

		FOR BHF USE					

LL1

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>0052506</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Aperion Care Wilmington</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>555 West Kahler</u> <u>Wilmington</u> <u>60481</u>			
Number City Zip Code			
County: <u>Will</u>			
Telephone Number: <u>(815) 476-7931</u> Fax # <u>(815) 476-7939</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>12/6/2006</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
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: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		Paid Preparer	
		(Signed) _____ 05/21/2021 (Date) _____	
		* Subject to the attached Accountants' Consulting Report	
		(Print Name and Title) <u>Steven N. Lavenda, CPA</u> <u>Partner</u>	
		(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>	
		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	

#	0052506	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 12/6/2006

YES ☒ Date 12/6/2006 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 80 and days of care provided 1,691

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.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **92.59%**

92.59%

Facility Name & ID Number Aperion Care Wilmington # 0052506 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	278,329	32,701	21,522	332,552		332,552	4,709	337,261			1
2	Food Purchase		356,653		356,653		356,653	(169)	356,484			2
3	Housekeeping	149,229	74,432		223,661		223,661	543	224,204			3
4	Laundry	2,768	7,365	117,989	128,122		128,122		128,122			4
5	Heat and Other Utilities			147,090	147,090		147,090	(8,065)	139,025			5
6	Maintenance	85,356	18,698	63,218	167,272		167,272	9,045	176,317			6
7	Other (specify):*							3,688	3,688			7
8	TOTAL General Services	515,682	489,849	349,819	1,355,350		1,355,350	9,751	1,365,101			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	2,608	14,608			9
10	Nursing and Medical Records	2,668,267	216,733	170,062	3,055,062		3,055,062	27,866	3,082,928			10
10a	Therapy	110,439	1,487		111,926		111,926		111,926			10a
11	Activities	207,820	3,550	3,835	215,205		215,205	28	215,233			11
12	Social Services	346,841		12,990	359,831		359,831		359,831			12
13	CNA Training											13
14	Program Transportation			1,365	1,365		1,365		1,365			14
15	Other (specify):*							10,866	10,866			15
16	TOTAL Health Care and Programs	3,333,367	221,770	200,252	3,755,389		3,755,389	41,367	3,796,756			16
	C. General Administration											
17	Administrative	137,458		532,108	669,566		669,566	(467,155)	202,411			17
18	Directors Fees											18
19	Professional Services			504,887	504,887		504,887	(330,915)	173,972			19
20	Dues, Fees, Subscriptions & Promotions			72,409	72,409		72,409	(27,053)	45,356			20
21	Clerical & General Office Expenses	164,206		276,811	441,017		441,017	(26,659)	414,358			21
22	Employee Benefits & Payroll Taxes			711,706	711,706		711,706		711,706			22
23	Inservice Training & Education											23
24	Travel and Seminar			466	466		466	718	1,184			24
25	Other Admin. Staff Transportation			7,101	7,101		7,101	2,179	9,280			25
26	Insurance-Prop.Liab.Malpractice			150,435	150,435		150,435	887	151,322			26
27	Other (specify):*							32,441	32,441			27
28	TOTAL General Administration	301,664		2,255,923	2,557,587		2,557,587	(815,557)	1,742,030			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,150,713	711,619	2,805,994	7,668,326		7,668,326	(764,439)	6,903,887			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			158,355	158,355		158,355	131,424	289,779			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,498	73,498		73,498	692,985	766,483			32
33	Real Estate Taxes							110,812	110,812			33
34	Rent-Facility & Grounds			1,410,000	1,410,000		1,410,000	(1,409,339)	661			34
35	Rent-Equipment & Vehicles			13,272	13,272		13,272	3,557	16,829			35
36	Other (specify):*			4,653	4,653		4,653	106,573	111,226			36
37	TOTAL Ownership			1,659,778	1,659,778		1,659,778	(363,988)	1,295,790			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,930	272,279	386,209		386,209	(41,621)	344,588			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			436,828	436,828		436,828		436,828			42
43	Other (specify):*			3,207	3,207		3,207	(3,207)				43
44	TOTAL Special Cost Centers		113,930	712,314	826,244		826,244	(44,828)	781,416			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,150,713	825,549	5,178,086	10,154,348		10,154,348	(1,173,255)	8,981,093			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	(9,117)	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	(171,198)	30		9
10	Interest and Other Investment Income	(1,990)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(1,810)	21		18
19	Entertainment				19
20	Contributions	(22,500)	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	(203,708)	21		24
25	Fund Raising, Advertising and Promotional	(3,207)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,090)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(55,870)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (483,553)		\$	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)	(689,702)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (689,702)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,173,255)		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	\$ (1,719)	19	1
2	Credit Card Processing	(1,151)	21	2
3	Bank Charges	(18,283)	21	3
4	Theft & Damage Loss	(52)	21	4
5	Amortization	(4,653)	36	5
6	Vending Commissions	(250)	02	6
7	Additional R&M	13,899	06	7
8	Other Professional Fees - Prior Year	(532)	19	8
9	PAC Dues	(11,979)	20	9
10	Building Company - Amortization	(7,184)	36	10
11	Building Company - License & Permits	(636)	20	11
12	Building Company - Accounting Fees	(11,330)	19	12
13	Building Company - Bookkeeping Fee	(12,000)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(55,870)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Aperion Care Wilmington# 0052506

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				4,709								4,709	1
2	Food Purchase	(313)		144									(169)	2
3	Housekeeping			51			492						543	3
4	Laundry													4
5	Heat and Other Utilities	(9,117)					1,052						(8,065)	5
6	Maintenance	13,899		2,610	(9,138)		1,674						9,045	6
7	Other (specify):*			274	3,414								3,688	7
8	TOTAL General Services	4,469		3,079	(1,015)		3,218						9,751	8
	B. Health Care and Programs													
9	Medical Director			2,608									2,608	9
10	Nursing and Medical Records			6,781	20,987		98						27,866	10
10a	Therapy													10a
11	Activities			28									28	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			755	10,111								10,866	15
16	TOTAL Health Care and Programs			10,171	31,098		98						41,367	16
	C. General Administration													
17	Administrative			(467,155)									(467,155)	17
18	Directors Fees													18
19	Professional Services	(25,581)	23,330	35,049	3,930	(362,420)	1,920		(6,504)	(639)			(330,915)	19
20	Fees, Subscriptions & Promotions	(35,115)	636	6,623	49	746	8						(27,053)	20
21	Clerical & General Office Expenses	(239,094)		49,602	723	160,577	1,533						(26,659)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			403	241	74							718	24
25	Other Admin. Staff Transportation			2,160	19								2,179	25
26	Insurance-Prop.Liab.Malpractice			887									887	26
27	Other (specify):*			12,829		19,612							32,441	27
28	TOTAL General Administration	(299,790)	23,966	(359,602)	4,962	(181,411)	3,461		(6,504)	(639)			(815,557)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(295,321)	23,966	(346,352)	35,045	(181,411)	6,777		(6,504)	(639)			(764,439)	29

Summary B

12/31/20

													SUMMARY	
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)		
Depreciation	(171,198)	285,899	1,780	307	315	14,322						131,424	30	
Amortization of Pre-Op. & Org.													31	
Interest	(1,990)	662,538	28,865			3,572						692,985	32	
Real Estate Taxes		108,014				2,798						110,812	33	
Rent-Facility & Grounds		(1,380,000)	400			(29,739)						(1,409,339)	34	
Rent-Equipment & Vehicles			1,826		422	1,309						3,557	35	
Other (specify):*	(11,837)	118,410										106,573	36	
TOTAL Ownership	(185,025)	(205,139)	32,870	307	737	(7,738)						(363,988)	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation													38	
Ancillary Service Centers										(41,621)		(41,621)	39	
Barber and Beauty Shops													40	
Coffee and Gift Shops													41	
Provider Participation Fee													42	
Other (specify):*	(3,207)											(3,207)	43	
TOTAL Special Cost Centers	(3,207)									(41,621)		(44,828)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(483,553)	(181,173)	(313,481)	35,352	(180,674)	(961)		(6,504)	(639)	(41,621)		(1,173,255)	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.

1OWNERS		2RELATED NURSING HOMES		3OTHER 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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,380,000	555 W. Kahler, LLC		\$	(1,380,000)	1
2	V	32	Interest	216	555 W. Kahler, LLC		662,754	662,538	2
3	V	36	Amortization		555 W. Kahler, LLC		7,184	7,184	3
4	V	36	Insurance MIP		555 W. Kahler, LLC		111,226	111,226	4
5	V	33	Real Estate Tax		555 W. Kahler, LLC		108,014	108,014	5
6	V	19	Bookkeeping Fees		555 W. Kahler, LLC		12,000	12,000	6
7	V	20	Licenses & Permits		555 W. Kahler, LLC		636	636	7
8	V	19	Accounting Fees		555 W. Kahler, LLC		11,330	11,330	8
9	V	30	Depreciation		555 W. Kahler, LLC		285,899	285,899	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,380,216			\$ 1,199,043	\$ * (181,173)	14

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

Facility Name & ID Number

Aperion Care Wilmington

0052506

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	The Rajchenbach Family Trust	16.6700%	Aperion Care Bradley	Bradley	555 W. Kahler, LLC	Wilmington	Building Co.	1
2	Rita Lipshitz	16.6600%	Aperion Care Bridgeport	Bridgeport	Aperion Care Demotte	Demotte, IN	ALF	2
3	Delcaration of Trust Yosef Meystel	40.6700%	Aperion Care Burbank	Burbank	Aperion Care, Inc.	Lincolnwood	Corporate Manager	3
4	David A. Berkowitz Revocable Trust	24.0000%	Aperion Care Capitol	Capitol	Aperion Consulting, LLC	Lincolnwood	Consulting Co.	4
5	Steven Turofsky	1.0000%	Aperion Care Chicago Heights	Chicago Heights	Aperion Estates Peru	Peru, IN	ALF	5
6	Fredrick S. Frankel Trust	1.0000%	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			Aperin Care West Ridge	Chicago				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.		\$ 144	\$ 144	15
16	V	3	Housekeeping		Aperion Care, Inc.		51	51	16
17	V	6	Maintenance Salary		Aperion Care, Inc.		2,457	2,457	17
18	V	6	Repairs & Maintenance		Aperion Care, Inc.		153	153	18
19	V	7	Emp. Ben.-Gen. Serv. & Dietary		Aperion Care, Inc.		274	274	19
20	V	9	Medical Director		Aperion Care, Inc.		2,608	2,608	20
21	V	10	Salary - Nurse		Aperion Care, Inc.		6,781	6,781	21
22	V	11	Activities		Aperion Care, Inc.		28	28	22
23	V	15	Payroll Taxes / Group Insurance		Aperion Care, Inc.		755	755	23
24	V	17	Administrative Salaries		Aperion Care, Inc.		64,953	64,953	24
25	V	19	Professional Fees		Aperion Care, Inc.		11,650	11,650	25
26	V	20	Fees, Subscriptions		Aperion Care, Inc.		6,623	6,623	26
27	V	21	Clerical Salary		Aperion Care, Inc.		47,784	47,784	27
28	V	21	Clerical & General		Aperion Care, Inc.		1,818	1,818	28
29	V	24	Seminars		Aperion Care, Inc.		403	403	29
30	V	25	Auto & Travel		Aperion Care, Inc.		2,160	2,160	30
31	V	26	Insurance		Aperion Care, Inc.		887	887	31
32	V	27	Emp. Ben.-Gen. Admin.		Aperion Care, Inc.		12,829	12,829	32
33	V	30	Depreciaiton		Aperion Care, Inc.		1,780	1,780	33
34	V	32	Interest		Aperion Care, Inc.		28,865	28,865	34
35	V	34	Rent		Aperion Care, Inc.		400	400	35
36	V	35	Auto Lease		Aperion Care, Inc.		1,826	1,826	36
37	V	17	Management Fee	532,108	Aperion Care, Inc.			(532,108)	37
38	V	19	Home Office	(23,399)	Aperion Care, Inc.			23,399	38
39	Total			\$ 508,709			\$ 195,228	\$ * (313,481)	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	1	Dietician Salary - Illinois Only	\$	Aperion Consulting, LLC		\$ 26,231	\$ 26,231	15
16	V	6	Maintenance Salary-Illinois Only		Aperion Consulting, LLC		4,440	4,440	16
17	V	6	Repairs & Maintenance		Aperion Consulting, LLC		95	95	17
18	V	7	Emp. Ben.-Gen. Serv. -Illinois		Aperion Consulting, LLC		3,414	3,414	18
19	V	10	Salary Nurse-Illinois		Aperion Consulting, LLC		89,303	89,303	19
20	V	15	Emp. Ben HC-Illinois		Aperion Consulting, LLC		10,111	10,111	20
21	V	19	Professional Fees		Aperion Consulting, LLC		3,930	3,930	21
22	V	20	Fees, Subscriptions		Aperion Consulting, LLC		49	49	22
23	V	21	Clerical & General		Aperion Consulting, LLC		723	723	23
24	V	24	Seminars		Aperion Consulting, LLC		241	241	24
25	V	25	Auto & Travel		Aperion Consulting, LLC		19	19	25
26	V	27	Emp. Ben Gen. Serv.-Illinois		Aperion Consulting, LLC				26
27	V	30	Depreciation		Aperion Consulting, LLC		307	307	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	10	RN Consulting	67,682	Aperion Consulting, LLC			(67,682)	33
34	V	10	Behavioral Health	634	Aperion Consulting, LLC			(634)	34
35	V	01	Dietician	21,522	Aperion Consulting, LLC			(21,522)	35
36	V	06	Project Manager	13,673	Aperion Consulting, LLC			(13,673)	36
37	V								37
38	V								38
39	Total			\$ 103,511			\$ 138,863	\$ * 35,352	39

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees		Aperion Financial, LLC		5,013	\$	5,013
16	V	20	Fees, Subscriptions		Aperion Financial, LLC		746		746
17	V	21	Clerical & General		Aperion Financial, LLC		94,583		94,583
18	V	24	Seminars		Aperion Financial, LLC		74		74
19	V	25	Auto & Travel		Aperion Financial, LLC				
20	V	27	Emp. Ben. - Gen. Admin.		Aperion Financial, LLC		11,463		11,463
21	V	30	Depreciaton		Aperion Financial, LLC		315		315
22	V	32	Interest		Aperion Financial, LLC				
23	V	35	Equipment Rental		Aperion Financial, LLC		422		422
24	V	21	Clerical & General -IL Only		Aperion Financial, LLC		65,994		65,994
25	V	27	Emp. Ben. - Gen. Admin.- IL Only		Aperion Financial, LLC		8,149		8,149
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V	19	Home Office Expense	367,433	Aperion Financial, LLC				(367,433)
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 367,433			\$ 186,759	\$ *	(180,674)

* 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		\$ 1,052	\$ 1,052	15
16	V	6	Repairs & Maintenance		Chase Office, LLC		1,674	1,674	16
17	V	3	Housekeeping		Chase Office, LLC		492	492	17
18	V	10	Medical Supplies		Chase Office, LLC		98	98	18
19	V	19	Professional Fees		Chase Office, LLC		1,920	1,920	19
20	V	20	Dues & Subscriptions		Chase Office, LLC		8	8	20
21	V	21	Office Expense		Chase Office, LLC		1,533	1,533	21
22	V	30	Depreciation		Chase Office, LLC		14,322	14,322	22
23	V	32	Interest Expense		Chase Office, LLC		3,572	3,572	23
24	V	33	Real Estate Taxes		Chase Office, LLC		2,798	2,798	24
25	V	35	Equipment Rental		Chase Office, LLC		1,309	1,309	25
26	V	34	Rent	30,000	Chase Office, LLC		261	(29,739)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,000			\$ 29,039	\$ * (961)	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	\$ 117,989	EcoBrite Linen		\$ 117,989	\$	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			\$ 117,989			\$ 117,989	\$ *	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	\$ 28,390	ProPay HR LLC		\$ 21,886	\$ (6,504)	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			\$ 28,390			\$ 21,886	\$ * (6,504)	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	Data Processing	\$ 4,200	EMSA Purchasing Group		\$ 3,561	\$ (639)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,200			\$ 3,561	\$ * (639)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	\$ 272,528	Renewal Rehab, LLC		\$ 230,907	\$ (41,621)	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			\$ 272,528			\$ 230,907	\$ * (41,621)	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	\$ 76,603	Aperion Incorporated Cell		\$ 76,603	\$	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			\$ 76,603			\$ 76,603	\$ *	39

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

Facility Name & ID Number Aperion Care Wilmington # 0052506 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0	See Attached	1.22	3.05%	Alloc Salary	\$ 7,625	17-7	1
2	Jay Meystel	Relative	Clerical	0	See Attached	1.22	3.05%	Alloc Salary	1,794	21-7	2
3	Elisheva Adest	Relative	Clerical	0	See Attached	0.83	3.05%	Alloc Salary	946	21-7	3
4	David Berkowitz	Relative	Administrative	0	See Attached	1.22	3.05%	Alloc Salary	3,505	17-7	4
5	Fred Frankel	Relative	Administrative	0	See Attached	1.22	3.05%	Alloc Salary	7,625	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.22	3.05%	Alloc Salary	7,625	17-7	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	\$ 29,120		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 Wilmington# 0052506

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	\$	57,947	\$ 144	1
2	3	Housekeeping	Census/Direct Cost	65	1,663		57,947	51	2
3	6	Maintenance Salary	Census/Direct Cost	65	64,200	64,200	57,947	2,457	3
4	6	Repairs & Maintenance	Census/Direct Cost	65	5,009		57,947	153	4
5	7	Emp. Ben.-Gen. Serv. & Dietary	Census/Direct Cost	65	7,146		57,947	274	5
6	9	Medical Director	Census/Direct Cost	65	85,500		57,947	2,608	6
7	10	Salary - Nurse	Census/Direct Cost	65	386,855	386,855	57,947	6,781	7
8	11	Activities	Census/Direct Cost	65	912		57,947	28	8
9	15	Payroll Taxes / Group Insurance	Census/Direct Cost	65	43,060		57,947	755	9
10	17	Administrative Salaries	Census/Direct Cost	65	2,197,984	2,197,984	57,947	64,953	10
11	19	Professional Fees	Census/Direct Cost	65	381,984		57,947	11,650	11
12	20	Fees, Subscriptions	Census/Direct Cost	65	217,158		57,947	6,623	12
13	21	Clerical Salary	Census/Direct Cost	65	1,613,779	1,613,779	57,947	47,784	13
14	21	Clerical & General	Census/Direct Cost	65	59,611		57,947	1,818	14
15	24	Seminars	Census/Direct Cost	65	13,215		57,947	403	15
16	25	Auto & Travel	Census/Direct Cost	65	70,828		57,947	2,160	16
17	26	Insurance	Census/Direct Cost	65	29,094		57,947	887	17
18	27	Emp. Ben.-Gen. Admin.	Census/Direct Cost	65	433,479		57,947	12,829	18
19	30	Depreciaton	Census/Direct Cost	65	58,358		57,947	1,780	19
20	32	Interest	Census/Direct Cost	65	946,429		57,947	28,865	20
21	34	Rent	Census/Direct Cost	65	13,110		57,947	400	21
22	35	Auto Lease	Census/Direct Cost	65	59,876		57,947	1,826	22
23									23
24									24
25	TOTALS				\$ 6,693,967	\$ 4,262,818		\$ 195,228	25

Facility Name & ID Number	Aperion Care Wilmington
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0052506

Report Period Beginning:

01/01/20

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

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	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	57,947	\$ 26,231	1
2	6	Maintenance Salary-Illinois Only	Census	1,102,074	46	84,435	84,435	57,947	4,440	2
3	6	Repairs & Maintenance	Census	1,488,113	65	2,434		57,947	95	3
4	7	Emp. Ben.-Gen. Serv. -Illinois	Census	1,102,074	46	64,932		57,947	3,414	4
5	10	Salary Nurse-Illinois	Census	1,102,074	46	1,698,414	1,698,414	57,947	89,303	5
6	15	Emp. Ben HC-Illinois	Census	1,102,074	46	192,301		57,947	10,111	6
7	19	Professional Fees	Census	1,488,113	65	100,933		57,947	3,930	7
8	20	Fees, Subscriptions	Census	1,488,113	65	1,250		57,947	49	8
9	21	Clerical & General	Census	1,488,113	65	18,558		57,947	723	9
10	24	Seminars	Census	1,488,113	65	6,182		57,947	241	10
11	25	Auto & Travel	Census	1,488,113	65	484		57,947	19	11
12	27	Emp. Ben Gen. Serv.-Illinois	Census	1,488,113	65			57,947		12
13	30	Depreciation	Census	1,488,113	46	7,885		57,947	307	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		\$ 138,863	25

Ending: 12/31/20

7

IL478-2471

Ending: 12/31/20

()

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.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct			\$	\$		\$ 21,886	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	TOTALS					\$	\$		\$ 21,886	25

Ending: 12/31/20

()

Ending: 12/31/20

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

IL478-2471

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Midwest Bank		X	Mortgage			\$	15,778,494			\$	662,754	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				1,523,496				72,113	6
7	Insurance Policies		X									1,384	7
8													8
9	TOTAL Facility Related						\$	17,301,990			\$	736,251	9
	B. Non-Facility Related*												
10	Interest Income											(1,990)	10
11	Interest Income (Bldg Co)											(216)	11
12	Alloc from Aperion Care Inc.	X										28,865	12
13	Alloc from Chase Office LLC	X										3,572	13
14	TOTAL Non-Facility Related						\$				\$	30,231	14
15	TOTALS (line 9+line14)						\$	17,301,990			\$	766,482	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 111,226 Line # 36

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	117,000	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.)			\$	112,561	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(4,439)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	115,251	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.			\$	110,812	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	156,743	8	
		2016	151,640	9	
		2017	111,423	10	
		2018	110,373	11	
		2019	109,763	12	
2020 Accrual = \$109,763 x 1.05 = \$115,251					
Allocated from Chase Office LLC \$2,798					

		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 Wilmington COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052506

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aperion Care Wilmington COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052506

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet:

40,500

B. General Construction Type:

Exterior

Brick

Frame

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	Facility	40,500	2006	\$ 145,000	1
2	Allocated from Chase Office LLC			1,799	2
3	TOTALS	40,500		\$ 146,799	3

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
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,153,509			107,675	107,675	753,725	67
68	Related Party Allocations (Pages 12H & 12I)		111,920	7,898		5,202	(2,696)	22,153	68
69	Financial Statement Depreciation			158,355			(158,355)		69
70	TOTAL (lines 4 thru 69)		\$ 6,055,009	\$ 452,152		\$ 222,654	\$ (229,497)	\$ 3,598,287	70

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

Facility Name & ID Number Aperion Care Wilmington

0052506

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,055,009	\$ 452,152		\$ 222,654	\$ (229,497)	\$ 3,598,287	1
2	Interior Remodel-Lobby,Conference Rm,Dining,Bathroom (25,000)	2017	23,823		20	1,191	1,191	4,169	2
3	Construction-Ceiling,Floors,Millwork,Plumbing-Whole Facility	2017	165,745		20	8,287	8,287	29,005	3
4	Access Keypads	2017	3,339		20	167	167	584	4
5	Doors And Hand Rails - Alzheimers Unit	2017	6,525		20	326	326	1,114	5
6	Repair Pipe Under Parking Lot	2017	2,800		20	140	140	478	6
7	New Grease Trap Floor	2018	8,271		20	414	414	1,138	7
8	Reseal Parking Lot	2018	3,250		20	163	163	434	8
9	Repair 11 Ptac Units	2018	4,803		20	240	240	640	9
10	Replace Pole Outlets Adjacent To Resident Rooms	2018	11,343		20	567	567	1,418	10
11	New Gate (8,930)	2018	8,688		20	434	434	1,049	11
12	Front Entrance - Flooring,Drop Ceiling,Carpeting,Furniture	2018	11,900		20	595	595	1,686	12
13	Econocare - 6 Offices Carpeting, Ceiling, Lights	2018	57,717		20	2,886	2,886	8,177	13
14	New 48" Sanitary Basin	2019	10,300		20	515	515	773	14
15	Dining Room Doors	2019	4,336		20	217	217	289	15
16	New Motor For Fire Sprinkler Pump	2019	8,726		20	436	436	545	16
17	Kitchenette Areas-Flooring, Millwork, Plumbing	2019	102,160		20	5,108	5,108	10,216	17
18	Replace 12.5 Ton Rooftop Unit (16,450)	2020	15,641		20	782	782	782	18
19	Install Two New Water Heaters	2020	16,905		20	845	845	845	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)		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	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		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	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)		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	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		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
12									12
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,521,281	\$ 452,152		\$ 245,968	\$ (206,184)	\$ 3,661,629	34

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

Facility Name & ID Number Aperion Care Wilmington

0052506

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	Plumbing System Repair	2014	24,700		20	1,235	1,235	8,645	9
10	18 New Wooden Doors	2014	9,067		20	453	453	3,171	10
11	Furnish and Install New 25 KW Kohler Generator	2014	20,487		20	1,024	1,024	7,168	11
12	Water Softener	2014	10,196		20	510	510	3,570	12
13	Facility Renovation: new water service,asphalt patching,lighting	2015	2,089,059		20	104,453	104,453	731,171	13
14	interior demo,millwork,roofing,painting,plumbing,fire protection								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)		\$ 2,153,509	\$		\$ 107,675	\$ 107,675	\$ 753,725	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,153,509	\$		\$ 107,675	\$ 107,675	\$ 753,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,153,509	\$		\$ 107,675	\$ 107,675	\$ 753,725	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from Chase Office LLC	2016	16,191	415	20	415		1,834	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Aperion Care	2010	909	146	20	45	(101)	454	9
10 Allocated from Aperion Care	2012	258	20	20	13	(7)	103	10
11 Allocated from Aperion Care	2013	110	14	20	5	(8)	38	11
12								12
13 Allocated from Chase Office LLC	2020	323		20	16	16	16	13
14 Allocated from Chase Office LLC	2019	8,246	374	20	412	38	825	14
15 Allocated from Chase Office LLC	2018	74	4	20	4	(0)	11	15
16 Allocated from Chase Office LLC	2017	3,748	916	20	187	(729)	750	16
17 Allocated from Chase Office LLC	2016	82,062	6,008	20	4,103	(1,905)	18,122	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)		\$ 111,920	\$ 7,898		\$ 5,202	\$ (2,696)	\$ 22,153	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 12H, Carried Forward		\$ 111,920	\$ 7,898		\$ 5,202	\$ (2,696)	\$ 22,153	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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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)		\$ 111,920	\$ 7,898		\$ 5,202	\$ (2,696)	\$ 22,153	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	\$ 345,237	\$ 8,482	\$ 34,641	\$ 26,159	10	\$ 144,385	71
72	Current Year Purchases	9,610	53	965	912	10	965	72
73	Fully Depreciated Assets	1,190,923				10	1,190,923	73
74								74
75	TOTALS	\$ 1,545,770	\$ 8,535	\$ 35,605	\$ 27,070		\$ 1,336,273	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		FORD CLUB WAGON / OTHER	1900	\$ 13,133	\$	\$	\$	5	\$ 13,133
77		1999 FORD SUPER DUTY F-250	2013	10,000		1,066	1,066	5	10,000
78		2013 GMC SAVANA VAN	2013	54,662		5,827	5,827	5	54,662
79		See Attached		6,569	291	1,314	1,023		3,289
80	TOTALS			\$ 84,364	\$ 291	\$ 8,207	\$ 7,916		\$ 81,084

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)			\$	8,298,213
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	460,978
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	289,780
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(171,198)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,078,986

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Aperion Care Inc.				400			5
6	Allocated from Chase Office LLC				261			6
7	TOTAL				\$ 661			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 15,003
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Aperion Care Inc.		\$	\$ 1,826	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 1,826	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	\$		\$ 117,077	\$		\$ 117,077	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			28,062			28,062	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			127,069			127,069	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				106,947		106,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					71	6,983		7,054	13
14	TOTAL			\$		\$ 272,279	\$ 113,930		\$ 386,209	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	\$ 1,029,311	\$ 1,119,569	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	782,576	782,576	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,489	120,286	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	5,731	365,711	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,915,107	\$ 2,391,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		3,064,500	14
15	Leasehold Improvements, at Historical Cost	1,341,789	3,510,071	15
16	Equipment, at Historical Cost	324,356	689,411	16
17	Accumulated Depreciation (book methods)	(862,558)	(3,021,819)	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	12,200,059	12,402,410	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,003,646	\$ 17,144,573	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,918,753	\$ 19,535,715	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,208,134	\$ 1,208,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,523,496	1,523,496	29
30	Accrued Salaries Payable	317,633	317,633	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,609	11,609	31
32	Accrued Real Estate Taxes(Sch.IX-B)		115,251	32
33	Accrued Interest Payable	4,099	56,694	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,201,492	1,201,492	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,266,463	\$ 4,434,310	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,778,494	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,778,494	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,266,463	\$ 20,212,804	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,652,290	\$ (677,089)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,918,753	\$ 19,535,715	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,089,988	1
2	Restatements (describe):		2
3	Bad Debt	(31,419)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,058,568	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,268,722	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	(675,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,593,722	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)	\$ 10,652,290	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Aperion Care Wilmington**# **0052506**Report Period Beginning: **01/01/20**Ending: **12/31/20****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,669,514	1
2	Discounts and Allowances for all Levels	(2,328,671)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,340,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,433	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,433	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	6,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111	19
20	Radiology and X-Ray	25	20
21	Other Medical Services	9,654	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,879	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,990	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,990	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	948,925	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 948,925	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,423,070	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,355,350	31
32	Health Care	3,755,389	32
33	General Administration	2,557,587	33
	B. Capital Expense		
34	Ownership	1,659,778	34
	C. Ancillary Expense		
35	Special Cost Centers	389,416	35
36	Provider Participation Fee	436,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,154,348	40
41	Income before Income Taxes (line 30 minus line 40)**	2,268,722	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,268,722	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,027,336	44
45	Private Pay - Net Inpatient Revenue	234,225	45
46	Medicare - Net Inpatient Revenue	1,055,210	46
47	Other-(specify) Insurance	723,565	47
48	Other-(specify) Managed Care	8,300,507	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,340,843	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	1,992	2,693	\$ 144,114	\$ 53.51	1
2	Assistant Director of Nursing	1,308	1,668	65,743	39.41	2
3	Registered Nurses	24,564	27,484	906,551	32.98	3
4	Licensed Practical Nurses	16,948	18,463	569,308	30.84	4
5	CNAs & Orderlies	43,444	46,952	947,970	20.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,642	5,254	110,439	21.02	8
9	Activity Director	1,842	2,122	36,374	17.14	9
10	Activity Assistants	11,814	12,713	171,446	13.49	10
11	Social Service Workers	14,148	15,236	337,243	22.13	11
12	Dietician					12
13	Food Service Supervisor	1,547	1,870	34,627	18.52	13
14	Head Cook	3,730	3,786	58,412	15.43	14
15	Cook Helpers/Assistants	12,138	13,742	185,290	13.48	15
16	Dishwashers					16
17	Maintenance Workers	3,926	4,344	85,356	19.65	17
18	Housekeepers	9,874	10,729	149,229	13.91	18
19	Laundry	220	272	2,768	10.18	19
20	Administrator	1,832	2,171	131,226	60.44	20
21	Assistant Administrator	216	216	6,232	28.85	21
22	Other Administrative					22
23	Office Manager	1,728	2,259	48,632	21.53	23
24	Clerical	6,535	7,392	115,574	15.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,897	2,152	34,581	16.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	771	803	9,598	11.95	33
34	TOTAL (lines 1 - 33)	165,116	182,321	\$ 4,150,713 *	\$ 22.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 21,522	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	67,682	10-03	38
39	Pharmacist Consultant	Per Unit	21,965	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	58	3,835	11-03	44
45	Social Service Consultant	15	990	12-03	45
46	Other(specify)				46
47	Psychiatric MC	Monthly	12,000	12-03	47
48	Behavioral Health Consultant	Monthly	634	10-03	48
49	TOTAL (lines 35 - 48)	74	\$ 140,628		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	604	\$ 30,830	10-03	50
51	Licensed Practical Nurses	145	7,051	10-03	51
52	Certified Nurse Assistants/Aides	1,272	41,900	10-03	52
53	TOTAL (lines 50 - 52)	2,021	\$ 79,781		53

STATE OF ILLINOIS

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Facility Name & ID Number

Aperion Care Wilmington

0052506

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jodi Jude	Administrator	0	\$ 131,226
Meir Pancer	Admin in Training	0	6,231
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,457

B. Administrative - Other

Description	Amount
Management Fees - Aperion Care, Inc.	\$ 532,108
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 532,108

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 19,055
Propay HR	Payroll Processing	28,390
Ability Network Inc.	Eligibility Software	6,664
Aperion Care, Inc.	Data Processing	14,613
Creative Technology Solutions	IT Consulting	9,940
DGTELL LLC	Telecommunications Service	500
EMSA Purchasing Group LLC	Procurement Solutions	4,200
PointClickCare Technologies	Data Processing	53,883
Reside Admissions LLC	Data Processing	5,081
Synapse PDI, LLC	Patient Data Integration	550
National Datacare Corp.	Resident Trust Fund Services	4,181
See Supplemental Schedule		357,828
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 504,885

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 135,630
Unemployment Compensation Insurance	15,367
FICA Taxes	317,530
Employee Health Insurance	114,178
Employee Meals	1,064
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	21,478
Employee Physicals	76,690
Other Employee Benefits	29,768
TOTAL (agree to Schedule V, line 22, col.8)	\$ 711,705

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	11,023
Health Care Worker Background Check (Indicate # of checks performed 146)	1,455
Patient Background Checks 76	760
Dues & Subscriptions	18,228
Licenses & Fees	2,484
See Supplemental Schedule	7,426
Less: Public Relations Expense (	
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 45,356

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	466
See Supplemental Schedule	718
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,184

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number <u>Aperion Care Wilmington</u>	STATE OF ILLINOIS # <u>0052506</u>	Report Period Beginning: <u>01/01/20</u>	Ending: <u>12/31/20</u>
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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$23,959

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,797 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 436,828
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,064 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

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

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

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

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