Medical Director	Census/Direct Cost	65	85,500		41,586	1,871	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	41,586	4,867	7
8	11	Activities	Census/Direct Cost	65	912		41,586	20	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		41,586	542	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	41,586	46,614	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		41,586	8,361	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		41,586	4,753	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	41,586	34,292	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		41,586	1,305	14
15	24	Seminars	Census/Direct Cost	65	13,215		41,586	289	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		41,586	1,550	16
17	26	Insurance	Census/Direct Cost	65	29,094		41,586	637	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		41,586	9,207	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		41,586	1,277	19
20	32	Interest	Census/Direct Cost	65	946,429		41,586	20,715	20
21	34	Rent	Census/Direct Cost	65	13,110		41,586	287	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		41,586	1,311	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 140,106	25

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

7

IL478-2471

Ending: 12/31/20

()

NO ☐IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

()

Ending: 12/31/20

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

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			\$	13,254,048			\$	757,003	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	First Midwest		X	Line of Credit				1,737,926				83,333	6	
7	Insurance Financing		X									728	7	
8													8	
9	TOTAL Facility Related						\$	14,991,974				\$	841,064	9
	B. Non-Facility Related*													
10	Interest Income		X									(13,354)	10	
11	Interest Income - Bldg Co.		X									(12)	11	
12	Allocated from Aperion Care		X									20,715	12	
13	Allocated from Chase Office		X									2,564	13	
14	TOTAL Non-Facility Related						\$					\$	9,913	14
15	TOTALS (line 9+line14)						\$	14,991,974				\$	850,977	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2019 report.				\$	445,200	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.)				\$	465,703	2
3. Under or (over) accrual (line 2 minus line 1).				\$	20,503	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	463,800	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.)				\$	8,500	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.				\$	492,803	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	384,077	8	FOR BHF USE ONLY	
		2016	387,015	9		
		2017	450,641	10		
		2018	444,342	11		
		2019	463,695	12		
2020 Accrual = 2019 Tax (rounded up)					13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
Allocated from Chase Office - \$2,008					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 Oak Lawn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050500

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Oak Lawn COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050500

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

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

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.)

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.

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:

41,133

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	CNR Realty		2012	\$ 49,613	1
2	Allocated from Chase Office			1,291	2
3	TOTALS			\$ 50,904	3

XI. OWNERSHIP COSTS (continued)

1		2	3	4	5	
---	--	---	---	---	---	--

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Oak Lawn

0050500

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)		80,320	5,668		3,733	(1,935)	15,898	68
69	Financial Statement Depreciation			159,368			(159,368)		69
70	TOTAL (lines 4 thru 69)		\$ 9,155,458	\$ 288,283		\$ 322,400	\$ 34,117	\$ 2,336,437	70

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

Facility Name & ID Number Aperion Care Oak Lawn

0050500

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		\$ 9,155,458	\$ 288,283		\$ 322,400	\$ 34,117	\$ 2,336,437	1
2	New Cabinet	2017	2,598		20	130	130	433	2
3	Install Paging System Speaker	2017	3,463		20	173	173	534	3
4	Sewer Ejector Pump In Basement	2017	3,700		20	185	185	601	4
5	Repair Roof, Replace Shingles Over West Bay Windows	2017	2,900		20	145	145	532	5
6	Repair Receptical In All Resident Rooms & Hallways	2017	4,765		20	238	238	754	6
7	Elevator Repair	2017	5,964		20	298	298	944	7
8	Heat Start Up & Repairs	2017	3,458		20	173	173	562	8
9	Storm Drain - Install Concrete Catch Basin, Connet To 8" Pipe (3	2018	3,331		20	167	167	445	9
10	Elevator Work - Install New Cylinder & Piston (30,150)	2018	29,872		20	1,494	1,494	3,734	10
11	Rooms 53-59 - Radiator Repair	2018	2,896		20	145	145	435	11
12	Basement - Mechanical Room - Boiler Repair	2018	3,794		20	190	190	427	12
13	Furnish & Install New Door Edge On Elevator	2018	2,850		20	143	143	309	13
14	1St Flr Cooridor-Repair Light Fixture, Shower Rm-Ceramic Repa	2019	7,144		20	357	357	714	14
15	Mechanical Door Lock Installation	2019	3,538		20	177	177	354	15
16	North Side Boiler - Replace Circuit Pump	2019	7,440		20	372	372	744	16
17	North Roof Top Ac Unit - Compressor Repair	2019	3,339		20	167	167	334	17
18	Remove Drop Ceiling & Install Drywall Plaster & Paint, Crown M	2020	4,140		20	207	207	207	18
19	Tear Off Southwest Section Of Roof & Replace Shingles (\$7,450)	2020	7,056		20	353	353	353	19
20	Installation Of New Boiler & Pump (\$5,535)	2020	4,996		20	250	250	250	20
21	New Hardware For Egress Door - Stairwell #7 & West Wing (\$6,6	2020	6,462		20	323	323	323	21
22	Installation Of New Roof For Pt Gym (\$12,200)	2020	11,702		20	585	585	585	22
23	Multiple Dome & Turret Security Cameras (\$9,585)	2020	8,341		20	417	417	417	23
24	Kitchen Hot Water Heater (\$5,600)	2020	5,310		20	265	265	265	24
25	Parking Lot Seal Coating And Striping, Crack Filling	2020	2,702		20	135	135	135	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,297,219	\$ 288,283		\$ 329,490	\$ 41,207	\$ 2,350,828	34

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,297,219	\$ 288,283		\$ 329,490	\$ 41,207	\$ 2,350,828	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,297,219	\$ 288,283		\$ 329,490	\$ 41,207	\$ 2,350,828	34

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

Facility Name & ID Number Aperion Care Oak Lawn

0050500

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		\$ 9,297,219	\$ 288,283		\$ 329,490	\$ 41,207	\$ 2,350,828	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,297,219	\$ 288,283		\$ 329,490	\$ 41,207	\$ 2,350,828	34

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

Facility Name & ID Number Aperion Care Oak Lawn

0050500

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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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 Oak Lawn

0050500

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	11,620	298	20	298		1,316	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	652	105	20	33	(72)	326	9
10	Allocated from Aperion Care	2012	185	14	20	9	(5)	74	10
11	Allocated from Aperion Care	2013	79	10	20	4	(6)	28	11
12									12
13	Allocated from Chase Office LLC	2020	232		20	12	12	12	13
14	Allocated from Chase Office LLC	2019	5,918	269	20	296	27	592	14
15	Allocated from Chase Office LLC	2018	53	3	20	3	(0)	8	15
16	Allocated from Chase Office LLC	2017	2,690	658	20	134	(523)	538	16
17	Allocated from Chase Office LLC	2016	58,892	4,312	20	2,945	(1,367)	13,005	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)		\$ 80,320	\$ 5,668		\$ 3,733	\$ (1,935)	\$ 15,898	34

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

Facility Name & ID Number Aperion Care Oak Lawn

0050500

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		\$ 80,320	\$ 5,668		\$ 3,733	\$ (1,935)	\$ 15,898	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 80,320	\$ 5,668		\$ 3,733	\$ (1,935)	\$ 15,898	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	\$ 1,975,777	\$ 6,087	\$ 197,662	\$ 191,575	10	\$ 1,188,421	71
72	Current Year Purchases	30,777	38	3,080	3,042	10	3,080	72
73	Fully Depreciated Assets	177,735				10	177,735	73
74								74
75	TOTALS	\$ 2,184,289	\$ 6,125	\$ 200,742	\$ 194,617		\$ 1,369,237	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		GMC Passanger Van	2014	\$ 50,337	\$	\$ 10,067	\$ 10,067	5	\$ 47,819	76
77		Allocated from Aperion Care, Inc	2020	4,714	209	943	734	5	2,361	77
78										78
79										79
80	TOTALS			\$ 55,051	\$ 209	\$ 11,010	\$ 10,801		\$ 50,180	80

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)	\$ 11,587,463	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 294,617	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 541,242	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 246,624	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,770,245	85

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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Aperion Care				287			5
6	Allocated from Chase Office				187			6
7	TOTAL				\$ 474			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: \$ 17,775
- 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		\$	\$ 1,311	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,311	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	\$		\$ 193,586	\$		\$ 193,586	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			55,328			55,328	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			234,399			234,399	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				206,302		206,302	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					179	51,527		51,706	13
14	TOTAL			\$		\$ 483,492	\$ 257,829		\$ 741,321	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	\$ 633,819	\$ 844,626	1
2	Cash-Patient Deposits	1,693	1,693	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,300,519	1,300,519	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86,891	86,891	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	22	175,059	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,022,944	\$ 2,408,788	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		590,000	13
14	Buildings, at Historical Cost		3,950,000	14
15	Leasehold Improvements, at Historical Cost	2,064,405	2,921,025	15
16	Equipment, at Historical Cost	597,481	1,132,481	16
17	Accumulated Depreciation (book methods)	(2,145,233)	(3,594,466)	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	11,559,094	11,717,215	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,075,747	\$ 16,716,255	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,098,691	\$ 19,125,043	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,389,002	\$ 1,389,001	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,737,926	1,737,926	29
30	Accrued Salaries Payable	198,709	198,709	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,412	10,412	31
32	Accrued Real Estate Taxes(Sch.IX-B)		463,800	32
33	Accrued Interest Payable	4,494	71,980	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,380,731	2,139,138	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,721,274	\$ 6,010,966	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,254,048	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	2,237,246		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,237,246	\$ 13,254,048	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,958,520	\$ 19,265,014	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,140,171	\$ (139,971)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,098,691	\$ 19,125,043	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,567,228	1
2	Restatements (describe):		2
3	Bad Debt	(95,467)	3
4	Rounding	5	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,471,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	843,315	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(174,910)	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)	\$ 668,405	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,140,171	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Oak Lawn**# **0050500**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	\$ 12,682,066	1
2	Discounts and Allowances for all Levels	(1,916,460)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,765,606	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	168,221	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 168,221	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	1,200	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,652	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	145	19
20	Radiology and X-Ray	39	20
21	Other Medical Services	8,567	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,603	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,354	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	557,619	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 557,619	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,529,403	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,308,959	31
32	Health Care	3,964,398	32
33	General Administration	2,607,300	33
	B. Capital Expense		
34	Ownership	1,760,562	34
	C. Ancillary Expense		
35	Special Cost Centers	746,647	35
36	Provider Participation Fee	298,222	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,686,088	40
41	Income before Income Taxes (line 30 minus line 40)**	843,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 843,315	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,702,709	44
45	Private Pay - Net Inpatient Revenue	379,480	45
46	Medicare - Net Inpatient Revenue	2,259,046	46
47	Other-(specify) <u>Insurance/MC</u>	6,029,078	47
48	Other-(specify) <u>Veterans/PPHP/ISNP</u>	395,293	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,765,606	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,052	\$ 105,101	\$ 51.22	1
2	Assistant Director of Nursing	1,654	1,757	67,876	38.63	2
3	Registered Nurses	15,012	15,921	637,656	40.05	3
4	Licensed Practical Nurses	23,698	25,352	861,222	33.97	4
5	CNAs & Orderlies	68,923	72,774	1,277,951	17.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,045	7,160	159,662	22.30	8
9	Activity Director	653	688	13,766	20.01	9
10	Activity Assistants	8,624	9,036	124,888	13.82	10
11	Social Service Workers	7,729	8,101	207,256	25.58	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,120	66,039	31.15	13
14	Head Cook	4,991	5,249	73,715	14.04	14
15	Cook Helpers/Assistants	10,994	11,854	172,815	14.58	15
16	Dishwashers					16
17	Maintenance Workers	1,912	2,080	43,006	20.68	17
18	Housekeepers	11,247	12,553	184,038	14.66	18
19	Laundry	1,852	2,107	40,338	19.14	19
20	Administrator	2,000	2,000	84,491	42.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,016	2,160	64,523	29.87	23
24	Clerical	7,269	7,538	148,476	19.70	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	223	320	4,810	15.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	24	24	804	33.50	33
34	TOTAL (lines 1 - 33)	178,938	190,846	\$ 4,338,433 *	\$ 22.73	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,975	10-03	38
39	Pharmacist Consultant	per unit	17,448	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	107	3,195	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,618	11-03	44
45	Social Service Consultant	40	2,460	12-03	45
46	Other(specify)				46
47	<u>Behavioral Health Consultant</u>	10	634	10-03	47
48					48
49	TOTAL (lines 35 - 48)	199	\$ 151,852		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	120	\$ 8,977	10-03	50
51	Licensed Practical Nurses	240	14,680	10-03	51
52	Certified Nurse Assistants/Aides	41	1,653	10-03	52
53	TOTAL (lines 50 - 52)	401	\$ 25,310		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 Oak Lawn

0050500

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Katherine Lauren Geigel	Administrator	0	\$ 2,000
Jonathan Eastman	Administrator	0	82,491
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,491

B. Administrative - Other

Description	Amount
Aperion Care Inc. - Management Fees	\$ 493,853
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 493,853

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	\$ 13,261
Aperion Care, Inc.	Home Office Expense	109,550
National Datacare Corporation	Resident Trust Fund Services	3,028
ProPay HR	Payroll Processing	30,967
Marcum LLP	Accounting	19,055
Achieve Accreditation LLC	Accreditation Services	11,740
Interbuild	Energy Procurement	953
GCHMO	Liaison Service	4,900
Formation HC Group	Clinical/Regulatory Consulting	6,335
Personnel Planners	Unemployment Consulting	2,625
Stout Risius Ross Inc.	Tax Appeal	5,500
See Supplemental Schedule		101,139
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 309,053

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 130,893
Unemployment Compensation Insurance	47,210
FICA Taxes	331,890
Employee Health Insurance	145,936
Employee Meals	1,790
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	30,666
Employee Physicals	960
Other Employee Benefits	20,907
TOTAL (agree to Schedule V, line 22, col.8)	\$ 710,252

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	\$
Advertising: Employee Recruitment	3,955
Health Care Worker Background Check (Indicate # of checks performed 108)	1,077
Patient Background Checks 242	2,415
Dues & Subscriptions	19,078
Licenses & Fees	2,637
See Supplemental Schedule	5,329
Less: Public Relations Expense (	
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,491

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	695
See Supplemental Schedule	515
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,210

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>Yes</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>HCCI - \$21,906</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 Years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>24,499</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>298,222</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?	<u>Yes</u>
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?	\$ <u>1,790</u> <u>N/A</u> Indicate the amount. \$
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>N/A</u> <u>N/A</u> <u>100% Ln 14</u> <u>N/A</u> <u>Yes</u> <u>N/A</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?	<u>Yes</u>
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees.	<u>Yes</u>