

		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: 0054734

Facility Name: Aperion Care Peoria Heights

Address: 1629 Gardner Lane Peoria Heights 61616
Number City Zip Code

County: Peoria

Telephone Number: (309) 685-1545 Fax # (309) 685-1571

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2017

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

Facility Name & ID Number Aperion Care Peoria Heights

0054734 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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,260</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,260</u>	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	<u>26,728</u>	<u>985</u>	<u>2,703</u>	<u>30,416</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,728</u>	<u>985</u>	<u>2,703</u>	<u>30,416</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.55%

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)
N/A

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/1/2017

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/1/2017 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 110 and days of care provided 1,551

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Aperion Care Peoria Heights # 0054734 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	157,621	26,593	21,522	205,736		205,736	(7,753)	197,983			1
2	Food Purchase		170,814		170,814		170,814	(479)	170,335			2
3	Housekeeping	99,528	53,580		153,108		153,108	285	153,393			3
4	Laundry	37,909	16,055		53,964		53,964		53,964			4
5	Heat and Other Utilities			88,954	88,954		88,954	(14,745)	74,209			5
6	Maintenance	38,803	7,786	66,754	113,343		113,343	(2,414)	110,929			6
7	Other (specify):*							1,936	1,936			7
8	TOTAL General Services	333,861	274,828	177,230	785,919		785,919	(23,170)	762,749			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	1,369	19,369			9
10	Nursing and Medical Records	1,985,657	173,241	81,144	2,240,042		2,240,042	(18,371)	2,221,671			10
10a	Therapy		1,271		1,271		1,271		1,271			10a
11	Activities	55,567	4,150	2,139	61,856		61,856	15	61,871			11
12	Social Services	152,289		1,656	153,945		153,945		153,945			12
13	CNA Training											13
14	Program Transportation			9,234	9,234		9,234		9,234			14
15	Other (specify):*							5,703	5,703			15
16	TOTAL Health Care and Programs	2,193,513	178,662	112,173	2,484,348		2,484,348	(11,285)	2,473,063			16
	C. General Administration											
17	Administrative	137,049		282,900	419,949		419,949	(248,806)	171,143			17
18	Directors Fees											18
19	Professional Services			287,043	287,043		287,043	(154,827)	132,216			19
20	Dues, Fees, Subscriptions & Promotions			42,278	42,278		42,278	(14,782)	27,496			20
21	Clerical & General Office Expenses	122,446		168,183	290,629		290,629	(19,532)	271,097			21
22	Employee Benefits & Payroll Taxes			385,026	385,026		385,026		385,026			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,462	1,462		1,462	377	1,839			24
25	Other Admin. Staff Transportation			744	744		744	1,144	1,888			25
26	Insurance-Prop.Liab.Malpractice			81,322	81,322		81,322	466	81,788			26
27	Other (specify):*							17,028	17,028			27
28	TOTAL General Administration	259,495		1,248,958	1,508,453		1,508,453	(418,934)	1,089,519			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,786,869	453,490	1,538,361	4,778,720		4,778,720	(453,389)	4,325,331			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			19,053	19,053		19,053	(3,495)	15,558			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,079	16,079		16,079	13,230	29,309			32
33	Real Estate Taxes			64,047	64,047		64,047	(18,871)	45,176			33
34	Rent-Facility & Grounds			488,344	488,344		488,344	(11,653)	476,691			34
35	Rent-Equipment & Vehicles			18,612	18,612		18,612	1,868	20,480			35
36	Other (specify):*			2,002	2,002		2,002	(2,002)	0			36
37	TOTAL Ownership			608,137	608,137		608,137	(20,924)	587,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,782	340,223	482,005		482,005	(62,650)	419,355			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			231,152	231,152		231,152		231,152			42
43	Other (specify):*			920	920		920	(920)	0			43
44	TOTAL Special Cost Centers		141,782	572,295	714,077		714,077	(63,570)	650,507			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,786,869	595,272	2,718,793	6,100,934		6,100,934	(537,883)	5,563,051			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	(15,297)	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	(12,273)	30		9
10	Interest and Other Investment Income	(3,796)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	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	(83)	21		18
19	Entertainment				19
20	Contributions	(9,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128,984)	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	(31,135)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,123)		\$	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)	(336,760)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (336,760)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (537,883)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Allowable Legal	\$ (2,322)	19	1
2	Credit Card Processing	(144)	21	2
3	Advertising/Marketing	(920)	43	3
4	Bank Charges	(1,283)	21	4
5	Prior Year Professional Fees	(532)	19	5
6	Theft & Damage Loss	(365)	21	6
7	Amortization	(2,002)	36	7
8	Other Unclassified Income	(179)	21	8
9	Vending Commissions	(500)	02	9
10	Additional R&M	6,631	06	10
11	PAC Dues	(9,180)	20	11
12	Real Estate Tax	(20,340)	33	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(31,135)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Peoria Heights

0054734

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				(7,753)								(7,753)	1
2	Food Purchase	(555)		76									(479)	2
3	Housekeeping			27			258						285	3
4	Laundry													4
5	Heat and Other Utilities	(15,297)					552						(14,745)	5
6	Maintenance	6,631		1,370	(11,293)		879						(2,414)	6
7	Other (specify):*			144	1,792								1,936	7
8	TOTAL General Services	(9,221)		1,616	(17,254)		1,689						(23,170)	8
	B. Health Care and Programs													
9	Medical Director			1,369									1,369	9
10	Nursing and Medical Records			3,559	(21,982)		51						(18,371)	10
10a	Therapy													10a
11	Activities			15									15	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			396	5,307								5,703	15
16	TOTAL Health Care and Programs			5,338	(16,675)		51						(11,285)	16
	C. General Administration													
17	Administrative			(248,806)									(248,806)	17
18	Directors Fees													18
19	Professional Services	(2,854)		22,722	2,063	(173,188)	1,008	(3,939)	(639)				(154,827)	19
20	Fees, Subscriptions & Promotions	(18,680)		3,476	26	391	4						(14,782)	20
21	Clerical & General Office Expenses	(131,038)		26,036	379	84,286	805						(19,532)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			212	126	39							377	24
25	Other Admin. Staff Transportation			1,134	10								1,144	25
26	Insurance-Prop.Liab.Malpractice			466									466	26
27	Other (specify):*			6,734		10,294							17,028	27
28	TOTAL General Administration	(152,571)		(188,027)	2,604	(78,178)	1,817	(3,939)	(639)				(418,934)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(161,793)		(181,073)	(31,325)	(78,178)	3,557	(3,939)	(639)				(453,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Peoria Heights # 0054734 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	(12,273)		934	161	165	7,517						(3,495)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,796)		15,151			1,875						13,230	32
33	Real Estate Taxes	(20,340)					1,469						(18,871)	33
34	Rent-Facility & Grounds			210			(11,863)						(11,653)	34
35	Rent-Equipment & Vehicles			959		222	687						1,868	35
36	Other (specify):*	(2,002)											(2,002)	36
37	TOTAL Ownership	(38,411)		17,253	161	387	(315)						(20,924)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(51,942)		(10,708)	(62,650)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(920)											(920)	43
44	TOTAL Special Cost Centers	(920)								(51,942)		(10,708)	(63,570)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(201,123)		(163,819)	(31,164)	(77,791)	3,242	(3,939)	(639)	(51,942)		(10,708)	(537,883)	45

VII. RELATED PARTIES

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

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

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

YES

X NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number

Aperion Care Peoria Heights

0054734

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	David A. Berkowitz Revocable Trust	30.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	Yosef Meystel Delta Trust	15.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	David Berkowitz Delta Trust	15.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Steven Turofsky	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Frederick S. Frankel Trust	1.50%	Aperion Care Demotte	Demotte, IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Naftali Wilhelm	1.50%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jennifer Spector	1.50%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9	257 Limited Partnership	1.34%	Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10	1219 Limited Partnership	1.33%	Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11	42170 Limited Partnership	1.33%	Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consutling	11
12			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	18
19			Aperion Care Marseilles	Marseilles	Renewal Rehab, LLC	Lincolnwood	Therapy Services	19
20			Aperion Care Mascoutah	Mascoutah	San Antonio Property, LLC	San Antonio, TX	Building Co.	20
21			Aperion Care Midlothian	Midlothian				21
22			Aperion Care Morton Villa	Morton				22
23			Aperion Care Oak Lawn	Oak Lawn				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.		\$ 76	\$ 76	15
16	V	3	Housekeeping		Aperion Care, Inc.		27	27	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,290	1,290	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		80	80	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		144	144	19
20	V	9	Medical Director		Aperion Care, Inc.		1,369	1,369	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		3,559	3,559	21
22	V	11	Activities		Aperion Care, Inc.		15	15	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		396	396	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		34,093	34,093	24
25	V	19	Professional Fees		Aperion Care, Inc.		6,115	6,115	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,476	3,476	26
27	V	21	Clerical Salary		Aperion Care, Inc.		25,081	25,081	27
28	V	21	Clerical & General		Aperion Care, Inc.		954	954	28
29	V	24	Seminars		Aperion Care, Inc.		212	212	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,134	1,134	30
31	V	26	Insurance		Aperion Care, Inc.		466	466	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		6,734	6,734	32
33	V	30	Depreciaiton		Aperion Care, Inc.		934	934	33
34	V	32	Interest		Aperion Care, Inc.		15,151	15,151	34
35	V	34	Rent		Aperion Care, Inc.		210	210	35
36	V	35	Auto Lease		Aperion Care, Inc.		959	959	36
37	V	17	Management Fee	282,900	Aperion Care, Inc.			(282,900)	37
38	V	19	Home Office	(16,607)	Aperion Care, Inc.			16,607	38
39	Total			\$ 266,292			\$ 102,473	\$ * (163,819)	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		\$ 13,769	\$ 13,769	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,330	2,330	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		50	50	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,792	1,792	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		46,874	46,874	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		5,307	5,307	20
21	V	19	Professional Fees		Aperion Consulting, LLC		2,063	2,063	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		26	26	22
23	V	21	Clerical & General		Aperion Consulting, LLC		379	379	23
24	V	24	Seminars		Aperion Consulting, LLC		126	126	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		161	161	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	68,856	Aperion Consulting, LLC			(68,856)	33
34	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	34
35	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 104,051			\$ 72,887	\$ * (31,164)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		2,631	\$ 2,631	15
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		391	391	16
17	V	21	Clerical & General		Aperion Financial, LLC		49,646	49,646	17
18	V	24	Seminars		Aperion Financial, LLC		39	39	18
19	V	25	Auto & Travel		Aperion Financial, LLC				19
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		6,017	6,017	20
21	V	30	Depreciaiton		Aperion Financial, LLC		165	165	21
22	V	32	Interest		Aperion Financial, LLC				22
23	V	35	Equipment Rental		Aperion Financial, LLC		222	222	23
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		34,640	34,640	24
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,277	4,277	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	19	Home Office Expense	175,819	Aperion Financial, LLC			(175,819)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 175,819			\$ 98,028	\$ * (77,791)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Chase Office, LLC		\$ 552	\$ 552	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		879	879	16
17	V	3	Housekeeping		Chase Office, LLC		258	258	17
18	V	10	Medical Supplies		Chase Office, LLC		51	51	18
19	V	19	Professional Fees		Chase Office, LLC		1,008	1,008	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		4	4	20
21	V	21	Office Expense		Chase Office, LLC		805	805	21
22	V	30	Depreciation		Chase Office, LLC		7,517	7,517	22
23	V	32	Interest Expense		Chase Office, LLC		1,875	1,875	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,469	1,469	24
25	V	35	Equipment Rental		Chase Office, LLC		687	687	25
26	V	34	Rent	12,000	Chase Office, LLC		137	(11,863)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 12,000			\$ 15,242	\$ * 3,242	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	\$ 17,194	ProPay HR LLC		\$ 13,255	\$ (3,939)	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			\$ 17,194			\$ 13,255	\$ * (3,939)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Data Processing	\$ 4,200	EMSA PURCHASING GROUP		\$ 3,561	\$ (639)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,200			\$ 3,561	\$ * (639)	39

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

VII. RELATED PARTIES (continued)

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

☒ 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	\$ 340,109	Renewal Rehab, LLC		\$ 288,167	\$ (51,942)	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			\$ 340,109			\$ 288,167	\$ * (51,942)	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	26	Insurance	\$ 46,206	Aperion Incorporated Cell		\$ 46,206	\$	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			\$ 46,206			\$ 46,206	\$ *	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	\$ 18,809	Lifescan Labs of Illinois		\$ 8,101	\$ (10,708)	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			\$ 18,809			\$ 8,101	\$ * (10,708)	39

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

Facility Name & ID Number Aperion Care Peoria Heights # 0054734 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	0.64	1.60%	Alloc. Salary	\$ 4,002	17-7	1
2	Jay Meystel	Relative	Clerical	0%	See Attached	0.64	1.60%	Alloc. Salary	942	21-7	2
3	Elisheva Adest	Relative	Clerical	0%	See Attached	0.44	1.60%	Alloc. Salary	496	21-7	3
4	David Berkowitz	Relative	Administrative	0%	See Attached	0.64	1.60%	Alloc. Salary	1,840	17-7	4
5	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.64	1.60%	Alloc. Salary	3,641	21-7	5
6	Dovid Spector	Relative	Clerical	0%	See Attached	0.64	1.60%	Alloc. Salary	1,906	21-7	6
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.64	1.60%	Alloc. Salary	4,002	17-7	7
8	Fred Frankel	Relative	Administrative	0%	See Attached	0.64	1.60%	Alloc. Salary	4,002	17-7	8
9	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.64	1.60%	Alloc. Salary	1,320	21-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 22,151		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 Peoria Heights# 0054734

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	\$	30,416	\$ 76	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		30,416	27	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	30,416	1,290	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		30,416	80	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		30,416	144	5
6	9	Medical Director	Census/Direct Cost	65	85,500		30,416	1,369	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	30,416	3,559	7
8	11	Activities	Census/Direct Cost	65	912		30,416	15	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		30,416	396	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	30,416	34,093	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		30,416	6,115	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		30,416	3,476	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	30,416	25,081	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		30,416	954	14
15	24	Seminars	Census/Direct Cost	65	13,215		30,416	212	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		30,416	1,134	16
17	26	Insurance	Census/Direct Cost	65	29,094		30,416	466	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		30,416	6,734	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		30,416	934	19
20	32	Interest	Census/Direct Cost	65	946,429		30,416	15,151	20
21	34	Rent	Census/Direct Cost	65	13,110		30,416	210	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		30,416	959	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 102,473	25

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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Ending: 12/31/20

(847) 410-9720

IL478-2471

Ending: 12/31/20

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Ending: 12/31/20

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Fax NumberIL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2							\$		\$			\$	2
3							\$		\$			\$	3
4							\$		\$			\$	4
5							\$		\$			\$	5
	Working Capital												
6	Congressional Bank	X		Line of Credit				-				15,601	6
7								-				-	7
8													8
9	TOTAL Facility Related						\$		\$			\$ 15,601	9
	B. Non-Facility Related*												
10	Interest - Insurance Policies	X										478	10
11	Interest Income	X										(3,796)	11
12	Allocated from Aperion Care	X										15,151	12
13	Allocated from Chase Office	X										1875	13
14	TOTAL Non-Facility Related						\$		\$			\$ 13,708	14
15	TOTALS (line 9+line14)						\$		\$			\$ 29,309	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.			\$	43,141	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.)			\$	44,893	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,752	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	43,424	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	45,176	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	41,603	8	
		2016	43,079	9	
		2017	43,289	10	
		2018	43,141	11	
		2019	43,424	12	
2020 Accrual = 2019 tax					
Allocated from Chase Office \$1,469					

		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 Peoria Heights COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0054734

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

B. Real Estate Tax Cost Allocations

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

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

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Peoria Heights COUNTY Peoria
FACILITY IDPH LICENSE NUMBER 0054734
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 X 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

25,000

B. General Construction Type:

Exterior

Cement Block

Frame

Metal Beam

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				\$	1
2	Allocated from Chase Office LLC			944	2
3	TOTALS			\$ 944	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care Peoria Heights

0054734

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)		58,746	4,145		2,730	(1,415)	11,628	68
69	Financial Statement Depreciation			19,053			(19,053)		69
70	TOTAL (lines 4 thru 69)		\$ 58,746	\$ 23,198		\$ 2,730	\$ (20,468)	\$ 11,628	70

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

Facility Name & ID Number Aperion Care Peoria Heights

0054734

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 58,746	\$ 23,198		\$ 2,730	\$ (20,468)	\$ 11,628	1
2	Furnish & Install Heat Exchanger	2019	2,800		20	140	140	280	2
3	Two Rooftop Heating Units	2019	25,500		20	1,275	1,275	2,550	3
4	Install State Mandated Door Locking System	2019	15,525		20	776	776	1,552	4
5	Install Hospital Grade Outlets And New Alarm System	2019	4,454		20	223	223	446	5
6	Install New Hot Water Boiler	2020	7,800		20	390	390	390	6
7	Condensor Fan Motors For Dining & Laundry Room Rooftop Uni	2020	4,952		20	248	248	248	7
8	Installed New Water Tank	2020	4,017		20	201	201	201	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)		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	34

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

Facility Name & ID Number Aperion Care Peoria Heights

0054734

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		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	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)		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	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		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	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)		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 123,795	\$ 23,198		\$ 5,983	\$ (17,215)	\$ 17,294	34

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

Facility Name & ID Number Aperion Care Peoria Heights

0054734

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.

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Chase Office LLC	2016	8,499	218	20	218		962	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Aperion Care	2010	477	77	20	24	(53)	238	9
10 Allocated from Aperion Care	2012	135	10	20	7	(4)	54	10
11 Allocated from Aperion Care	2013	58	7	20	3	(4)	20	11
12								12
13 Allocated from Chase Office LLC	2020	170		20	8	8	8	13
14 Allocated from Chase Office LLC	2019	4,328	197	20	216	20	433	14
15 Allocated from Chase Office LLC	2018	39	2	20	2	(0)	6	15
16 Allocated from Chase Office LLC	2017	1,967	481	20	98	(383)	393	16
17 Allocated from Chase Office LLC	2016	43,074	3,154	20	2,154	(1,000)	9,512	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)		\$ 58,746	\$ 4,145		\$ 2,730	\$ (1,415)	\$ 11,628	34

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

Facility Name & ID Number Aperion Care Peoria Heights

0054734

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		\$ 58,746	\$ 4,145		\$ 2,730	\$ (1,415)	\$ 11,628	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)		\$ 58,746	\$ 4,145		\$ 2,730	\$ (1,415)	\$ 11,628	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	\$ 47,108	\$ 4,452	\$ 4,773	\$ 321	10	\$ 17,584	71
72	Current Year Purchases	10,031	28	1,005	977	10	1,005	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 57,139	\$ 4,480	\$ 5,778	\$ 1,298		\$ 18,589	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		2013 Ford Goshen Bus	2018	\$ 15,534	\$ 153	\$ 3,107	\$ 2,954	5	\$ 8,285
77		Alloc from Aperion Care	2020	3,448		690	690	5	1,727
78									
79									
80	TOTALS			\$ 18,982	\$ 153	\$ 3,797	\$ 3,644		\$ 10,012

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)			\$	200,860
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	27,831
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	15,558
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(12,273)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	45,895

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		\$
93		
94		
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: American Realty Cap Healthcare Trust Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$476,344			3
4	Additions							4
5	Allocated from Aperion Care				210			5
6	Allocated from Chase Office				137			6
7	TOTAL				\$476,691			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: \$19,521
- 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		\$	\$959	17
18					18
19					19
20					20
21	TOTAL		\$	\$959	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	\$		\$ 164,497	\$		\$ 164,497	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			34,155			34,155	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			141,571			141,571	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				115,056		115,056	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						26,726		26,726	13
14	TOTAL			\$		\$ 340,223	\$ 141,782		\$ 482,005	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 427,401	\$	1
2	Cash-Patient Deposits	2,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	543,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,966		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	57,264		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,086,134	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	67,658		15
16	Equipment, at Historical Cost	62,355		16
17	Accumulated Depreciation (book methods)	(42,332)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	37,075		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 124,756	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,210,890	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 186,329	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	243,091		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,423		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,424		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	720,381		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,205,648	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	308,689		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 308,689	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,514,337	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (303,447)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,210,890	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,107,365)	1
2	Restatements (describe):		2
3	Bad Debt	(23,691)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,131,057)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	827,610	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 827,610	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)	\$ (303,447)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Peoria Heights**# **0054734**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	\$ 6,375,894	1
2	Discounts and Allowances for all Levels	(244,811)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,131,083	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	235,462	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 235,462	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	5,544	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	104	19
20	Radiology and X-Ray	21	20
21	Other Medical Services	921	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,590	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,796	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,796	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	551,613	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 551,613	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,928,544	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	785,919	31
32	Health Care	2,484,348	32
33	General Administration	1,508,453	33
	B. Capital Expense		
34	Ownership	608,137	34
	C. Ancillary Expense		
35	Special Cost Centers	482,925	35
36	Provider Participation Fee	231,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,100,934	40
41	Income before Income Taxes (line 30 minus line 40)**	827,610	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 827,610	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,262,197	44
45	Private Pay - Net Inpatient Revenue	204,704	45
46	Medicare - Net Inpatient Revenue	841,867	46
47	Other-(specify) <u>Insurance</u>	331,675	47
48	Other-(specify) <u>Managed Care</u>	3,490,640	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,131,083	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,080	\$ 110,333	\$ 53.04	1
2	Assistant Director of Nursing	515	523	26,214	50.12	2
3	Registered Nurses	5,321	5,844	220,258	37.69	3
4	Licensed Practical Nurses	17,055	18,313	681,099	37.19	4
5	CNAs & Orderlies	42,552	45,570	915,611	20.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,751	2,029	35,936	17.71	9
10	Activity Assistants	1,923	1,952	19,631	10.06	10
11	Social Service Workers	3,848	4,160	119,295	28.68	11
12	Dietician					12
13	Food Service Supervisor	1,288	1,414	25,287	17.88	13
14	Head Cook	4,469	4,701	52,778	11.23	14
15	Cook Helpers/Assistants	6,129	6,440	79,556	12.35	15
16	Dishwashers					16
17	Maintenance Workers	1,565	1,805	38,803	21.50	17
18	Housekeepers	6,983	7,451	99,528	13.36	18
19	Laundry	3,240	3,471	37,909	10.92	19
20	Administrator	2,016	2,080	137,049	65.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,190	6,513	122,446	18.80	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	1,397	1,670	32,142	19.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,059	1,203	32,994	27.43	33
34	TOTAL (lines 1 - 33)	109,253	117,219	\$ 2,786,869 *	\$ 23.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	68,856	10-03	38
39	Pharmacist Consultant	Per Unit	12,288	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	33	2,139	11-03	44
45	Social Service Consultant	25	1,656	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	\$ 124,461		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount			
Randi Lienhart	Administrator		\$ 137,049	Workers' Compensation Insurance	\$	59,996	IDPH License Fee	\$			
				Unemployment Compensation Insurance		15,574	Advertising: Employee Recruitment	6,881			
				FICA Taxes		213,195	Health Care Worker Background Check				
				Employee Health Insurance		71,855	(Indicate # of checks performed 66)	660			
				Employee Meals		871	Patient Background Checks	113.8 1,138			
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	13,198			
				401K Expense		743	Licenses & Fees	1,721			
				Employee Physicals		240					
				Employee Benefits - Other		12,507					
				Employee Physicals - Covid		6,500	See Supplemental Schedule	3,897			
				Employee Meal - Covid		357	Less: Public Relations Expense	()			
				Employee Benefit Other - Covid		3,188	Non-allowable advertising	()			
							Yellow page advertising	()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$	137,049	TOTAL (agree to Sch. V, line 20, col. 8)		\$	27,495	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description	Line #	Amount	Description	Amount			
Management Fees - Aperion Care Inc			\$ 282,900				Out-of-State Travel	\$			
							In-State Travel				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)											
C. Professional Services				TOTAL			Seminar Expense				
Vendor/Payee	Type		Amount					1,462			
Marcum LLP	Accounting Fees		\$ 19,055								
National Datacare Corp	Resident Trust Fund Services		2,295								
ProPay HR	Payroll Processing		17,194								
Aperion Care, Inc	Data Processing		24,094								
Creative Technology Solutions	IT Consulting		5,075								
EMSA Purchasing Group, LLP	Procurement Solutions		4,200								
PointClickCare Technologies Inc.	Data Processing		38,264								
Reside Admissions LLC	Data Processing		3,481								
Synapse PDI, LLC	Data Processing		600								
Z Core Analytics	Reimbursement Consulting		2,200								
See Attached	Legal		2,685								
See Supplemental Schedule			167,900								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$			(agree to Sch. V, line 24, col. 8)			\$	1,839

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Aperion Care Peoria Heights</u>	STATE OF ILLINOIS # <u>0054734</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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Page 22

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. HCCI & \$18,359

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,675 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. \$ 231,152
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. \$ 1,228 Has any meal income been offset against related costs? No 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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

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

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