

		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>0053785</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																				
Facility Name: <u>Citadel Care Center Elgin</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>180 South State St</u> <u>Elgin</u> <u>60123</u>																																																																																						
Number City Zip Code																																																																																						
County: <u>Kane</u>																																																																																						
Telephone Number: <u>(847) 742-3310</u> Fax # <u>(847) 742-0924</u>																																																																																						
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ <u>05/23/2021</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td>& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>1/5/2016</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/23/2021</u>	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>	& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>1/5/2016</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<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 colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____					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: _____			
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Facility Name & ID Number Citadel Care Center Elgin

0053785 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,208	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	16,867	982	8,199	26,048	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,867	982	8,199	26,048	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.87%

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 ☒

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

YES ☐ NO ☒

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

Date started 01/05/2016

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

YES ☒ Date 01/05/2016 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 88 and days of care provided 3,443

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Citadel Care Center Elgin # 0053785 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	268,163	20,532	11,054	299,749		299,749		299,749			1
2	Food Purchase		155,423		155,423		155,423	(59)	155,364			2
3	Housekeeping	78,622	24,420	4,045	107,087		107,087	946	108,033			3
4	Laundry	28,555	5,820	1,480	35,855		35,855		35,855			4
5	Heat and Other Utilities			118,994	118,994		118,994	(10,467)	108,527			5
6	Maintenance	61,794	18,422	91,918	172,134		172,134	3,102	175,236			6
7	Other (specify):*							1,573	1,573			7
8	TOTAL General Services	437,134	224,617	227,491	889,242		889,242	(4,905)	884,337			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,332,602	343,230	69,624	2,745,456		2,745,456	(77,390)	2,668,066			10
10a	Therapy		14,751		14,751		14,751	(14,751)	0			10a
11	Activities	57,885	1,095	988	59,968		59,968		59,968			11
12	Social Services	125,681		1,158	126,839		126,839		126,839			12
13	CNA Training											13
14	Program Transportation			23,846	23,846		23,846	(1,248)	22,598			14
15	Other (specify):*							13,237	13,237			15
16	TOTAL Health Care and Programs	2,516,168	359,076	113,616	2,988,860		2,988,860	(80,151)	2,908,709			16
	C. General Administration											
17	Administrative	118,504		369,279	487,783		487,783	(318,090)	169,693			17
18	Directors Fees											18
19	Professional Services			138,022	138,022	(658)	137,364	(13,033)	124,331			19
20	Dues, Fees, Subscriptions & Promotions			71,165	71,165		71,165	(11,787)	59,378			20
21	Clerical & General Office Expenses	128,737	1,976	358,039	488,752		488,752	(232,524)	256,228			21
22	Employee Benefits & Payroll Taxes			484,803	484,803		484,803		484,803			22
23	Inservice Training & Education											23
24	Travel and Seminar			845	845		845	28	873			24
25	Other Admin. Staff Transportation			6,426	6,426		6,426	1,692	8,118			25
26	Insurance-Prop.Liab.Malpractice			345,816	345,816		345,816	2,125	347,941			26
27	Other (specify):*							24,584	24,584			27
28	TOTAL General Administration	247,241	1,976	1,774,395	2,023,612	(658)	2,022,954	(547,004)	1,475,950			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,543	585,669	2,115,502	5,901,714	(658)	5,901,056	(632,060)	5,268,996			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			34,657	34,657		34,657	194,519	229,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,613	17,613		17,613	229,453	247,066			32
33	Real Estate Taxes					658	658	40,523	41,181			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(494,545)	9,455			34
35	Rent-Equipment & Vehicles			20,657	20,657		20,657	9,721	30,378			35
36	Other (specify):*							37,574	37,574			36
37	TOTAL Ownership			576,927	576,927	658	577,585	17,246	594,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,227	533,180	616,407		616,407	(18,554)	597,853			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,933	181,933		181,933		181,933			42
43	Other (specify):*	68,121		72,058	140,179		140,179	(140,179)	0			43
44	TOTAL Special Cost Centers	68,121	83,227	787,171	938,519		938,519	(158,733)	779,786			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,268,664	668,896	3,479,600	7,417,160		7,417,160	(773,547)	6,643,613			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	(11,249)	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	191,896	30		9
10	Interest and Other Investment Income	(10,187)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	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	(601)	21		18
19	Entertainment				19
20	Contributions	(3,100)	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	(221,594)	21		24
25	Fund Raising, Advertising and Promotional	(1,800)	20		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	(285,038)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (341,732)		\$	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)	(431,816)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (431,816)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (773,548)		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	Bank Charges	\$ (8,816)	21	1
2	OT Veterans	(4,928)	10A	2
3	PT Veterans	(9,823)	10A	3
4	Pharmacy Veterans	(49,300)	10	4
5	Radiology Veterans	(1,798)	10	5
6	Sequestration	(12,949)	21	6
7	Patient Needs	(1,202)	10	7
8	Marketing Salary	(68,120)	43	8
9	Marketing Expense	(71,803)	43	9
10	Credit Card/Pymt Process Fees	(1,883)	21	10
11	Additional R&M	5,833	06	11
12	Non Allowable Legal	(13,866)	19	12
13	Promotional Fees	(255)	43	13
14	PAC Dues	(7,832)	20	14
15	Bldg Co - Accounting	(11,085)	19	15
16	Bldg Co - Bank Charges	(1,162)	21	16
17	Bldg Co - Legal & Professional Fees	(1,886)	19	17
18	Ancillary Veterans	(15,236)	39	18
19	Refund for Settlement Fees	(11,332)	21	19
20	Bldg Co - Additional R&M	2,405	06	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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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	(285,038)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center Elgin# 0053785

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													1
2	Food Purchase	(59)											(59)	2
3	Housekeeping			946									946	3
4	Laundry													4
5	Heat and Other Utilities	(11,249)		782									(10,467)	5
6	Maintenance	8,238		(5,268)	131								3,102	6
7	Other (specify):*			1,573									1,573	7
8	TOTAL General Services	(3,070)		(1,967)	131								(4,905)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52,299)		(24,097)			(993)						(77,390)	10
10a	Therapy	(14,751)											(14,751)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							(1,248)					(1,248)	14
15	Other (specify):*			13,237									13,237	15
16	TOTAL Health Care and Programs	(67,050)		(10,860)			(993)	(1,248)					(80,151)	16
	C. General Administration													
17	Administrative			(318,090)									(318,090)	17
18	Directors Fees													18
19	Professional Services	(26,837)	12,971	175	658								(13,033)	19
20	Fees, Subscriptions & Promotions	(12,732)		945									(11,787)	20
21	Clerical & General Office Expenses	(258,337)	1,162	24,651									(232,524)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			28									28	24
25	Other Admin. Staff Transportation			1,692									1,692	25
26	Insurance-Prop.Liab.Malpractice			2,125									2,125	26
27	Other (specify):*			24,584									24,584	27
28	TOTAL General Administration	(297,906)	14,133	(263,889)	658								(547,004)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(368,026)	14,133	(276,716)	789		(993)	(1,248)					(632,060)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	191,896		1,559	1,064								194,519	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10,187)	234,872	1,567	3,201								229,453	32
33	Real Estate Taxes		36,791		3,732								40,523	33
34	Rent-Facility & Grounds		(504,000)	14,282	(4,827)								(494,545)	34
35	Rent-Equipment & Vehicles			9,721									9,721	35
36	Other (specify):*		37,574										37,574	36
37	TOTAL Ownership	181,709	(194,763)	27,130	3,170								17,246	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(15,236)					(3,318)						(18,554)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(140,179)											(140,179)	43
44	TOTAL Special Cost Centers	(155,415)					(3,318)						(158,733)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(341,732)	(180,630)	(249,586)	3,959		(4,311)	(1,248)					(773,547)	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	Rental Income	\$ 504,000	180 S. State Street, LLC		\$	(504,000)	1
2	V	32	Interest	29	180 S. State Street, LLC		234,901	234,872	2
3	V	36	MIP Insurance		180 S. State Street, LLC		37,574	37,574	3
4	V	19	Accounting		180 S. State Street, LLC		11,085	11,085	4
5	V	21	Bank Charges		180 S. State Street, LLC		1,162	1,162	5
6	V	19	Legal & Prof Fees		180 S. State Street, LLC		1,886	1,886	6
7	V	33	Real Estate Taxes		180 S. State Street, LLC		36,791	36,791	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 504,029			\$ 323,399	\$ * (180,630)	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	Citadel Opco Holding LLC	99.90%	AMBERWOOD CARE CENTER	ROCKFORD, IL	180 S. STATE STREET		BUILDING COMPANY	1
2	Jonathan Aaron	0.10%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3			CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4			CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5			THE WATERFORD CARE CENTER LLC	CHICAGO, IL	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	5
6			CITADEL CARE CENTER-STERLING LLC	STERLING, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7			THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				7
8			PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				8
9			SKOKIE MEADOWS LLC	SKOKIE, IL				9
10			THE CITADEL OF SKOKIE LLC	SKOKIE, IL				10
11			THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				11
12			THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				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

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								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

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	3	Housekeeping	\$	Damen Healthcare Group, LLC		\$ 946	\$ 946	15
16	V	5	Utilities		Damen Healthcare Group, LLC		782	782	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		7,401	7,401	17
18	V	6	Maintenance	13,642	Damen Healthcare Group, LLC		973	(12,669)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		1,573	1,573	19
20	V	10	Nursing	87,805	Damen Healthcare Group, LLC		63,708	(24,097)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		13,237	13,237	21
22	V	17	Administrative	369,279	Damen Healthcare Group, LLC		16,419	(352,860)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		175	175	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		945	945	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		92,131	92,131	25
26	V	21	Office Expense - Other	74,178	Damen Healthcare Group, LLC		6,698	(67,480)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		28	28	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		1,692	1,692	28
29	V	26	Insurance		Damen Healthcare Group, LLC		2,125	2,125	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		24,584	24,584	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		1,559	1,559	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		1,567	1,567	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		9,455	9,455	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		4,827	4,827	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		522	522	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		9,199	9,199	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		18,352	18,352	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		16,419	16,419	38
39	Total			\$ 544,903			\$ 295,317	\$ * (249,586)	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.

☒ 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	6	Maintenance	\$	3755 W Chase, LLC		\$ 131	\$ 131	15
16	V	30	Depreciation		3755 W Chase, LLC		1,064	1,064	16
17	V	32	Interest Expense		3755 W Chase, LLC		3,201	3,201	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		3,732	3,732	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		658	658	19
20	V								20
21	V	34	Rent	4,827	3755 W Chase, LLC			(4,827)	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			\$ 4,827			\$ 8,786	\$ * 3,959	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	\$ 229,517	Biltmore Incorporated Cell		\$ 229,517	\$	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			\$ 229,517			\$ 229,517	\$ *	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	10	Medical Supplies/DME	\$ 6,404	Integra Healthcare Equipment		\$ 5,411	\$ (993)	15
16	V	39	Ancillary Expense	21,406	Integra Healthcare Equipment		18,088	(3,318)	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			\$ 27,810			\$ 23,499	\$ * (4,311)	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	14	Patient Transportation	\$ 6,604	Lifeline Ambulance LLC		\$ 5,356	\$ (1,248)	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			\$ 6,604			\$ 5,356	\$ * (1,248)	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	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			\$			\$	\$	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			\$			\$	\$ *	39

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

Facility Name & ID Number Citadel Care Center Elgin # 0053785 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	Jonathan Aaron	Owner	Administrative	0.10%	See Attached	2.94	7.35%	Alloc Mgt Fee	\$ 18,352	17-7	1
2	Kenneth Ripstein	Administrative	Administrative		See Attached	2.63	6.58%	Alloc Mgt Fee	16,419	17-7	2
3	Yakov Kohen	Clerical	Clerical		See Attached	2.63	6.58%	Alloc Salary	9,004	21-7	3
4											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	\$ 43,775		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Ending: 12/31/20

Facility Name & ID Number Citadel Care Center Elgin# 0053785

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

Damen Healthcare Group, LLC

Street Address

3755 W. Chase Ave.

City / State / Zip Code

Skokie, IL 60076

Phone Number

(224) 470-2044

Fax Number

(224) 470-2952

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	3	Housekeeping	Patient Days	396,623	14	\$ 14,400	\$ 26,048	\$ 946	1
2	5	Utilities	Patient Days	396,623	14	11,913	26,048	782	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	26,048	7,401	3
4	6	Maintenance	Patient Days	396,623	14	14,821	26,048	973	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951	26,048	1,573	5
6	10	Nursing	Patient Days	396,623	14	970,057	26,048	63,708	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561	26,048	13,237	7
8	17	Administrative	Patient Days	396,623	14	250,000	26,048	16,419	8
9	19	Professional Fees	Patient Days	396,623	14	2,669	26,048	175	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390	26,048	945	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	26,048	92,131	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995	26,048	6,698	12
13	24	Seminars & Education	Patient Days	396,623	14	431	26,048	28	13
14	25	Auto Expense	Patient Days	396,623	14	25,762	26,048	1,692	14
15	26	Insurance	Patient Days	396,623	14	32,350	26,048	2,125	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325	26,048	24,584	16
17	30	Depreciation	Patient Days	396,623	14	23,745	26,048	1,559	17
18	32	Interest Expense	Patient Days	396,623	14	23,867	26,048	1,567	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975	26,048	9,455	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500	26,048	4,827	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954	26,048	522	21
22	35	Auto Lease	Patient Days	396,623	14	140,073	26,048	9,199	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000	26,048	18,352	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000	26,048	16,419	24
25	TOTALS					\$ 4,467,270	\$ 2,713,873	\$ 295,317	25

Facility Name & ID Number Citadel Care Center Elgin # 0053785 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 3755 W Chase, LLC
Street Address 3755 W. Chase Ave.
City / State / Zip Code Skokie, IL 60076
Phone Number (224) 470-2044
Fax Number (224) 470-2952

	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,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	Patient Days	396,623	14	\$ 2,000	\$	26,048	\$ 131	1
2	30	Depreciation	Patient Days	396,623	14	16,199		26,048	1,064	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		26,048	3,201	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		26,048	3,732	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		26,048	658	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					\$ 133,796	\$		\$ 8,786	25

Ending: 12/31/20

()

Ending: 12/31/20

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

Facility Name & ID Number	Citadel Care Center Elgin
--------------------------------------	----------------------------------

0053785

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

Lifeline Ambulance

Street Address

2424 S Wabash Ave

City / State / Zip Code

Chicago, IL 60616

Phone Number

(312) 949-9595

Fax Number

(312) 949-9262

	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	14	Patient Transportation	Direct			\$	\$		\$ 5,356	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					\$	\$		\$ 5,356	25

Ending: 12/31/20

Facility Name & ID Number Citadel Care Center Elgin # 0053785 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 _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
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
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					\$	\$		\$	25

Ending: 12/31/20

IL478-2471

Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	First American Capital Group		X	Mortgage			\$	5,818,646			\$	234,901	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	First Midwest Bank		X	Line of Credit				422,371				17,613	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	6,241,017				\$	252,514	9
	B. Non-Facility Related*													
10	Interest Income		X									(10,187)	10	
11	Interest Income - Bldg Co		X									(29)	11	
12	Allocated from Damen HC	X										1,567	12	
13	Allocated from 3755 Chase	X										3,201	13	
14	TOTAL Non-Facility Related						\$					\$	(5,448)	14
15	TOTALS (line 9+line14)						\$	6,241,017				\$	247,066	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 37,574 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

[illegible]

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 Citadel Care Center Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0053785

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

B. Real Estate Tax Cost Allocations

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

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

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 Citadel Care Center Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0053785

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

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.)

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

23,117

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

2

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		2016	\$ 464,185	1
2	Allocated from 3755 W Chase		2019	44,146	2
3	TOTALS			\$ 508,331	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88		2016	1967	\$ 3,499,207	\$	39	\$ 89,723	\$ 89,723	\$ 448,615	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2016		23,537		20	1,177	1,177	5,885	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Citadel Care Center Elgin

0053785

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		148,053			7,403	7,403	14,625	67
68	Related Party Allocations (Pages 12H & 12I)		250,162	1,630		1,426	(204)	11,019	68
69	Financial Statement Depreciation			34,657			(34,657)		69
70	TOTAL (lines 4 thru 69)		\$ 3,920,959	\$ 36,287		\$ 99,728	\$ 63,442	\$ 480,144	70

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

Facility Name & ID Number Citadel Care Center Elgin

0053785

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		\$ 3,920,959	\$ 36,287		\$ 99,728	\$ 63,442	\$ 480,144	1
2	New Camera System	2017	8,758		20	438	438	1,752	2
3	Wander Guard System	2017	5,121		20	256	256	1,024	3
4	Intersign Corportation	2017	2,868		20	143	143	573	4
5	Repair To Mixing Valve On Water Heater	2017	4,364		20	218	218	873	5
6	Chiller Repair On A/C	2017	4,646		20	232	232	929	6
7	Hc Dekor - Architectural Plans & Idph Submission/Demo/Doors,	2018	5,694		20	285	285	1,045	7
8	Geostar Mechanical - Domestic Water Storage Tank Replacement	2018	11,074		20	554	554	1,292	8
9	New Doors And Demo/Framing/Drywall In Memory Care	2018	9,970		20	499	499	1,163	9
10	Hot Water Tank	2018	3,640		20	182	182	546	10
11	Replaced Advantage 500De Exit Panel On Sec. Door	2019	2,936		20	147	147	294	11
12	Boilers Repair & Relief Valve Replacement	2019	3,246		20	162	162	324	12
13	Repair Boiler-New Tank	2019	2,634		20	132	132	264	13
14	Burnham Boiler Repairs-New Box Assembly & Gasketing	2019	2,590		20	130	130	260	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)		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	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		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	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		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	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		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,988,500	\$ 36,287		\$ 103,106	\$ 66,820	\$ 490,483	34

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

Facility Name & ID Number Citadel Care Center Elgin

0053785

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	High Volumn Radon Fan	2019	47,350		20	2,367	2,367	4,735	9
10	Parking Lot Repairs / Seal / Stripe	2019	4,761		20	238	238	476	10
11	Flooring for Lobby Reception	2018	35,000		20	1,750	1,750	3,500	11
12	Painting/Repairs Reception Area	2018	24,402		20	1,220	1,220	2,440	12
13	New Lobby Wallcoverings	2018	32,926		20	1,646	1,646	3,293	13
14	Service Hallway Doors Replacement	2020	3,614		20	181	181	181	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)		\$ 148,053	\$		\$ 7,403	\$ 7,403	\$ 14,625	34

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

Facility Name & ID Number Citadel Care Center Elgin

0053785

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 148,053	\$		\$ 7,403	\$ 7,403	\$ 14,625	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 148,053	\$		\$ 7,403	\$ 7,403	\$ 14,625	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 3737 Chase	2019	250,162	1,064	35	1,426	362	11,019	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		566			(566)		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)		\$ 250,162	\$ 1,630		\$ 1,426	\$ (204)	\$ 11,019	34

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

Facility Name & ID Number Citadel Care Center Elgin

0053785

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 250,162	\$ 1,630		\$ 1,426	\$ (204)	\$ 11,019	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 250,162	\$ 1,630		\$ 1,426	\$ (204)	\$ 11,019	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,237,736	\$540	\$123,730	\$123,190	10	\$615,242	71
72	Current Year Purchases	23,335	366	2,253	1,887	10	2,253	72
73	Fully Depreciated Assets	15,745	87	87		10	15,745	73
74								74
75	TOTALS	\$1,276,816	\$994	\$126,070	\$125,076		\$633,240	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,773,648	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$37,280	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$229,176	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$191,896	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,123,723	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Elevator Repair	\$2,850	92
93	Water Softener	4,929	93
94			94
95		\$7,779	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 Damen HC				9,455			5
6								6
7	TOTAL				\$ 9,455			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: \$ 9,910
- 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	Facility	2012 Ford E-450	\$ 939	\$ 11,269	17
18	Allocated from Damen HC			9,199	18
19					19
20					20
21	TOTAL		\$ 939	\$ 20,468	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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 149,040	\$		\$ 149,040	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105,233			105,233	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			222,852			222,852	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				83,085		83,085	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					56,055	142		56,197	13
14	TOTAL			\$		\$ 533,180	\$ 83,227		\$ 616,407	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	\$ 1,758,389	\$ 1,871,319	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,084,123	1,084,123	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	274,012	305,723	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	18,317	295,201	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,134,841	\$ 3,556,366	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		511,185	13
14	Buildings, at Historical Cost		3,239,645	14
15	Leasehold Improvements, at Historical Cost	62,385	349,724	15
16	Equipment, at Historical Cost	136,194	1,419,932	16
17	Accumulated Depreciation (book methods)	(120,730)	(1,666,909)	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	56,849	212,833	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 134,698	\$ 4,066,410	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,269,539	\$ 7,622,776	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 485,778	\$ 511,776	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	422,371	422,371	29
30	Accrued Salaries Payable	127,813	127,813	30
31	Accrued Taxes Payable (excluding real estate taxes)	154,308	154,308	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,518	32
33	Accrued Interest Payable	1,329	22,281	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	848,925	848,925	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,040,524	\$ 2,125,992	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,818,646	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)	\$	\$ 5,818,646	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,040,524	\$ 7,944,638	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,229,015	\$ (321,862)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,269,539	\$ 7,622,776	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 393,076	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 393,075	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	835,940	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 835,940	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,229,015	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Citadel Care Center Elgin

0053785

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	\$ 9,034,142	1
2	Discounts and Allowances for all Levels	(2,102,433)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,931,709	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	452,834	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 452,834	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	31	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45	19
20	Radiology and X-Ray	(1)	20
21	Other Medical Services	955	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,030	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,187	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,187	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	857,340	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 857,340	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,253,100	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	889,242	31
32	Health Care	2,988,860	32
33	General Administration	2,023,612	33
	B. Capital Expense		
34	Ownership	576,927	34
	C. Ancillary Expense		
35	Special Cost Centers	756,586	35
36	Provider Participation Fee	181,933	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,417,160	40
41	Income before Income Taxes (line 30 minus line 40)**	835,940	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 835,940	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,548,664	44
45	Private Pay - Net Inpatient Revenue	244,000	45
46	Medicare - Net Inpatient Revenue	1,936,578	46
47	Other-(specify) <u>Managed Care</u>	315,015	47
48	Other-(specify) <u>Hospice/Veterans</u>	887,452	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,931,709	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,052	2,160	\$ 103,636	\$ 47.98	1
2	Assistant Director of Nursing	330	347	14,958	43.11	2
3	Registered Nurses	19,246	20,259	764,730	37.75	3
4	Licensed Practical Nurses	18,836	19,828	560,238	28.26	4
5	CNAs & Orderlies	49,929	52,556	889,040	16.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,048	2,156	32,311	14.99	9
10	Activity Assistants	2,380	2,505	25,574	10.21	10
11	Social Service Workers	4,104	4,320	125,681	29.09	11
12	Dietician					12
13	Food Service Supervisor	2,060	2,168	48,029	22.15	13
14	Head Cook	6,154	6,478	98,498	15.21	14
15	Cook Helpers/Assistants	11,013	11,593	121,636	10.49	15
16	Dishwashers					16
17	Maintenance Workers	2,155	2,269	61,794	27.24	17
18	Housekeepers	6,786	7,143	78,622	11.01	18
19	Laundry	2,159	2,273	28,555	12.56	19
20	Administrator	2,135	2,247	118,504	52.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,052	2,160	64,300	29.77	23
24	Clerical	4,377	4,608	64,437	13.98	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,802	1,897	68,121	35.91	33
34	TOTAL (lines 1 - 33)	139,618	146,966	\$ 3,268,664 *	\$ 22.24	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	216	\$ 11,054	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,000	10-03	38
39	Pharmacist Consultant	Monthly	15,738	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	17	988	11-03	44
45	Social Service Consultant	18	1,158	12-03	45
46	Other(specify) MDS Consultant	Monthly	21,581	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	\$ 71,519		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,082	29,305	10-03	52
53	TOTAL (lines 50 - 52)	1,082	\$ 29,305		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Ben Kramer	Administrator	0	\$ 19,199	Workers' Compensation Insurance	\$	44,953	IDPH License Fee	\$	
Tiffany Barton - 2/18/20	Administrator		99,305	Unemployment Compensation Insurance		14,465	Advertising: Employee Recruitment	31,943	
				FICA Taxes		250,053	Health Care Worker Background Check		
				Employee Health Insurance		135,354	(Indicate # of checks performed 145)	5,038	
				Employee Meals			Patient Background Checks	141	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	17,960	
				Life Insurance		4,028	Licenses & Fees	2,082	
				Employee Benefits - Other		13,937			
				Holiday Expense		2,069			
				401K Employer Match Expense		19,944			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 118,504						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees - Damen Healthcare Group, LLC		\$	369,279				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 369,279				In-State Travel		
(Attach a copy of any management service agreement)									
C. Professional Services				TOTAL					
Vendor/Payee	Type		Amount			\$			
Marcum LLP	Accounting	\$	32,290						
ProPay HR	Payroll Services		17,908						
Esolutions Inc.	Data Processing		2,295						
IIT/SourceTech	Data Processing		2,170						
National Datacare Corporation	Data Processing		1,912						
Point Click Care Technologies	Data Processing		38,556						
Prime Care Technologies	Data Processing		2,590						
Reside Admissions LLC	Data Processing		2,614				Seminar Expense	845	
Telemedicine Solutions LLC	Data Processing		2,880						
Achieve Accreditation	Accreditation		5,614						
See Attached	Legal		24,387				See Supplemental Schedule	28	
See Supplemental Schedule			4,804				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)							(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)			\$ 138,021				line 24, col. 8)	\$ 873	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

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

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
HCCI \$15,664

(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
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.

\$ 26,186 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 X NO

(10)

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

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 181,933

(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?

\$ N/A
Indicate the amount. \$

(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?

No

e.

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

Yes

f.

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

Yes

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