

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0054775</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Aperion Care Princeton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>515 Bureau Vly Prkwy</u> <u>Princeton</u> <u>61356</u>																									
Number City Zip Code																									
County: <u>Bureau</u>																									
Telephone Number: <u>(815) 875-3347</u> Fax # <u>(815) 875-2012</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Print Name and Title) _____																								
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>11/1/2017</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

#	0054775	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 11/01/2017

YES ☒ Date 11/01/2017 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 92 and days of care provided 4,300

IV. ACCOUNTING BASIS

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

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

	1	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	14,673	4,752	5,604	25,029	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,673	4,752	5,604	25,029	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **74.33%**

Facility Name & ID Number Aperion Care Princeton # 0054775 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	193,945	14,894	21,522	230,361		230,361	(10,192)	220,169			1
2	Food Purchase		160,337		160,337		160,337	(482)	159,855			2
3	Housekeeping	137,355	41,467		178,822		178,822	234	179,056			3
4	Laundry	23,114	7,316		30,430		30,430		30,430			4
5	Heat and Other Utilities			104,003	104,003		104,003	(7,314)	96,689			5
6	Maintenance	76,460	3,871	44,315	124,646		124,646	(5,255)	119,391			6
7	Other (specify):*							1,593	1,593			7
8	TOTAL General Services	430,874	227,885	169,840	828,599		828,599	(21,415)	807,184			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400	1,126	15,526			9
10	Nursing and Medical Records	1,754,476	160,388	106,235	2,021,099		2,021,099	(27,019)	1,994,080			10
10a	Therapy		2,688		2,688		2,688		2,688			10a
11	Activities	85,330	1,645	631	87,606		87,606	12	87,618			11
12	Social Services	88,928		1,863	90,791		90,791		90,791			12
13	CNA Training											13
14	Program Transportation			2,331	2,331		2,331		2,331			14
15	Other (specify):*							4,693	4,693			15
16	TOTAL Health Care and Programs	1,928,734	164,721	125,460	2,218,915		2,218,915	(21,188)	2,197,727			16
	C. General Administration											
17	Administrative	95,630		294,547	390,177		390,177	(266,492)	123,685			17
18	Directors Fees											18
19	Professional Services			308,075	308,075		308,075	(168,456)	139,619			19
20	Dues, Fees, Subscriptions & Promotions			36,733	36,733		36,733	(13,616)	23,117			20
21	Clerical & General Office Expenses	81,935		229,820	311,755		311,755	(104,347)	207,408			21
22	Employee Benefits & Payroll Taxes			370,156	370,156		370,156		370,156			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,491	1,491		1,491	263	1,754			24
25	Other Admin. Staff Transportation			2,778	2,778		2,778	941	3,719			25
26	Insurance-Prop.Liab.Malpractice			63,602	63,602		63,602	383	63,985			26
27	Other (specify):*							14,012	14,012			27
28	TOTAL General Administration	177,565		1,307,202	1,484,767		1,484,767	(537,311)	947,456			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,537,173	392,606	1,602,502	4,532,281		4,532,281	(579,913)	3,952,368			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			12,687	12,687		12,687	(1,230)	11,457			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,614	36,614		36,614	13,893	50,507			32
33	Real Estate Taxes			55,319	55,319		55,319	(17,122)	38,197			33
34	Rent-Facility & Grounds			462,222	462,222		462,222	(11,715)	450,507			34
35	Rent-Equipment & Vehicles			9,480	9,480		9,480	1,536	11,016			35
36	Other (specify):*			2,002	2,002		2,002	(2,002)	0			36
37	TOTAL Ownership			578,324	578,324		578,324	(16,640)	561,684			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,259	476,020	648,279		648,279	(81,398)	566,881			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,840	178,840		178,840		178,840			42
43	Other (specify):*			5,079	5,079		5,079	(5,079)				43
44	TOTAL Special Cost Centers		172,259	659,939	832,198		832,198	(86,477)	745,721			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,537,173	564,865	2,840,765	5,942,803		5,942,803	(683,030)	5,259,773			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	(240)	02		4
5	Telephone, TV & Radio in Resident Rooms	(7,768)	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	(8,454)	30		9
10	Interest and Other Investment Income	(117)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(304)	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	(10)	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	(194,088)	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	(35,038)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (255,519)		\$	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)	(427,511)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (427,511)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (683,030)		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	\$ (3,925)	19	1
2	Credit Card Processing	(422)	21	2
3	Advertising/Marketing	(2,901)	43	3
4	Promotional Products	(2,178)	43	4
5	Bank Charges	(1,396)	21	5
6	Theft & Damage Loss	(187)	21	6
7	Amortization	(2,002)	36	7
8	Chamber of Commerce	(550)	20	8
9	PAC Dues	(6,773)	20	9
10	Additional R&M	4,609	06	10
11	Non-Allowable Professional	(935)	19	11
12	Non-Allowable Seminar	(47)	24	12
13	Real Estate Tax	(18,331)	33	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
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27				27
28				28
29				29
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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	(35,038)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Princeton# 0054775

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(10,192)								(10,192)	1
2	Food Purchase	(544)		62									(482)	2
3	Housekeeping			22			213						234	3
4	Laundry													4
5	Heat and Other Utilities	(7,768)					454						(7,314)	5
6	Maintenance	4,609		1,127	(11,714)		723						(5,255)	6
7	Other (specify):*			118	1,475								1,593	7
8	TOTAL General Services	(3,703)		1,329	(20,431)		1,390						(21,415)	8
	B. Health Care and Programs													
9	Medical Director			1,126									1,126	9
10	Nursing and Medical Records			2,929	(29,990)		42						(27,019)	10
10a	Therapy													10a
11	Activities			12									12	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			326	4,367								4,693	15
16	TOTAL Health Care and Programs			4,393	(25,623)		42						(21,188)	16
	C. General Administration													
17	Administrative			(266,492)									(266,492)	17
18	Directors Fees													18
19	Professional Services	(4,860)		32,464	1,698	(193,231)	829	(4,717)				(639)	(168,456)	19
20	Fees, Subscriptions & Promotions	(16,823)		2,861	21	322	3						(13,616)	20
21	Clerical & General Office Expenses	(196,104)		21,425	312	69,358	662						(104,347)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(47)		174	104	32							263	24
25	Other Admin. Staff Transportation			933	8								941	25
26	Insurance-Prop.Liab.Malpractice			383									383	26
27	Other (specify):*			5,541		8,471							14,012	27
28	TOTAL General Administration	(217,834)		(202,711)	2,143	(115,048)	1,495	(4,717)				(639)	(537,311)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(221,537)		(196,989)	(43,911)	(115,048)	2,927	(4,717)				(639)	(579,913)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care Princeton # 0054775 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	(8,454)		769	133	136	6,186						(1,230)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(117)		12,467			1,543						13,893	32
33	Real Estate Taxes	(18,331)					1,209						(17,122)	33
34	Rent-Facility & Grounds			173			(11,887)						(11,715)	34
35	Rent-Equipment & Vehicles			789		182	565						1,536	35
36	Other (specify):*	(2,002)											(2,002)	36
37	TOTAL Ownership	(28,904)		14,198	133	318	(2,384)						(16,640)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(8,753)	(72,645)			(81,398)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,079)											(5,079)	43
44	TOTAL Special Cost Centers	(5,079)							(8,753)	(72,645)			(86,477)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(255,519)		(182,791)	(43,778)	(114,730)	543	(4,717)	(8,753)	(72,645)		(639)	(683,030)	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 Princeton

0054775

Report Period Beginning:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Yosef Meystel Delta Trust	15.00%	Aperion Care Bradley	Bradley	Aperion Care Demotte	Demotte, IN	ALF	1
2	David Berkowitz Delta Trust	15.00%	Aperion Care Bridgeport	Bridgeport	Aperion Care, Inc.	Lincolnwood	Corporate Manager	2
3	David A. Berkowitz Revocable Trust	30.00%	Aperion Care Burbank	Burbank	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	3
4	Declaration of Trust of Yosef Meystel	30.00%	Aperion Care Capitol	Capitol	Aperion Estates Peru	Peru, IN	ALF	4
5	Steven Turofsky	1.50%	Aperion Care Chicago Heights	Chicago Heights	Aperion Financial, LLC	Lincolnwood	Bookkeeping	5
6	Frederick S. Frankel Trust	1.50%	Aperion Care Demotte	Demotte,IN	Aperion Incorporated Cell	Burlington, VT	Insurance	6
7	Naftali Wilhelm	1.50%	Aperion Care Dolton	Dolton	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	7
8	Jennifer Spector	1.50%	Aperion Care Elgin	Elgin	Chase Office, LLC	Lincolnwood	Building Co.	8
9	257 Limited Partnership	1.34%	Aperion Care Evanston	Evanston	Concerto Dialysis	Lincolnwood	Dialysis	9
10	1219 Limited Partnership	1.33%	Aperion Care Fairfield	Fairfield	Eco-Brite Linen	Skokie	Laundry	10
11	42170 Limited Partnership	1.33%	Aperion Care Forest Park	Forest Park	Elevate Care, Inc.	Skokie	Consutling	11
12			Aperion Care Glenwood	Glenwood	EMSA Purchasing Group	Lincolnwood	Purchasing	12
13			Aperion Care Highwood	Highwood	Interbuild Construction	Chicago	Bldg Improvements	13
14			Aperion Care International	Chicago	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	14
15			Aperion Care Jacksonville	Jacksonville	OnTray, LLC	Lincolnwood	Kitchen Management	15
16			Aperion Care Kokomo	Kokomo, IN	Pointe Group Care, LLC	Boston, MA	Bookkeeping	16
17			Aperion Care Litchfield	Litchfield	Pointe Property, LLC	Boston, MA	Property Management	17
18			Aperion Care Marion	Marion, IN	PropayHR	Evanston	Payroll Services	18
19			Aperion Care 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 Peoria Heights	Peoria Heights				24
25			Aperion Care Peru	Peru, IN				25
26			Aperion Care Plum Grove	Palatine				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.		\$ 62	\$ 62	15
16	V	3	Housekeeping		Aperion Care, Inc.		22	22	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,061	1,061	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		66	66	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		118	118	19
20	V	9	Medical Director		Aperion Care, Inc.		1,126	1,126	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		2,929	2,929	21
22	V	11	Activities		Aperion Care, Inc.		12	12	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		326	326	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		28,055	28,055	24
25	V	19	Professional Fees		Aperion Care, Inc.		5,032	5,032	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		2,861	2,861	26
27	V	21	Clerical Salary		Aperion Care, Inc.		20,639	20,639	27
28	V	21	Clerical & General		Aperion Care, Inc.		785	785	28
29	V	24	Seminars		Aperion Care, Inc.		174	174	29
30	V	25	Auto & Travel		Aperion Care, Inc.		933	933	30
31	V	26	Insurance		Aperion Care, Inc.		383	383	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		5,541	5,541	32
33	V	30	Depreciaiton		Aperion Care, Inc.		769	769	33
34	V	32	Interest		Aperion Care, Inc.		12,467	12,467	34
35	V	34	Rent		Aperion Care, Inc.		173	173	35
36	V	35	Auto Lease		Aperion Care, Inc.		789	789	36
37	V	17	Management Fee	294,547	Aperion Care, Inc.			(294,547)	37
38	V	19	Home Office	(27,432)	Aperion Care, Inc.			27,432	38
39	Total			\$ 267,115			\$ 84,324	\$ * (182,791)	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	1	Dietician Salary - Illinois Only	\$	Aperion Consulting, LLC		\$ 11,330	\$ 11,330	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		1,918	1,918	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		41	41	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		1,475	1,475	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		38,572	38,572	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		4,367	4,367	20
21	V	19	Professional Fees		Aperion Consulting, LLC		1,698	1,698	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		21	21	22
23	V	21	Clerical & General		Aperion Consulting, LLC		312	312	23
24	V	24	Seminars		Aperion Consulting, LLC		104	104	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		8	8	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		133	133	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	68,562	Aperion Consulting, LLC			(68,562)	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			\$ 103,757			\$ 59,979	\$ * (43,778)	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		2,165	\$	2,165
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		322		322
17	V	21	Clerical & General		Aperion Financial, LLC		40,853		40,853
18	V	24	Seminars		Aperion Financial, LLC		32		32
19	V	25	Auto & Travel		Aperion Financial, LLC				
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		4,951		4,951
21	V	30	Depreciaton		Aperion Financial, LLC		136		136
22	V	32	Interest		Aperion Financial, LLC				
23	V	35	Equipment Rental		Aperion Financial, LLC		182		182
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		28,505		28,505
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		3,520		3,520
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V	19	Home Office Expense	195,396	Aperion Financial, LLC				(195,396)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 195,396			\$ 80,666	\$ *	(114,730)

* 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		\$ 454	\$ 454	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		723	723	16
17	V	3	Housekeeping		Chase Office, LLC		213	213	17
18	V	10	Medical Supplies		Chase Office, LLC		42	42	18
19	V	19	Professional Fees		Chase Office, LLC		829	829	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		3	3	20
21	V	21	Office Expense		Chase Office, LLC		662	662	21
22	V	30	Depreciation		Chase Office, LLC		6,186	6,186	22
23	V	32	Interest Expense		Chase Office, LLC		1,543	1,543	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,209	1,209	24
25	V	35	Equipment Rental		Chase Office, LLC		565	565	25
26	V	34	Rent	12,000	Chase Office, LLC		113	(11,887)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 12,000			\$ 12,543	\$ * 543	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 20,590	ProPay HR LLC		\$ 15,873	\$ (4,717)	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			\$ 20,590			\$ 15,873	\$ * (4,717)	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	\$ 15,375	Lifescan Labs of Illinois		\$ 6,622	\$ (8,753)	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			\$ 15,375			\$ 6,622	\$ * (8,753)	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	\$ 475,666	Renewal Rehab, LLC		\$ 403,021	\$ (72,645)	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			\$ 475,666			\$ 403,021	\$ * (72,645)	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	\$ 31,087	Aperion Incorporated Cell		\$ 31,087	\$	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			\$ 31,087			\$ 31,087	\$ *	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.

Facility Name & ID Number Aperion Care Princeton # 0054775 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	0.53	1.32%	Alloc Sal	\$ 3,293	17-7	1
2	Jay Meystel	Relative	Clerical	0.00%	See Attached	0.53	1.32%	Alloc Sal	775	21-7	2
3	Elisheva Adest	Relative	Clerical	0.00%	See Attached	0.36	1.32%	Alloc Sal	408	21-7	3
4	David Berkowitz	Relative	Administrative	0.00%	See Attached	0.53	1.32%	Alloc Sal	1,514	17-7	4
5	Jennifer Spector	Owner	Clerical	1.50%	See Attached	0.53	1.32%	Alloc Sal	1,568	21-7	5
6	Dovid Spector	Relative	Clerical	0.00%	See Attached	0.53	1.32%	Alloc Sal	1,086	21-7	6
7	Steve Turofsky	Owner	Administrative	1.50%	See Attached	0.53	1.32%	Alloc Sal	3,293	17-7	7
8	Fred Frankel	Relative	Administrative	0.00%	See Attached	0.53	1.32%	Alloc Sal	3,293	17-7	8
9	Naftali Wilhelm	Owner	Clerical	1.50%	See Attached	0.53	1.32%	Alloc Sal	2,996	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	\$ 18,226		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 Princeton# 0054775

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

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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	\$	25,029	\$ 62	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		25,029	22	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	25,029	1,061	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		25,029	66	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		25,029	118	5
6	9	Medical Director	Census/Direct Cost	65	85,500		25,029	1,126	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	25,029	2,929	7
8	11	Activities	Census/Direct Cost	65	912		25,029	12	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		25,029	326	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	25,029	28,055	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		25,029	5,032	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		25,029	2,861	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	25,029	20,639	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		25,029	785	14
15	24	Seminars	Census/Direct Cost	65	13,215		25,029	174	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		25,029	933	16
17	26	Insurance	Census/Direct Cost	65	29,094		25,029	383	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		25,029	5,541	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		25,029	769	19
20	32	Interest	Census/Direct Cost	65	946,429		25,029	12,467	20
21	34	Rent	Census/Direct Cost	65	13,110		25,029	173	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		25,029	789	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 84,324	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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IL478-2471

Ending: 12/31/20

(847) 410-9720

IL478-2471

Ending: 12/31/20

()

Ending: 12/31/20

()

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1							\$	\$			\$	1		
2							\$	\$			\$	2		
3							\$	\$			\$	3		
4							\$	\$			\$	4		
5							\$	\$			\$	5		
	Working Capital													
6	Congressional Bank	X		Line of Credit				-			36,154	6		
7												-	7	
8													8	
9	TOTAL Facility Related						\$	\$			\$ 36,154	9		
	B. Non-Facility Related*													
10	Interest Income												(117)	10
11	Interest - Insurance Policies												460	11
12	Allocated from Aperion Care												12,467	12
13	Allocated from Chase Office												1543	13
14	TOTAL Non-Facility Related						\$	\$			\$ 14,352	14		
15	TOTALS (line 9+line14)						\$	\$			\$ 50,506	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.)

FACILITY NAME Aperion Care Princeton COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0054775

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

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.

Page 10A

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 Princeton COUNTY Bureau
FACILITY IDPH LICENSE NUMBER 0054775
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:

24,295

B. General Construction Type:

Exterior

Brick

Frame

1

Number of Stories

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			777	2
3	TOTALS			\$ 777	3

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

0054775

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
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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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		48,341	3,411		2,247	(1,164)	9,568	68
69	Financial Statement Depreciation			12,687			(12,687)		69
70	TOTAL (lines 4 thru 69)		\$ 48,341	\$ 16,098		\$ 2,247	\$ (13,851)	\$ 9,568	70

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

Facility Name & ID Number Aperion Care Princeton

0054775

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		\$ 48,341	\$ 16,098		\$ 2,247	\$ (13,851)	\$ 9,568	1
2	Signage	2018	4,908		20	245	245	613	2
3	Replacement Of Oversized Gutters On Rear Of Building (6,770)	2018	6,625		20	331	331	800	3
4	Installation Of New Hot Water Heater (9,095)	2018	8,877		20	444	444	999	4
5	5 Ton A/C Unit	2020	2,813		20	141	141	141	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)		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	34

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

Facility Name & ID Number Aperion Care Princeton

0054775

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		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	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
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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)		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	34

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

Facility Name & ID Number Aperion Care Princeton

0054775

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 12C, Carried Forward		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	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
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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)		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	34

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

Facility Name & ID Number Aperion Care Princeton

0054775

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		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	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)		\$ 71,565	\$ 16,098		\$ 3,407	\$ (12,690)	\$ 12,121	34

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

Facility Name & ID Number Aperion Care Princeton

0054775

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
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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	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	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	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Chase Office LLC	2016	6,993	179	20	179		792	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	392	63	20	20	(43)	196	9
10	Allocated from Aperion Care	2012	111	9	20	6	(3)	45	10
11	Allocated from Aperion Care	2013	47	6	20	2	(4)	17	11
12									12
13	Allocated from Chase Office LLC	2020	140		20	7	7	7	13
14	Allocated from Chase Office LLC	2019	3,562	162	20	178	16	356	14
15	Allocated from Chase Office LLC	2018	32	2	20	2	(0)	5	15
16	Allocated from Chase Office LLC	2017	1,619	396	20	81	(315)	324	16
17	Allocated from Chase Office LLC	2016	35,445	2,595	20	1,772	(823)	7,827	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)		\$ 48,341	\$ 3,411		\$ 2,247	\$ (1,164)	\$ 9,568	34

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

Facility Name & ID Number Aperion Care Princeton

0054775

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		\$ 48,341	\$ 3,411		\$ 2,247	\$ (1,164)	\$ 9,568	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 48,341	\$ 3,411		\$ 2,247	\$ (1,164)	\$ 9,568	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	\$ 47,138	\$ 3,664	\$ 4,766	\$ 1,102	10	\$ 16,152	71
72	Current Year Purchases	342	23	36	13	10	36	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 47,480	\$ 3,687	\$ 4,801	\$ 1,115		\$ 16,187	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		2014 CHAMPION CHALLENGER	2019	\$ 13,406	\$	\$ 2,681	\$ 2,681	5	\$ 4,245
77		Alloc from Aperion Care	2020	2,837	126	567	441	5	1,421
78									
79									
80	TOTALS			\$ 16,243	\$ 126	\$ 3,248	\$ 3,122		\$ 5,666

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)			\$	136,065
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	19,910
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	11,457
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(8,454)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	33,975

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:		92		\$ 450,222			3
4	Additions							4
5	Allocated from Aperion Care				173			5
6	Allocated from Chase Office				113			6
7	TOTAL		92		\$ 450,508			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 10,227
- 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		\$	\$ 789	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 789	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 210,086	\$		\$ 210,086	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			37,652			37,652	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			226,144			226,144	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				147,935		147,935	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					2,138	24,324		26,462	13
14	TOTAL			\$		\$ 476,020	\$ 172,259		\$ 648,279	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	\$ 632,777	\$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,313,683		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,103		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	50,116		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,055,679	\$	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	16,486		15
16	Equipment, at Historical Cost	55,881		16
17	Accumulated Depreciation (book methods)	(28,528)		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):	546,639		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 590,478	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,646,157	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 244,967	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,257		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,817		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,317		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		897,011		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,356,369	\$	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		100,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,456,369	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,189,788	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,646,157	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 77,188	1
2	Restatements (describe):		2
3	Bad Debt	(2,208)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,979	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,114,809	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)	\$ 1,114,809	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)	\$ 1,189,788	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Aperion Care Princeton# 0054775Report Period Beginning: 01/01/20Ending: 12/31/20**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**1**

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,170,643	1
2	Discounts and Allowances for all Levels	1,328,781	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,499,424	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	186,974	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 186,974	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	240	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,972	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	427	19
20	Radiology and X-Ray	23	20
21	Other Medical Services	26,366	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,028	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	117	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 117	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		336,069	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 336,069	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,057,612	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	828,599	31
32	Health Care	2,218,915	32
33	General Administration	1,484,767	33
	B. Capital Expense		
34	Ownership	578,324	34
	C. Ancillary Expense		
35	Special Cost Centers	653,358	35
36	Provider Participation Fee	178,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,942,803	40
41	Income before Income Taxes (line 30 minus line 40)**	1,114,809	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,114,809	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 918,656	44
45	Private Pay - Net Inpatient Revenue	945,380	45
46	Medicare - Net Inpatient Revenue	2,403,397	46
47	Other-(specify) <u>Insurance</u>	457,707	47
48	Other-(specify) <u>Managed Care</u>	1,774,284	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,499,424	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	2,109	2,202	\$ 99,705	\$ 45.28	1
2	Assistant Director of Nursing	1,863	2,061	76,035	36.89	2
3	Registered Nurses	9,090	10,152	355,024	34.97	3
4	Licensed Practical Nurses	10,626	11,574	326,181	28.18	4
5	CNAs & Orderlies	47,696	51,510	885,418	17.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	2,080	35,541	17.09	9
10	Activity Assistants	4,352	4,917	49,789	10.13	10
11	Social Service Workers	3,489	3,706	82,722	22.32	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	47,727	22.95	13
14	Head Cook	3,311	3,644	40,017	10.98	14
15	Cook Helpers/Assistants	8,813	9,597	106,201	11.07	15
16	Dishwashers					16
17	Maintenance Workers	2,346	2,442	76,460	31.31	17
18	Housekeepers	11,376	12,103	137,355	11.35	18
19	Laundry	1,938	2,095	23,114	11.03	19
20	Administrator	1,840	2,040	95,630	46.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,912	2,080	38,651	18.58	23
24	Clerical	1,948	2,180	43,284	19.86	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	556	666	12,113	18.19	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	364	527	6,206	11.78	33
34	TOTAL (lines 1 - 33)	117,433	127,656	\$ 2,537,173 *	\$ 19.88	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	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	68,562	10-03	38
39	Pharmacist Consultant	Per Unit	10,356	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	11	631	11-03	44
45	Social Service Consultant	12	1,863	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	23	\$ 117,334		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	19	\$ 934	10-03	50
51	Licensed Practical Nurses	312	20,374	10-03	51
52	Certified Nurse Assistants/Aides	178	6,009	10-03	52
53	TOTAL (lines 50 - 52)	509	\$ 27,317		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 Princeton

0054775

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sue Pamela Verway	Administrator		\$ 62,047
Chi Hedgecock	Administrator		33,583
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,630

B. Administrative - Other

Description	Amount
Management Fees - Aperion Care Inc	\$ 294,547
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 294,547

C. Professional Services

Vendor/Payee	Type	Amount
Aperion Care Inc	Data Processing	\$ 23,942
Creative Technology Solutions	Data Processing	5,250
EMSA Purchasing	Procurement Solutions	4,200
PointClick Care Technologies	Data Processing	31,257
Reside Admissions	Data Processing	3,000
Synapse PDI	Patient Data Integration	463
Z-Core Analytics	Data Processing	2,050
Aperion Financial	Home Office Expense	167,964
Propay HR	Payroll Processing	20,590
Marcum LLP	Accounting Fees	19,055
See Attached	Legal	4,288
See Supplemental Schedule		26,016
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 308,075

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 66,114
Unemployment Compensation Insurance	6,250
FICA Taxes	194,094
Employee Health Insurance	77,620
Employee Meals	1,019
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	111
Employee Physicals	8,650
Employee Benefits Other	16,298
TOTAL (agree to Schedule V, line 22, col.8)	\$ 370,155

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	1,311
Health Care Worker Background Check (Indicate # of checks performed 132)	1,314
Patient Background Checks 142	1,415
Dues & Subscriptions	10,198
Licenses & Fees	1,692
See Supplemental Schedule	3,207
Less: Public Relations Expense (	
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,117

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	1,445
See Supplemental Schedule	310
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,755

* Attach copy of IMRF notifications

**See instructions.

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IL478-2471

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 \$13,546

(3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

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

Yes

10 Years

(6)

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

\$ 18,763

Line 10-02

(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?
If YES, give effective date of lease.

No

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

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.
This amount is to be recorded on line 42 of Schedule V.

\$ 178,840

(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.

\$ 1,019

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 240

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c.

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

100% Ln 14

d.

Have vehicle usage logs been maintained?

No

e.

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

N/A

f.

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

N/A

g.

Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17)

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

No

Firm Name:

N/A

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

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