

		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>0056291</u> Facility Name: <u>Aperion Care West Ridge</u> Address: <u>6450 N Ridge Blvd</u> <u>Chicago</u> <u>60626</u> Number City Zip Code County: <u>Cook</u> Telephone Number: <u>(773) 743-8700</u> Fax # <u>(773) 743-8700</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>2/1/2020</u> Type of Ownership: <table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table> In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____	☐	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 _____			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/20</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. <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><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> 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	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____ (Date) _____	(Title) _____	Paid Preparer	(Signed) _____	* 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>
☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL																																																						
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Facility Name & ID Number

Aperion Care West Ridge

#

0056291

Report Period Beginning:

02/01/20

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	110	Skilled (SNF)	110	36,850	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	8,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	45,560	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	14,867	61	1,354	16,282	8
9	SNF/PED					9
10	ICF	18,599			18,599	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,466	61	1,354	34,881	14

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

76.56%

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

None

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

X

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

YES

NO

X

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

Date started

2/1/2020

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

YES

X

Date

2/1/2020

NO

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

YES

X

NO

If YES, enter number of beds certified

110

and days of care provided

332

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

S

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

S

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 West Ridge # 0056291 Report Period Beginning: 02/01/20 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	262,378	23,187	9,090	294,655		294,655	6,823	301,478			1
2	Food Purchase		191,399		191,399		191,399	(363)	191,036			2
3	Housekeeping	200,782	80,446		281,228		281,228	327	281,555			3
4	Laundry	65,132	10,249		75,381		75,381		75,381			4
5	Heat and Other Utilities			115,067	115,067		115,067	(5,833)	109,234			5
6	Maintenance	31,059	19,765	36,287	87,111		87,111	1,911	89,022			6
7	Other (specify):*							2,220	2,220			7
8	TOTAL General Services	559,351	325,046	160,444	1,044,841		1,044,841	5,085	1,049,926			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500	1,570	7,070			9
10	Nursing and Medical Records	1,826,522	169,059	78,856	2,074,437		2,074,437	23,321	2,097,758			10
10a	Therapy	90,097	263		90,360		90,360		90,360			10a
11	Activities	117,565	3,635	1,122	122,322		122,322	17	122,339			11
12	Social Services	127,160		2,278	129,438		129,438		129,438			12
13	CNA Training											13
14	Program Transportation			108	108		108		108			14
15	Other (specify):*							6,540	6,540			15
16	TOTAL Health Care and Programs	2,161,344	172,957	87,864	2,422,165		2,422,165	31,448	2,453,613			16
	C. General Administration											
17	Administrative	102,166		275,983	378,149		378,149	(236,885)	141,264			17
18	Directors Fees											18
19	Professional Services			295,923	295,923		295,923	(155,735)	140,188			19
20	Dues, Fees, Subscriptions & Promotions			62,045	62,045		62,045	(5,186)	56,859			20
21	Clerical & General Office Expenses	139,453		119,375	258,828		258,828	28,479	287,307			21
22	Employee Benefits & Payroll Taxes			470,572	470,572		470,572		470,572			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,018	1,018		1,018	433	1,451			24
25	Other Admin. Staff Transportation			662	662		662	1,311	1,973			25
26	Insurance-Prop.Liab.Malpractice			205,263	205,263		205,263	534	205,797			26
27	Other (specify):*							19,527	19,527			27
28	TOTAL General Administration	241,619		1,430,841	1,672,460		1,672,460	(347,522)	1,324,938			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,962,314	498,003	1,679,149	5,139,466		5,139,466	(310,990)	4,828,476			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			4,320	4,320		4,320	339,155	343,475			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,122	9,122		9,122	309,460	318,582			32
33	Real Estate Taxes			225,500	225,500		225,500	6,499	231,999			33
34	Rent-Facility & Grounds			770,000	770,000		770,000	(769,602)	398			34
35	Rent-Equipment & Vehicles			3,613	3,613		3,613	2,141	5,754			35
36	Other (specify):*			11,394	11,394		11,394	(11,394)				36
37	TOTAL Ownership			1,023,949	1,023,949		1,023,949	(123,740)	900,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,324	208,719	215,043		215,043	(59,327)	155,716			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,647	215,647		215,647		215,647			42
43	Other (specify):*			6,793	6,793		6,793	(6,793)				43
44	TOTAL Special Cost Centers		6,324	431,159	437,483		437,483	(66,120)	371,363			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,962,314	504,327	3,134,257	6,600,898		6,600,898	(500,850)	6,100,048			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,466)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	75,760	30		9
10	Interest and Other Investment Income	(3,156)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,454)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(91,170)	21		24
25	Fund Raising, Advertising and Promotional	(6,793)	43		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	(60,545)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,824)		\$	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)	(407,026)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (407,026)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (500,850)		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	Veteran Ancillary Expenses	\$ (4,471)	10	1
2	Credit Card Processing	(2,107)	21	2
3	Bank Charges	(4,541)	21	3
4	Theft & Damage Loss	(124)	21	4
5	Amortization	(11,394)	36	5
6	Vending Commissions	(450)	02	6
7	Additional R&M	5,667	06	7
8	Capitalized R&M	(3,366)	06	8
9	PAC Dues	(9,656)	20	9
10	Non-Allowable Legal Fees	(1,000)	19	10
11	Building Company - Licenses & Permits	(518)	20	11
12	Building Company - Amortization	(28,585)	36	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(60,545)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care West Ridge # 0056291 Report Period Beginning: 02/01/20 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				6,823								6,823	1
2	Food Purchase	(450)		87									(363)	2
3	Housekeeping			31			296						327	3
4	Laundry													4
5	Heat and Other Utilities	(6,466)					633						(5,833)	5
6	Maintenance	2,301		1,571	(2,968)		1,008						1,911	6
7	Other (specify):*			165	2,055								2,220	7
8	TOTAL General Services	(4,615)		1,853	5,909		1,937						5,085	8
	B. Health Care and Programs													
9	Medical Director			1,570									1,570	9
10	Nursing and Medical Records	(4,471)		4,082	23,651		59						23,321	10
10a	Therapy													10a
11	Activities			17									17	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			454	6,086								6,540	15
16	TOTAL Health Care and Programs	(4,471)		6,122	29,737		59						31,448	16
	C. General Administration													
17	Administrative			(236,885)									(236,885)	17
18	Directors Fees													18
19	Professional Services	(1,000)		7,013	2,366	(160,153)	1,156	(4,530)	(586)				(155,735)	19
20	Fees, Subscriptions & Promotions	(10,174)	518	3,987	29	449	5						(5,186)	20
21	Clerical & General Office Expenses	(99,396)		29,858	435	96,659	923						28,479	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			243	145	45							433	24
25	Other Admin. Staff Transportation			1,300	11								1,311	25
26	Insurance-Prop.Liab.Malpractice			534									534	26
27	Other (specify):*			7,722		11,805							19,527	27
28	TOTAL General Administration	(110,570)	518	(186,228)	2,986	(51,195)	2,083	(4,530)	(586)				(347,522)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(119,656)	518	(178,253)	38,633	(51,195)	4,079	(4,530)	(586)				(310,990)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Aperion Care West Ridge # 0056291 Report Period Beginning: 02/01/20 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	75,760	253,328	1,071	185	190	8,621						339,155	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,156)	293,091	17,375			2,150						309,460	32
33	Real Estate Taxes		4,815				1,684						6,499	33
34	Rent-Facility & Grounds		(770,000)	241			157						(769,602)	34
35	Rent-Equipment & Vehicles			1,099		254	788						2,141	35
36	Other (specify):*	(39,979)	28,585										(11,394)	36
37	TOTAL Ownership	32,625	(190,181)	19,786	185	444	13,401						(123,740)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(27,413)	(31,914)		(59,327)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(6,793)											(6,793)	43
44	TOTAL Special Cost Centers	(6,793)								(27,413)	(31,914)		(66,120)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(93,824)	(189,663)	(158,467)	38,818	(50,751)	17,480	(4,530)	(586)	(27,413)	(31,914)		(500,850)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 770,000	West Ridge Propco, LLC		\$	(770,000)	1
2	V	33	Real Estate Tax	225,500	West Ridge Propco, LLC		230,315	4,815	2
3	V	20	Licenses & Permits		West Ridge Propco, LLC		518	518	3
4	V	36	Amortization		West Ridge Propco, LLC		28,585	28,585	4
5	V	30	Depreciation		West Ridge Propco, LLC		253,328	253,328	5
6	V	32	Interest		West Ridge Propco, LLC		293,091	293,091	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 995,500			\$ 805,837	\$ * (189,663)	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Declaration of Trust of Yosef Meystel	25 %	Aperion Care Bradley	Bradley	West Ridge Propco, LLC	Chicago	Building Co.	1
2	David A. Berkowitz Revocable Trust	25 %	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Aperion Care Exec Holdings, LLC	10 %	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	Ridgeview Investor Group, LLC	30 %	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	Joshua Hoffman	10 %	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6			Aperion Care Demotte	Demotte,IN	Aperion Financial, LLC	Lincolnwood	Bookkeeping	6
7			Aperion Care Dolton	Dolton	Aperion Incorporated Cell	Burlington, VT	Insurance	7
8			Aperion Care Elgin	Elgin	Benton Harbor Property, LLC	Benton Harbor, MI	Building Co.	8
9			Aperion Care Evanston	Evanston	Chase Office, LLC	Lincolnwood	Building Co.	9
10			Aperion Care Fairfield	Fairfield	Concerto Dialysis	Lincolnwood	Dialysis	10
11			Aperion Care Forest Park	Forest Park	Eco-Brite Linen	Skokie	Laundry	11
12			Aperion Care Glenwood	Glenwood	Elevate Care, Inc.	Skokie	Consutling	12
13			Aperion Care Highwood	Highwood	EMSA Purchasing Group	Lincolnwood	Purchasing	13
14			Aperion Care International	Chicago	Interbuild Construction	Chicago	Bldg Improvements	14
15			Aperion Care Jacksonville	Jacksonville	Lifescan Labs of Illinois, LLC	Skokie	Laboratory	15
16			Aperion Care Kokomo	Kokomo, IN	OnTray, LLC	Lincolnwood	Kitchen Management	16
17			Aperion Care Litchfield	Litchfield	Pointe Group Care, LLC	Boston, MA	Bookkeeping	17
18			Aperion Care Marion	Marion, IN	Pointe Property, LLC	Boston, MA	Property Management	18
19			Aperion Care Marseilles	Marseilles	PropayHR	Evanston	Payroll Services	19
20			Aperion Care Mascoutah	Mascoutah	Renewal Rehab, LLC	Lincolnwood	Therapy Services	20
21			Aperion Care Midlothian	Midlothian	San Antonio Property, LLC	San Antonio, TX	Building Co.	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 Princeton	Princeton				27
28			Aperion Care Spring Valley	Spring Valley				28
29			Aperion Care Springfield	Springfield				29
30			Aperion Care St. Elmo	St. Elmo				30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aperion Care Tolleston Park	Gary, IN				1
2			Aperion Care Toluca	Toluca				2
3			Aperion Care West Chicago	Springfield				3
4			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.		\$ 87	\$ 87	15
16	V	3	Housekeeping		Aperion Care, Inc.		31	31	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		1,479	1,479	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		92	92	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		165	165	19
20	V	9	Medical Director		Aperion Care, Inc.		1,570	1,570	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		4,082	4,082	21
22	V	11	Activities		Aperion Care, Inc.		17	17	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		454	454	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		39,098	39,098	24
25	V	19	Professional Fees		Aperion Care, Inc.		7,013	7,013	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		3,987	3,987	26
27	V	21	Clerical Salary		Aperion Care, Inc.		28,763	28,763	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,094	1,094	28
29	V	24	Seminars		Aperion Care, Inc.		243	243	29
30	V	25	Auto & Travel		Aperion Care, Inc.		1,300	1,300	30
31	V	26	Insurance		Aperion Care, Inc.		534	534	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		7,722	7,722	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,071	1,071	33
34	V	32	Interest		Aperion Care, Inc.		17,375	17,375	34
35	V	34	Rent		Aperion Care, Inc.		241	241	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,099	1,099	36
37	V	17	Management Fee	275,983	Aperion Care, Inc.			(275,983)	37
38	V								38
39	Total			\$ 275,983			\$ 117,517	\$ * (158,467)	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		\$ 15,790	\$ 15,790	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		2,672	2,672	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		57	57	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		2,055	2,055	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		53,755	53,755	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		6,086	6,086	20
21	V	19	Professional Fees		Aperion Consulting, LLC		2,366	2,366	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		29	29	22
23	V	21	Clerical & General		Aperion Consulting, LLC		435	435	23
24	V	24	Seminars		Aperion Consulting, LLC		145	145	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		11	11	25
26	V	30	Depreciation		Aperion Consulting, LLC		185	185	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	28,201	Aperion Consulting, LLC			(28,201)	33
34	V	10	Behavioral Health	1,903	Aperion Consulting, LLC			(1,903)	34
35	V	01	Dietician	8,967	Aperion Consulting, LLC			(8,967)	35
36	V	06	Project Manager	5,697	Aperion Consulting, LLC			(5,697)	36
37	V								37
38	V								38
39	Total			\$ 44,768			\$ 83,586	\$ * 38,818	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		3,018	\$	3,018
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		449		449
17	V	21	Clerical & General		Aperion Financial, LLC		56,934		56,934
18	V	24	Seminars		Aperion Financial, LLC		45		45
19	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		6,900		6,900
20	V	30	Depreciaton		Aperion Financial, LLC		190		190
21	V	35	Equipment Rental		Aperion Financial, LLC		254		254
22	V	21	Clerical & General -IL Only		Aperion Financial, LLC		39,725		39,725
23	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		4,905		4,905
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V	19	Home Office Expense	163,171	Aperion Financial, LLC				(163,171)
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 163,171			\$ 112,420	\$ *	(50,751)

* 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		\$ 633	\$ 633	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,008	1,008	16
17	V	3	Housekeeping		Chase Office, LLC		296	296	17
18	V	10	Medical Supplies		Chase Office, LLC		59	59	18
19	V	19	Professional Fees		Chase Office, LLC		1,156	1,156	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		5	5	20
21	V	21	Office Expense		Chase Office, LLC		923	923	21
22	V	30	Depreciation		Chase Office, LLC		8,621	8,621	22
23	V	32	Interest Expense		Chase Office, LLC		2,150	2,150	23
24	V	33	Real Estate Taxes		Chase Office, LLC		1,684	1,684	24
25	V	35	Equipment Rental		Chase Office, LLC		788	788	25
26	V	34	Rent		Chase Office, LLC		157	157	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			\$			\$ 17,480	\$ * 17,480	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	\$ 19,772	ProPay HR LLC		\$ 15,242	\$ (4,530)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 19,772			\$ 15,242	\$ * (4,530)	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	\$ 3,850	EMSA Purchasing Group		\$ 3,264	\$ (586)	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			\$ 3,850			\$ 3,264	\$ * (586)	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	\$ 48,153	Lifescan Labs of Illinois		\$ 20,740	\$ (27,413)	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			\$ 48,153			\$ 20,740	\$ * (27,413)	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	\$ 208,968	Renewal Rehab, LLC		\$ 177,054	\$ (31,914)	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			\$ 208,968			\$ 177,054	\$ * (31,914)	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	\$ 184,238	Aperion Incorporated Cell		\$ 184,238	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 184,238			\$ 184,238	\$ *	39

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

Facility Name & ID Number Aperion Care West Ridge # 0056291 Report Period Beginning: 02/01/20 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	0.73	1.84%	Alloc Sal	\$ 4,590	17-7	1
2	David Berkowitz	Relative	Administrative	0	See Attached	0.73	1.84%	Alloc Sal	2,110	17-7	2
3	Jay Meystel	Relative	Clerical	0	See Attached	0.73	1.84%	Alloc Sal	1,080	21-7	3
4	Elisheva Adest	Relative	Clerical	0	See Attached	0.50	1.84%	Alloc Sal	569	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 8,349		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

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

IL478-2471

Facility Name & ID Number Aperion Care West Ridge# 0056291

Report Period Beginning:

02/01/20Ending: 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	\$	34,881	\$ 87	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		34,881	31	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	34,881	1,479	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		34,881	92	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		34,881	165	5
6	9	Medical Director	Census/Direct Cost	65	85,500		34,881	1,570	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	34,881	4,082	7
8	11	Activities	Census/Direct Cost	65	912		34,881	17	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		34,881	454	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	34,881	39,098	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		34,881	7,013	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		34,881	3,987	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	34,881	28,763	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		34,881	1,094	14
15	24	Seminars	Census/Direct Cost	65	13,215		34,881	243	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		34,881	1,300	16
17	26	Insurance	Census/Direct Cost	65	29,094		34,881	534	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		34,881	7,722	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		34,881	1,071	19
20	32	Interest	Census/Direct Cost	65	946,429		34,881	17,375	20
21	34	Rent	Census/Direct Cost	65	13,110		34,881	241	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		34,881	1,099	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 117,517	25

Facility Name & ID Number	Aperion Care West Ridge
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0056291

Report Period Beginning:

02/01/20

Ending: 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 Consulting, LLC

Street Address

4655 W. Chase Ave.

City / State / Zip Code

Lincolnwood, Illinois 60712

Phone Number

(847) 262-3800

Fax Number

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietician Salary - Illinois Only	Census	1,102,074	46	\$ 498,880	\$ 498,880	34,881	\$ 15,790	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	34,881	2,672	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		34,881	57	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		34,881	2,055	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	34,881	53,755	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		34,881	6,086	6
7	19	Professional Fees	Census	1,488,113	65	100,933		34,881	2,366	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		34,881	29	8
9	21	Clerical & General	Census	1,488,113	65	18,558		34,881	435	9
10	24	Seminars	Census	1,488,113	65	6,182		34,881	145	10
11	25	Auto & Travel	Census	1,488,113	65	484		34,881	11	11
12	30	Depreciation	Census	1,488,113	46	7,885		34,881	185	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	TOTALS					\$ 2,676,688	\$ 2,281,729		\$ 83,586	25

Ending: 12/31/20

()

Ending: 12/31/20

7

IL478-2471

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

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

Ending: 12/31/20

()

Ending: 12/31/20

(847) 410-9720

Ending: 12/31/20

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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	First Financial Bank		X	Mortgage			\$		\$ 8,249,600			\$ 293,091	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Financial Bank		X	Line of Credit					450,000			8,957	6
7	Insurance Policies		X									165	7
8													8
9	TOTAL Facility Related						\$		\$ 8,699,600			\$ 302,213	9
	B. Non-Facility Related*												
10	Interest Income		X									(3,156)	10
11	Alloc from Aperion Care	X										17,375	11
12	Alloc from Chase Office	X										2,150	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ 16,369	14
15	TOTALS (line 9+line14)						\$		\$ 8,699,600			\$ 318,582	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	261,640	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.)				\$	247,639	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(14,001)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	246,000	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.				\$	231,999	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	199,118	8		
		2016	217,637	9		
		2017	233,916	10		
		2018	241,819	11		
		2019	245,955	12		
2020 Accrual = 2019 Tax (rounded)						
Allocated from Chase Office \$1,684						

		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 West Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056291

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.

FACILITY NAME Aperion Care West Ridge COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0056291

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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

B. **Real Estate Tax Cost Allocations**

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

C. Tax Bills

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

A. Square Feet:29,742

B. General Construction Type:ExteriorBrickFrameNumber of Stories3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2020	\$357,237	1
2	Allocated from Chase Office LLC			1,083	2
3	TOTALS			\$358,320	3

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

See Page 12A, Line 70 for total

Facility Name & ID Number Aperion Care West Ridge

0056291

Report Period Beginning:

02/01/20

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)		67,370	4,754		3,131	(1,623)	13,335	68
69	Financial Statement Depreciation			4,320			(4,320)		69
70	TOTAL (lines 4 thru 69)		\$ 6,459,066	\$ 262,402		\$ 170,533	\$ (91,869)	\$ 180,736	70

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

Facility Name & ID Number Aperion Care West Ridge

0056291

Report Period Beginning:

02/01/20

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		\$ 6,459,066	\$ 262,402		\$ 170,533	\$ (91,869)	\$ 180,736	1
2	Door Access For 8 Doors W/ Keypad & Door Sense; 2 Delayed Eg	2020	22,814		20	1,141	1,141	1,141	2
3	Canvas Awning Removed, Recovered, Reinstalled And Design (3,4	2020	3,313		20	166	166	166	3
4	Patch Work Paving - Removal & Replacement	2020	4,605		20	230	230	230	4
5	Generator Repair	2020	3,366		20	168	168	168	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)		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	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)		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	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)		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	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		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	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)		\$ 6,493,163	\$ 262,402		\$ 172,238	\$ (90,164)	\$ 182,441	34

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

Facility Name & ID Number Aperion Care West Ridge

0056291

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

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

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

Facility Name & ID Number Aperion Care West Ridge

0056291

Report Period Beginning:

02/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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.

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	9,746	250	20	250		1,104	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Aperion Care	2010	547	88	20	27	(61)	273	9
10	Allocated from Aperion Care	2012	155	12	20	8	(4)	62	10
11	Allocated from Aperion Care	2013	66	8	20	3	(5)	23	11
12									12
13	Allocated from Chase Office LLC	2020	194		20	10	10	10	13
14	Allocated from Chase Office LLC	2019	4,964	225	20	248	23	496	14
15	Allocated from Chase Office LLC	2018	44	2	20	2	(0)	7	15
16	Allocated from Chase Office LLC	2017	2,256	552	20	113	(439)	451	16
17	Allocated from Chase Office LLC	2016	49,397	3,616	20	2,470	(1,147)	10,908	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)		\$ 67,370	\$ 4,754		\$ 3,131	\$ (1,623)	\$ 13,335	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 12H, Carried Forward		\$ 67,370	\$ 4,754		\$ 3,131	\$ (1,623)	\$ 13,335	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)		\$ 67,370	\$ 4,754		\$ 3,131	\$ (1,623)	\$ 13,335	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	\$ 28,155	\$ 5,106	\$ 2,885	\$ (2,220)	10	\$ 12,361	71
72	Current Year Purchases	1,827,623	32	167,561	167,529	10	167,561	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,855,778	\$ 5,138	\$ 170,447	\$ 165,309		\$ 179,922	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		Alloc from Aperion Care	2020	\$ 3,954	\$ 175	\$ 791	\$ 616	5	\$ 1,980
77									
78									
79									
80	TOTALS			\$ 3,954	\$ 175	\$ 791	\$ 616		\$ 1,980

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)			\$ 8,711,215	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 267,715	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 343,475	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 75,760	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 364,343	

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	Nurse Call System	\$ 41,500
93	Security System	11,327
94	Gas Regulator for Generator	400
95		\$ 53,227

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Aperion Care				241			5
6	Allocated from Chase Office				157			6
7	TOTAL				\$ 398			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: \$ 4,655
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care		\$	\$ 1,099	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,099	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	\$		\$ 94,172	\$		\$ 94,172	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			19,755			19,755	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			94,792			94,792	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				4,732		4,732	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
			hrs							11
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached						1,592		1,592	13
14	TOTAL			\$		\$ 208,719	\$ 6,324		\$ 215,043	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	\$ 44,272	\$ 669,393	1
2	Cash-Patient Deposits	2,014	2,014	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	829,540	829,540	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,853	68,853	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	4,231	4,231	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 948,910	\$ 1,574,031	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		806,904	13
14	Buildings, at Historical Cost		7,262,132	14
15	Leasehold Improvements, at Historical Cost	32,184	32,184	15
16	Equipment, at Historical Cost	8,396	512,711	16
17	Accumulated Depreciation (book methods)	(4,320)	(447,310)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	2,296,499	2,068,053	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,332,759	\$ 10,234,674	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,281,669	\$ 11,808,705	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 163,172	\$ 167,673	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	450,000	450,000	29
30	Accrued Salaries Payable	143,826	143,826	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,529	3,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)		246,000	32
33	Accrued Interest Payable	1,286	28,221	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	500,933	500,933	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,262,746	\$ 1,540,182	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,249,600	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,565,837	1,565,837	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,565,837	\$ 9,815,437	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,828,583	\$ 11,355,619	46
47	TOTAL EQUITY(page 18, line 24)	\$ 453,086	\$ 453,086	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,281,669	\$ 11,808,705	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(358,414)	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	(88,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Member Contributions	900,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 453,086	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)	\$ 453,086	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care West Ridge**# **0056291**Report Period Beginning: **02/01/20**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	\$ 6,947,654	1
2	Discounts and Allowances for all Levels	(1,133,494)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,814,160	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	131,801	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 131,801	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,649	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,649	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,156	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,156	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	281,718	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 281,718	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,242,484	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,044,841	31
32	Health Care	2,422,165	32
33	General Administration	1,672,460	33
	B. Capital Expense		
34	Ownership	1,023,949	34
	C. Ancillary Expense		
35	Special Cost Centers	221,836	35
36	Provider Participation Fee	215,647	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,600,898	40
41	Income before Income Taxes (line 30 minus line 40)**	(358,414)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (358,414)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 799,026	44
45	Private Pay - Net Inpatient Revenue	11,711	45
46	Medicare - Net Inpatient Revenue	201,239	46
47	Other-(specify) <u>Insurance</u>	492	47
48	Other-(specify) <u>Managed Care/Veteran/PPHP/ISNP</u>	4,801,692	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,814,160	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	1,160	1,247	\$ 62,263	\$ 49.93	1
2	Assistant Director of Nursing	1,376	1,428	54,650	38.27	2
3	Registered Nurses	7,399	7,828	253,178	32.34	3
4	Licensed Practical Nurses	24,692	25,928	831,813	32.08	4
5	CNAs & Orderlies	32,735	34,154	619,454	18.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,382	3,607	90,097	24.98	8
9	Activity Director	1,433	1,498	29,610	19.77	9
10	Activity Assistants	5,232	5,692	87,955	15.45	10
11	Social Service Workers	5,822	6,269	127,160	20.28	11
12	Dietician					12
13	Food Service Supervisor	1,342	1,556	27,592	17.73	13
14	Head Cook	2,364	2,388	39,431	16.51	14
15	Cook Helpers/Assistants	11,609	12,583	195,355	15.53	15
16	Dishwashers					16
17	Maintenance Workers	1,808	1,839	31,059	16.89	17
18	Housekeepers	11,801	13,195	200,782	15.22	18
19	Laundry	3,284	3,732	65,132	17.45	19
20	Administrator	1,816	1,929	102,166	52.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,891	2,987	60,535	20.27	23
24	Clerical	4,676	5,094	78,918	15.49	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	313	313	5,164	16.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,135	133,267	\$ 2,962,314 *	\$ 22.23	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	\$ 9,090	01-03	35
36	Medical Director		5,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	28,201	10-03	38
39	Pharmacist Consultant	Per Unit	9,432	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	Monthly	1,122	11-03	44
45	Social Service Consultant	Monthly	2,278	12-03	45
46	Other(specify)				46
47	Behavioral Health Consultant	Monthy	1,903	10-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 57,526		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	320	\$ 39,320	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	320	\$ 39,320		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	
Orlando Arjona	Administrator	0	\$ 58,915	Workers' Compensation Insurance	\$	54,541	IDPH License Fee	\$ 1,652	
John Schlack	Administrator	0	4,250	Unemployment Compensation Insurance		13,405	Advertising: Employee Recruitment	23,909	
Nicholas Bilotta	Administrator	0	30,887	FICA Taxes		226,617	Health Care Worker Background Check	1,813	
Linda Williams	Administrator	0	8,114	Employee Health Insurance		100,227	(Indicate # of checks performed 181)		
				Employee Meals		1,384	Patient Background Checks	477 4,765	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	17,222	
				Union Pension Fund		19,131	Licenses & Fees	3,028	
				Employee Physicals		43,875			
				Other Employee Benefits		11,392			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)									

*** Attach copy of IMRF notifications**

****See instructions.**

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 \$19,312

(3)

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

Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

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.

\$ 9,109

Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(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

No

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

No

(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.

\$ 215,647

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 1,384

No

Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

\$ N/A

c.

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

100% Ln 14

d.

Have vehicle usage logs been maintained?

N/A

e.

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

N/A

f.

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

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$ N/A

(17)

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

No

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

Yes