

		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: 0053801 Facility Name: Citadel Care Center Wilmette Address: 432 Poplar Drive Wilmette 60091 County: Cook Telephone Number: (847) 256-5000 Fax #: (847) 256-0225 HFS ID Number: Date of Initial License for Current Owners: 1/5/2016 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steven N. Lavenda Telephone Number: (847) 282-6300 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) Paid Preparer (Signed) 05/24/2021 * Subject to the attached Accountants' Consulting Report (Date) (Print Name Steven N. Lavenda, CPA and Title Partner) (Firm Name Marcum, LLP & Address 9 Parkway North, Suite 200 Deerfield, IL 60015) (Telephone) (847) 282-6300 Fax #: (847) 282-6301 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Citadel Care Center Wilmette

0053801 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	80	Skilled (SNF)	80	29,280	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	80	TOTALS	80	29,280	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	9,857	4,101	6,694	20,652	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,857	4,101	6,694	20,652	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.53%

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 80 and days of care provided 5,629

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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	292,733	24,431	16,807	333,971		333,971		333,971			1
2	Food Purchase		156,707		156,707		156,707	(311)	156,396			2
3	Housekeeping	161,236	18,507	6,225	185,968		185,968	750	186,718			3
4	Laundry			98,561	98,561		98,561		98,561			4
5	Heat and Other Utilities			80,954	80,954		80,954	(7,925)	73,029			5
6	Maintenance	59,118	24,587	99,568	183,273		183,273	8,110	191,383			6
7	Other (specify):*							1,247	1,247			7
8	TOTAL General Services	513,087	224,232	302,115	1,039,434		1,039,434	1,871	1,041,305			8
	B. Health Care and Programs											
9	Medical Director			65,000	65,000		65,000		65,000			9
10	Nursing and Medical Records	2,147,086	223,959	56,216	2,427,261		2,427,261	(5,515)	2,421,746			10
10a	Therapy											10a
11	Activities	110,225	9,792	100	120,117		120,117		120,117			11
12	Social Services	52,720		300	53,020		53,020		53,020			12
13	CNA Training											13
14	Program Transportation			11,376	11,376		11,376	(892)	10,484			14
15	Other (specify):*							10,495	10,495			15
16	TOTAL Health Care and Programs	2,310,031	233,751	132,992	2,676,774		2,676,774	4,088	2,680,862			16
	C. General Administration											
17	Administrative	125,601		381,020	506,621		506,621	(340,435)	166,186			17
18	Directors Fees											18
19	Professional Services			186,761	186,761	(50,522)	136,239	(9,148)	127,091			19
20	Dues, Fees, Subscriptions & Promotions			38,190	38,190		38,190	(4,485)	33,705			20
21	Clerical & General Office Expenses	121,880	1,578	273,120	396,578		396,578	(156,527)	240,051			21
22	Employee Benefits & Payroll Taxes			473,255	473,255		473,255		473,255			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,139	1,139		1,139	22	1,161			24
25	Other Admin. Staff Transportation			5,592	5,592		5,592	1,341	6,933			25
26	Insurance-Prop.Liab.Malpractice			202,288	202,288		202,288	1,684	203,972			26
27	Other (specify):*							19,491	19,491			27
28	TOTAL General Administration	247,481	1,578	1,561,365	1,810,424	(50,522)	1,759,902	(488,058)	1,271,845			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,070,599	459,561	1,996,472	5,526,632	(50,522)	5,476,110	(482,098)	4,994,012			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			81,537	81,537		81,537	171,761	253,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,673	27,673		27,673	177,540	205,213			32
33	Real Estate Taxes					50,522	50,522	268,019	318,541			33
34	Rent-Facility & Grounds			567,913	567,913		567,913	(560,416)	7,497			34
35	Rent-Equipment & Vehicles			19,105	19,105		19,105	7,708	26,813			35
36	Other (specify):*											36
37	TOTAL Ownership			696,228	696,228	50,522	746,750	64,612	811,362			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,016	744,688	872,704		872,704	(2,322)	870,382			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,816	129,816		129,816		129,816			42
43	Other (specify):*	104,948		52,410	157,358		157,358	(157,358)	(0)			43
44	TOTAL Special Cost Centers	104,948	128,016	926,914	1,159,878		1,159,878	(159,680)	1,000,198			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,175,547	587,577	3,619,614	7,382,738		7,382,738	(577,166)	6,805,572			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	(8,545)	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	(282,062)	30		9
10	Interest and Other Investment Income	(1,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(311)	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	(1,302)	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	(152,408)	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	(245,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (695,729)		\$	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)	118,563		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 118,563		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (577,166)		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	\$ (5,389)	21	1
2	Medicare Sequestration Expense	(18,383)	21	2
3	Managed Care Sequestration Exp	(903)	21	3
4	Patient Needs	(1,230)	10	4
5	Salaries - Marketing	(104,948)	43	5
6	Marketing Expense	(52,155)	43	6
7	Credit Card/Pymt Process Fees	(10,562)	21	7
8	Bldg Co - Bank Charges	(496)	21	8
9	Bldg Co - Accounting	(4,911)	19	9
10	Bldg Co - Amortization	(45,555)	36	10
11	Additional R&M	15,934	06	11
12	Promotional Fees	(255)	43	12
13	Non Allowable Legal	(4,048)	19	13
14	Chamber of Commerce Dues	(334)	20	14
15	Capitalized R&M	(6,120)	06	15
16	Non-Allowable Appraisal Fee	(5,761)	19	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	(245,116)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center Wilmette

0053801

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	(311)											(311)	2
3	Housekeeping			750									750	3
4	Laundry													4
5	Heat and Other Utilities	(8,545)		620									(7,925)	5
6	Maintenance	9,814		(1,808)	104								8,110	6
7	Other (specify):*			1,247									1,247	7
8	TOTAL General Services	958		809	104								1,871	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,230)		(3,864)				(421)					(5,515)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation								(892)				(892)	14
15	Other (specify):*			10,495									10,495	15
16	TOTAL Health Care and Programs	(1,230)		6,631				(421)	(892)				4,088	16
	C. General Administration													
17	Administrative			(340,435)									(340,435)	17
18	Directors Fees													18
19	Professional Services	(14,720)	4,911	139	522								(9,148)	19
20	Fees, Subscriptions & Promotions	(5,234)		749									(4,485)	20
21	Clerical & General Office Expenses	(189,443)	496	32,420									(156,527)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			22									22	24
25	Other Admin. Staff Transportation			1,341									1,341	25
26	Insurance-Prop.Liab.Malpractice			1,684									1,684	26
27	Other (specify):*			19,491									19,491	27
28	TOTAL General Administration	(209,397)	5,407	(284,589)	522								(488,058)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(209,669)	5,407	(277,149)	626			(421)	(892)				(482,098)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(282,062)	451,743	1,236	843								171,761	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,085)	174,844	1,243	2,538								177,540	32
33	Real Estate Taxes		265,060		2,959								268,019	33
34	Rent-Facility & Grounds		(567,913)	11,324	(3,827)								(560,416)	34
35	Rent-Equipment & Vehicles			7,708									7,708	35
36	Other (specify):*	(45,555)	45,555											36
37	TOTAL Ownership	(328,702)	369,289	21,512	2,513								64,612	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,322)					(2,322)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(157,358)											(157,358)	43
44	TOTAL Special Cost Centers	(157,358)						(2,322)					(159,680)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(695,729)	374,696	(255,638)	3,140			(2,743)	(892)				(577,166)	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	\$ 567,913	432 Poplar Drive, LLC		\$	(567,913)	1
2	V	21	Bank Charges		432 Poplar Drive, LLC		496	496	2
3	V	32	Interest		432 Poplar Drive, LLC		174,844	174,844	3
4	V	33	Real Estate Taxes		432 Poplar Drive, LLC		265,060	265,060	4
5	V	19	Accounting		432 Poplar Drive, LLC		4,911	4,911	5
6	V	36	Amortization		432 Poplar Drive, LLC		45,555	45,555	6
7	V	30	Depreciation		432 Poplar Drive, LLC		451,743	451,743	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 567,913			\$ 942,609	\$ * 374,696	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	Jonathan Aaron	0.10%	AMBERWOOD CARE CENTER	ROCKFORD, IL	432 POPLAR DRIVE, LLC	WILMETTE	BUILDING COMPANY	1
2	Citadel Opco Holdings LLC	99.90%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE	BOOKKEEPING	2
3			CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4			CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5			THE WATERFORD CARE CENTER LLC	CHICAGO, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	5
6			CITADEL CARE CENTER-STERLING LLC	STERLING, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7			THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL	ECOBRITE LINEN	SKOKIE	LAUNDRY	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
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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
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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		\$ 750	\$ 750	15
16	V	5	Utilities		Damen Healthcare Group, LLC		620	620	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		5,868	5,868	17
18	V	6	Maintenance	8,448	Damen Healthcare Group, LLC		772	(7,676)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		1,247	1,247	19
20	V	10	Nursing	54,375	Damen Healthcare Group, LLC		50,510	(3,864)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		10,495	10,495	21
22	V	17	Administrative	381,020	Damen Healthcare Group, LLC		13,017	(368,003)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		139	139	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		749	749	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		73,045	73,045	25
26	V	21	Office Expense - Other	45,936	Damen Healthcare Group, LLC		5,311	(40,625)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		22	22	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		1,341	1,341	28
29	V	26	Insurance		Damen Healthcare Group, LLC		1,684	1,684	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		19,491	19,491	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		1,236	1,236	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		1,243	1,243	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		7,497	7,497	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		3,827	3,827	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		414	414	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		7,294	7,294	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		14,550	14,550	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		13,017	13,017	38
39	Total			\$ 489,778			\$ 234,141	\$ * (255,638)	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		\$ 104	\$ 104	15
16	V	30	Depreciation		3755 W Chase, LLC		843	843	16
17	V	32	Interest Expense		3755 W Chase, LLC		2,538	2,538	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		2,959	2,959	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		522	522	19
20	V								20
21	V	34	Rent	3,827	3755 W Chase, LLC			(3,827)	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			\$ 3,827			\$ 6,967	\$ * 3,140	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	\$ 134,400	Biltmore Incorporated Cell		\$ 134,400	\$	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			\$ 134,400			\$ 134,400	\$ *	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	\$ 98,562	EcoBrite Linen		\$ 98,562	\$	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			\$ 98,562			\$ 98,562	\$ *	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	\$ 2,715	Integra Healthcare Equipment		\$ 2,294	\$ (421)	15
16	V	39	Ancillary Expenses	14,982	Integra Healthcare Equipment		12,660	(2,322)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 17,697			\$ 14,954	\$ * (2,743)	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	\$ 4,721	Lifeline Ambulance		\$ 3,829	\$ (892)	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			\$ 4,721			\$ 3,829	\$ * (892)	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 Wilmette # 0053801 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	2.33	5.83%	Alloc Mgt Fee	\$ 14,550	17-7	1
2	Kenneth Ripstein	Administrative	Administrative		See Attached	2.08	5.20%	Alloc Mgt Fee	13,017	17-7	2
3	Yakov Kohen	Clerical	Clerical		See Attached	2.08	5.20%	Alloc Salary	7,139	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	\$ 34,706		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.

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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

Facility Name & ID Number Citadel Care Center Wilmette# 0053801

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	\$ 20,652	\$ 750	1
2	5	Utilities	Patient Days	396,623	14	11,913	20,652	620	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	20,652	5,868	3
4	6	Maintenance	Patient Days	396,623	14	14,821	20,652	772	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951	20,652	1,247	5
6	10	Nursing	Patient Days	396,623	14	970,057	20,652	50,510	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561	20,652	10,495	7
8	17	Administrative	Patient Days	396,623	14	250,000	20,652	13,017	8
9	19	Professional Fees	Patient Days	396,623	14	2,669	20,652	139	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390	20,652	749	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	20,652	73,045	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995	20,652	5,311	12
13	24	Seminars & Education	Patient Days	396,623	14	431	20,652	22	13
14	25	Auto Expense	Patient Days	396,623	14	25,762	20,652	1,341	14
15	26	Insurance	Patient Days	396,623	14	32,350	20,652	1,684	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325	20,652	19,491	16
17	30	Depreciation	Patient Days	396,623	14	23,745	20,652	1,236	17
18	32	Interest Expense	Patient Days	396,623	14	23,867	20,652	1,243	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975	20,652	7,497	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500	20,652	3,827	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954	20,652	414	21
22	35	Auto Lease	Patient Days	396,623	14	140,073	20,652	7,294	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000	20,652	14,550	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000	20,652	13,017	24
25	TOTALS					\$ 4,467,270	\$ 2,713,873	\$ 234,141	25

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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	\$	20,652	\$ 104	1
2	30	Depreciation	Patient Days	396,623	14	16,199		20,652	843	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		20,652	2,538	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		20,652	2,959	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		20,652	522	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	\$		\$ 6,967	25

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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 Biltmore Incorporated Cell
Street Address 30 Main street, Suite 330
City / State / Zip Code Burlington, Vermont 05401
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	26	Insurance	Direct Allocation			\$	\$		\$ 134,400	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					\$	\$		\$ 134,400	25

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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 EcoBrite Linen
Street Address 3712 Jarvis Avenue
City / State / Zip Code Skokie, IL 60076
Phone Number ((847) 582-4000)
Fax Number ()

	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	04	Laundry Services	Direct			\$	\$		\$ 98,562	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					\$	\$		\$ 98,562	25

Ending: 12/31/20

(630) 834-1500

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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	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	14	Patient Transportation	Direct			\$	\$		\$ 3,829	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					\$	\$		\$ 3,829	25

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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

Facility Name & ID Number Citadel Care Center Wilmette # 0053801 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

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			\$	4,399,379			\$	174,844	1
2	Ascentum Capital		X	Senior Television Equipment				9,649					2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line of Credit				678,739				27,673	6
7													7
8													8
9	TOTAL Facility Related						\$	5,087,767			\$	202,517	9
	B. Non-Facility Related*												
10	Interest Income		X									(1,085)	10
11	Allocated from Damen Healthcare	X										1,243	11
12	Allocated from 3755 Chase	X										2,538	12
13													13
14	TOTAL Non-Facility Related						\$				\$	2,696	14
15	TOTALS (line 9+line14)						\$	5,087,767			\$	205,213	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	269,332	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.)			\$	263,638	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(5,694)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	273,713	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.)			\$	50,522	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.			\$	318,541	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	284,600	8	
		2016	191,055	9	
		2017	255,744	10	
		2018	256,507	11	
		2019	260,679	12	
2020 Accrual = \$260,679 x 1.05 = \$273,713					
Allocated from 3755 Chase \$2,959					

		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	Citadel Care Center Wilmette	COUNTY	Cook
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CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

IL478-2471

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 Citadel Care Center Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053801

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

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: 21,881

B. General Construction Type: ExteriorMasonryFrameSteelNumber of Stories3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
	1Facility	30,199	2016	410,380	1
	2Allocated from 3755 W Chase		2019	35,001	2
	3TOTALS	30,199		\$ 445,381	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		2016	1969	\$ 3,228,258	\$ 451,743	39	\$ 82,776	\$ (368,967)	\$ 413,880	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2016		95,798		20	4,790	4,790	23,845	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	198,340	1,292		1,130	(162)	8,736	68
69	Financial Statement Depreciation		81,537			(81,537)		69
70	TOTAL (lines 4 thru 69)	\$ 3,522,396	\$ 534,572		\$ 88,696	\$ (445,876)	\$ 446,461	70

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

Facility Name & ID Number Citadel Care Center Wilmette

0053801

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		\$ 3,522,396	\$ 534,572		\$ 88,696	\$ (445,876)	\$ 446,461	1
2	Surveillance Camera Installation	2017	4,680		20	234	234	936	2
3	Wall Coverings For Facility- 2Nd Floor Resident Rooms	2017	3,484		20	174	174	697	3
4	Planting Landscape	2017	15,500		20	775	775	3,100	4
5	Flooring For Facility- 2Nd Floor Resident Rooms	2017	13,953		20	698	698	2,791	5
6	Repaired Wallpaper-Mentor/Resident Rms/Kitch/1St-3Rd Floors	2017	54,699		20	2,735	2,735	11,429	6
7	1St Floor Shower Room Floor & Ceiling Repair	2018	9,500		20	475	475	2,613	7
8	Fire Sprinkler System Overhaul Repair	2018	4,505		20	225	225	825	8
9	1St & 2Nd Fl Shower Rooms, Restroom, Hallways - New Walls, Pa	2018	3,265		20	163	163	707	9
10	Resident Room #208 - New Walls, Floors, Paint	2018	3,186		20	159	159	637	10
11	Resident Room #205 - Walls, Paint, Flooring, Electrical, Toilet	2018	4,905		20	245	245	735	11
12	Resident Room #203 - Walls, Paint, Electrical	2018	2,897		20	145	145	241	12
13	Resident Room #201 - Walls, Paint, Flooring, Electrical	2018	3,719		20	186	186	248	13
14	Vestibule/Lobby/Corridor/Dining/Resident Rms/Bath Shower	2018	631,098		20	31,555	31,555	94,665	14
15	Rms/Therapy: Flooring/Lighting/Window Treatments/Handrail	2018			20				15
16	Wallcovering/Cabinetry/Shower Stalls/Paint	2018			20				16
17	Elevator #1 - Install New Overhead Oil Line	2018	11,400		20	570	570	1,710	17
18	Remove & Repair Floor Tile, In 2Nd Floor Rooms 203 & 205	2019	3,981		20	199	199	398	18
19	Remove & Repair Walls, Floor & Bath Resident Rooms On 2Nd F	2019	6,438		20	322	322	644	19
20	Repair Walls, Paint, Remove Carpet	2019	4,982		20	249	249	498	20
21	Nurses Station Remodel-Wallcovering, Plumbing	2019	9,453		20	473	473	946	21
22	Reface Existing Exterior Signage	2019	2,544		20	127	127	254	22
23	3Rd Floor Corridor/Dining-Walls,Handrails,Carpet,Paint,Doors	2019	59,799		20	2,990	2,990	5,980	23
24	Repaired Leak In Ceiling Basement Bathroom	2019	3,805		20	190	190	380	24
25	Replaced Water Pump & Engine Start Battery On Generator	2019	3,071		20	154	154	308	25
26	Replacement Of Hvac Motors And Pulleys	2020	3,355		20	168	168	168	26
27	Hot Water Heater Replacement	2020	12,200		20	610	610	610	27
28	Roof Mounted Fresh Makeup Unit	2020	3,250		20	162	162	162	28
29	Fresh Air Unit Installed New Oem Replacement Parts	2020	2,870		20	144	144	144	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	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		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	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		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	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		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	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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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)		\$ 4,404,935	\$ 534,572		\$ 132,823	\$ (401,749)	\$ 578,287	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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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 3737 Chase	2019	198,340	844	35	1,130	287	8,736	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Damen Management	2015		449			(449)		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)		\$ 198,340	\$ 1,292		\$ 1,130	\$ (162)	\$ 8,736	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 198,340	\$ 1,292		\$ 1,130	\$ (162)	\$ 8,736	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 198,340	\$ 1,292		\$ 1,130	\$ (162)	\$ 8,736	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	\$1,193,683	\$428	\$119,337	\$118,909	10	\$572,215	71
72	Current Year Purchases	11,326	291	1,069	778	10	1,069	72
73	Fully Depreciated Assets	591	69	69		10	591	73
74								74
75	TOTALS	\$1,205,599	\$788	\$120,475	\$119,687		\$573,874	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)	\$6,055,915	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$535,360	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$253,298	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(282,062)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,152,161	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		\$	92
93			93
94			94
95		\$	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				7,497			5
6								6
7	TOTAL				\$7,497			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: \$8,372
- 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 Van	2012 Ford E-450 Super Du	\$929	\$11,146	17
18	Allocated from Damen HC			7,294	18
19					19
20					20
21	TOTAL		\$929	\$18,440	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	\$		\$ 322,197	\$		\$ 322,197	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			55,945			55,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			323,151			323,151	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				128,016		128,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					43,395			43,395	13
14	TOTAL			\$		\$ 744,688	\$ 128,016		\$ 872,704	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	\$ 1,663,577	\$ 1,711,942	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	943,674	943,674	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,019	168,019	6
7	Other Prepaid Expenses		25,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	1,221	85,840	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,776,491	\$ 2,934,475	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		457,380	13
14	Buildings, at Historical Cost		3,014,677	14
15	Leasehold Improvements, at Historical Cost	441,832	1,149,810	15
16	Equipment, at Historical Cost	180,899	1,223,164	16
17	Accumulated Depreciation (book methods)	(239,925)	(2,267,097)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	19,330	69,028	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 402,136	\$ 3,646,962	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,178,627	\$ 6,581,437	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 342,984	\$ 342,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	683,689	683,689	29
30	Accrued Salaries Payable	147,970	147,970	30
31	Accrued Taxes Payable (excluding real estate taxes)	152,155	152,155	31
32	Accrued Real Estate Taxes(Sch.IX-B)		273,713	32
33	Accrued Interest Payable	1,878	1,878	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	1,408,983	1,666,303	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,737,659	\$ 3,268,693	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,699	4,699	39
40	Mortgage Payable		4,399,379	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached</u>	321,416	34,583	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 326,115	\$ 4,438,661	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,063,774	\$ 7,707,354	46
47	TOTAL EQUITY(page 18, line 24)	\$ 114,853	\$ (1,125,917)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,178,627	\$ 6,581,437	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (945,996)	1
2	Restatements (describe):		2
3	Depreciation	34,670	3
4	Rounding	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (911,323)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,026,176	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,026,176	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)	\$ 114,853	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Citadel Care Center Wilmette

0053801

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	\$ 10,661,245	1
2	Discounts and Allowances for all Levels	(3,537,095)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,124,150	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,711	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 490,711	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	486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	563	19
20	Radiology and X-Ray	505	20
21	Other Medical Services	4,075	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,085	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,085	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	787,339	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 787,339	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,408,914	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,039,434	31
32	Health Care	2,676,774	32
33	General Administration	1,810,424	33
	B. Capital Expense		
34	Ownership	696,228	34
	C. Ancillary Expense		
35	Special Cost Centers	1,030,062	35
36	Provider Participation Fee	129,816	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,382,738	40
41	Income before Income Taxes (line 30 minus line 40)**	1,026,176	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,026,176	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,108,766	44
45	Private Pay - Net Inpatient Revenue	1,353,025	45
46	Medicare - Net Inpatient Revenue	3,252,070	46
47	Other-(specify) <u>Managed Care</u>	376,287	47
48	Other-(specify) <u>Hospice</u>	34,002	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,124,150	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	1,999	2,104	\$ 112,279	\$ 53.36	1
2	Assistant Director of Nursing	2,242	2,360	95,250	40.36	2
3	Registered Nurses	18,402	19,370	691,350	35.69	3
4	Licensed Practical Nurses	13,144	13,836	437,454	31.62	4
5	CNAs & Orderlies	47,731	50,243	810,753	16.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,934	2,036	46,329	22.76	9
10	Activity Assistants	4,103	4,319	63,896	14.80	10
11	Social Service Workers	2,052	2,160	52,720	24.41	11
12	Dietician					12
13	Food Service Supervisor	2,052	2,160	94,621	43.81	13
14	Head Cook	5,290	5,568	87,719	15.75	14
15	Cook Helpers/Assistants	7,757	8,165	110,393	13.52	15
16	Dishwashers					16
17	Maintenance Workers	2,079	2,188	59,118	27.02	17
18	Housekeepers	9,999	10,526	161,236	15.32	18
19	Laundry					19
20	Administrator	2,052	2,160	125,601	58.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,052	2,160	58,842	27.24	23
24	Clerical	3,878	4,082	63,038	15.44	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	2,052	2,160	104,948	48.59	33
34	TOTAL (lines 1 - 33)	128,817	135,596	\$ 3,175,547 *	\$ 23.42	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	310	\$ 16,807	01-03	35
36	Medical Director	Monthly	65,000	09-03	36
37	Medical Records Consultant	Monthly	800	10-03	37
38	Nurse Consultant	Monthly	4,000	10-03	38
39	Pharmacist Consultant	Monthly	9,222	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	2	100	11-03	44
45	Social Service Consultant	5	300	12-03	45
46	Other(specify) MDS Consultant	Monthly	42,194	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	316	\$ 138,423		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Lara Lieberman	Administrator	0	\$ 125,601
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,601
B. Administrative - Other			
Description			Amount
Management Fee-Damen Healthcare Group, LLC			\$ 381,020
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 381,020
C. Professional Services			
Vendor/Payee	Type		Amount
Marcum LLP	Accounting		\$ 34,102
ProPay HR	Payroll Processing		16,269
eSolutions Inc.	Data Processing		2,243
IIT/SourceTech	Data Processing		2,565
National Datacare Corporation	Data Processing		1,214
Point Click Care Technologies	Data Processing		31,393
Prime Care Technologies	Data Processing		2,405
Reside Admissions, LLC	Data Processing		3,745
Telemedicine Solutions, LLC	Data Processing		2,340
Third Eye Health, Inc.	Data Processing		9,737
See Attached	Legal		58,571
See Supplemental Schedule			22,176
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 186,761
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 46,365
Unemployment Compensation Insurance			15,535
FICA Taxes			242,929
Employee Health Insurance			125,737
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Life Insurance - Involuntary			4,266
Employee Benefits - Other			24,400
Holiday Expense			786
401K Employer Match Expense			13,237
TOTAL (agree to Schedule V, line 22, col.8)			\$ 473,255
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			\$
Advertising: Employee Recruitment			9,433
Health Care Worker Background Check (Indicate # of checks performed 69)			5,783
Patient Background Checks 59			975
Dues & Subscriptions			11,820
Licenses & Fees			4,945
See Supplemental Schedule			749
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 33,705
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,139
See Supplemental Schedule			22
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,161

*** 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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,689 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. \$ 129,816
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. \$ N/A 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? 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? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.