

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE

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

I. IDPH License ID Number: 0055988

Facility Name: The Citadel of Skokie

Address: 9615 North Knox Ave Skokie 60076

NumberCityZip Code

County: Cook

Telephone Number: (847) 679-4161
Fax # (847) 679-3241

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2020

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:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/20 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)
(Date)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) 05/23/2021
* Subject to the attached Accountants' Consulting Report (Date)

(Print Name and Title) Steven N. Lavenda, CPA Partner

(Firm Name & Address) Marcum, LLP 9 Parkway North, Suite 200 Deerfield, IL 60015

(Telephone) (847) 282-6300
Fax # (847) 282-6301

HFS 3745 (N-4-99)

IL478-2471

#	0055988	Report Period Beginning:	02/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 2/1/2020

YES ☒ Date 2/1/2020 NO ☐

YES ☒ NO ☐ If YES, enter number
of beds certified 113 and days of care provided 4,718

IV. ACCOUNTING BASIS

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

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **66.32%**

66.32%

Facility Name & ID Number The Citadel of Skokie # 0055988 Report Period Beginning: 02/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	399,396	37,789	16,749	453,934		453,934		453,934			1
2	Food Purchase		212,469		212,469		212,469	(146)	212,323			2
3	Housekeeping	294,936	31,024	12,400	338,360		338,360	912	339,272			3
4	Laundry	67,478	4,625	39,675	111,778		111,778		111,778			4
5	Heat and Other Utilities			86,546	86,546		86,546	(8,606)	77,940			5
6	Maintenance	54,414	21,141	106,362	181,917		181,917	26,711	208,628			6
7	Other (specify):*							1,516	1,516			7
8	TOTAL General Services	816,224	307,048	261,732	1,385,004		1,385,004	20,387	1,405,391			8
	B. Health Care and Programs											
9	Medical Director			22,120	22,120		22,120		22,120			9
10	Nursing and Medical Records	2,203,740	292,824	28,521	2,525,085		2,525,085	(49,462)	2,475,623			10
10a	Therapy	17,035		8,085	25,120		25,120		25,120			10a
11	Activities	77,778	1,500	288	79,566		79,566		79,566			11
12	Social Services	150,168		22,764	172,932		172,932		172,932			12
13	CNA Training											13
14	Program Transportation			42,964	42,964		42,964	(7,774)	35,190			14
15	Other (specify):*							12,759	12,759			15
16	TOTAL Health Care and Programs	2,448,721	294,324	124,742	2,867,787		2,867,787	(44,477)	2,823,310			16
	C. General Administration											
17	Administrative	112,446		412,210	524,656		524,656	(362,870)	161,786			17
18	Directors Fees											18
19	Professional Services			147,755	147,755	(32,134)	115,621	(4,195)	111,426			19
20	Dues, Fees, Subscriptions & Promotions			25,526	25,526		25,526	(9,689)	15,837			20
21	Clerical & General Office Expenses	119,201	875	229,815	349,891		349,891	(106,160)	243,731			21
22	Employee Benefits & Payroll Taxes			530,635	530,635		530,635		530,635			22
23	Inservice Training & Education											23
24	Travel and Seminar			788	788		788	27	815			24
25	Other Admin. Staff Transportation			4,967	4,967		4,967	1,631	6,598			25
26	Insurance-Prop.Liab.Malpractice			173,785	173,785		173,785	2,048	175,833			26
27	Other (specify):*							23,695	23,695			27
28	TOTAL General Administration	231,647	875	1,525,481	1,758,003	(32,134)	1,725,869	(455,513)	1,270,356			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,496,592	602,247	1,911,955	6,010,794	(32,134)	5,978,660	(479,603)	5,499,056			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			26,902	26,902		26,902	284,872	311,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,472	21,472		21,472	139,395	160,867			32
33	Real Estate Taxes					32,134	32,134	248,969	281,103			33
34	Rent-Facility & Grounds			1,068,537	1,068,537		1,068,537	(1,059,423)	9,114			34
35	Rent-Equipment & Vehicles			3,522	3,522		3,522	9,371	12,893			35
36	Other (specify):*							37,290	37,290			36
37	TOTAL Ownership			1,120,433	1,120,433	32,134	1,152,567	(339,527)	813,041			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,062	591,055	731,117		731,117	(1,072)	730,045			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,588	219,588		219,588		219,588			42
43	Other (specify):*	44,120		42,732	86,852		86,852	(86,852)	0			43
44	TOTAL Special Cost Centers	44,120	140,062	853,375	1,037,557		1,037,557	(87,924)	949,633			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,540,712	742,309	3,885,763	8,168,784		8,168,784	(907,053)	7,261,731			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,360)	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	282,343	30		9
10	Interest and Other Investment Income	(1,165)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	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				18
19	Entertainment				19
20	Contributions	(9,100)	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	(155,308)	21		24
25	Fund Raising, Advertising and Promotional	(1,500)	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	(147,823)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,059)		\$	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)	(864,994)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (864,994)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (907,053)		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	\$ (1,514)	21	1
2	OT Veterans	(2,464)	10	2
3	PT Veterans	(4,137)	10	3
4	Pharmacy Veterans	(55,470)	10	4
5	Speech Veterans	(17)	10	5
6	Medical Supply Veterans	(150)	10	6
7	Radiology Veterans	(1,425)	10	7
8	Rentals Veterans	(20)	10	8
9	Telephone Revenue	(50)	21	9
10	Wound Care Veterans	(1,319)	10	10
11	Sequestration	(9,216)	21	11
12	Patient Needs	(1,081)	10	12
13	Marketing Salary	(44,120)	43	13
14	Marketing Expense	(42,476)	43	14
15	Credit Card/Pymt Process Fees	(239)	21	15
16	Additional R&M	37,390	06	16
17	Capitalized R&M	(12,556)	06	17
18	Promotion Fees	(255)	43	18
19	Bldg Co - Bank Charges & Fees	(240)	21	19
20	Bldg Co - Legal & Professional Services	(3,467)	19	20
21	Non Allowable Legal	(4,998)	19	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	(147,823)		49

DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS			Page 58
<u>The Citadel of Shiloh</u>			
	<u>0055085</u>		
Report Period Beginning:	<u>6/28/120</u>		
Ending:	<u>12/31/20</u>		
NON-ALLOWABLE EXPENSES		Amount	Sch. Y Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

1	2	3	4	5	6	7	8	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Citadel of Skokie # 0055988 Report Period Beginning: 02/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(146)											(146)	2
3	Housekeeping			912									912	3
4	Laundry													4
5	Heat and Other Utilities	(9,360)		754									(8,606)	5
6	Maintenance	24,834		1,751	127								26,711	6
7	Other (specify):*			1,516									1,516	7
8	TOTAL General Services	15,328		4,932	127								20,387	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(66,082)		20,782				(4,163)					(49,462)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation								(7,774)				(7,774)	14
15	Other (specify):*			12,759									12,759	15
16	TOTAL Health Care and Programs	(66,082)		33,541				(4,163)	(7,774)				(44,477)	16
	C. General Administration													
17	Administrative			(362,870)									(362,870)	17
18	Directors Fees													18
19	Professional Services	(8,465)	3,467	169	634								(4,195)	19
20	Fees, Subscriptions & Promotions	(10,600)		911									(9,689)	20
21	Clerical & General Office Expenses	(166,567)	240	60,167									(106,160)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			27									27	24
25	Other Admin. Staff Transportation			1,631									1,631	25
26	Insurance-Prop.Liab.Malpractice			2,048									2,048	26
27	Other (specify):*			23,695									23,695	27
28	TOTAL General Administration	(185,632)	3,707	(274,222)	634								(455,513)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(236,386)	3,707	(235,749)	761			(4,163)	(7,774)				(479,603)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Citadel of Skokie # 0055988 Report Period Beginning: 02/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	282,343		1,503	1,025								284,872	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,165)	135,963	1,511	3,086								139,395	32
33	Real Estate Taxes		245,371		3,598								248,969	33
34	Rent-Facility & Grounds		(1,068,537)	13,767	(4,653)								(1,059,423)	34
35	Rent-Equipment & Vehicles			9,371									9,371	35
36	Other (specify):*		37,290										37,290	36
37	TOTAL Ownership	281,178	(649,913)	26,152	3,056								(339,527)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,072)					(1,072)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(86,852)											(86,852)	43
44	TOTAL Special Cost Centers	(86,852)						(1,072)					(87,924)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(42,059)	(646,205)	(209,597)	3,817			(5,235)	(7,774)				(907,053)	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	\$ 1,068,537	Golf Knox Properties LLC		\$	(1,068,537)	1
2	V	32	HUD Mortgage Interest	21	Golf Knox Properties LLC		135,984	135,963	2
3	V	36	MIP Insurance		Golf Knox Properties LLC		37,290	37,290	3
4	V	21	Bank Charges & Fees		Golf Knox Properties LLC		240	240	4
5	V	19	Legal & Professional Services		Golf Knox Properties LLC		3,467	3,467	5
6	V	33	Real Estate Tax Expense		Golf Knox Properties LLC		245,371	245,371	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,068,558			\$ 422,353	\$ * (646,205)	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	27.04%	AMBERWOOD CARE CENTER	ROCKFORD, IL	GOLF KNOX PROPERTIES LLC		BUILDING COMPANY	1
2	Kenneth Ripstein	27.04%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3	Stern Family Investment Trust U/A/D 06/11/15	4.99%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Raphaela Stern	4.99%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Berger Family Trust U/A/D 06/25/14	4.99%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	5
6	Menachem Berger	4.99%	THE WATERFORD CARE CENTER LLC	CHICAGO, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7	Israel Family Investment Trust U/A/D 05/20/15	4.99%	CITADEL CARE CENTER-STERLING LLC	STERLING, IL				7
8	Israel Family Trust U/A/D 06/18/15	4.99%	THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				8
9	Leonard Weiss	2.50%	PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				9
10	Jonah Bruck	2.50%	THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				10
11	Ilana Teller	4.99%	THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				11
12	Marcella Graf	2.00%	SKOKIE MEADOWS LLC	SKOKIE, IL				12
13	Lisa Trudeau	2.00%						13
14	Yakov Kohen	2.00%						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		\$ 912	\$ 912	15
16	V	5	Utilities		Damen Healthcare Group, LLC		754	754	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		7,134	7,134	17
18	V	6	Maintenance	6,321	Damen Healthcare Group, LLC		938	(5,383)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		1,516	1,516	19
20	V	10	Nursing	40,624	Damen Healthcare Group, LLC		61,407	20,782	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		12,759	12,759	21
22	V	17	Administrative	412,210	Damen Healthcare Group, LLC		15,825	(396,385)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		169	169	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		911	911	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		88,803	88,803	25
26	V	21	Office Expense - Other	35,092	Damen Healthcare Group, LLC		6,456	(28,636)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		27	27	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		1,631	1,631	28
29	V	26	Insurance		Damen Healthcare Group, LLC		2,048	2,048	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		23,695	23,695	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		1,503	1,503	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		1,511	1,511	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		9,114	9,114	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		4,653	4,653	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		504	504	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		8,867	8,867	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		17,689	17,689	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		15,825	15,825	38
39	Total			\$ 494,248			\$ 284,650	\$ * (209,597)	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		\$ 127	\$ 127	15
16	V	30	Depreciation		3755 W Chase, LLC		1,025	1,025	16
17	V	32	Interest Expense		3755 W Chase, LLC		3,086	3,086	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		3,598	3,598	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		634	634	19
20	V								20
21	V	34	Rent	4,653	3755 W Chase, LLC			(4,653)	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			\$ 4,653			\$ 8,470	\$ * 3,817	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	\$ 31,842	Biltmore Incorporated Cell		\$ 31,842	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 31,842			\$ 31,842	\$ *	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	\$ 36,353	EcoBrite Linen		\$ 36,353	\$	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			\$ 36,353			\$ 36,353	\$ *	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 Rental	\$ 26,860	Integra Healthcare Equipment		\$ 22,697	\$ (4,163)	15
16	V	39	Ancillary Expense	6,913	Integra Healthcare Equipment		5,841	(1,072)	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			\$ 33,773			\$ 28,538	\$ * (5,235)	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	14	Patient Transportation	\$ 41,132	Lifeline Ambulance		\$ 33,358	\$ (7,774)	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			\$ 41,132			\$ 33,358	\$ * (7,774)	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 The Citadel of Skokie # 0055988 Report Period Beginning: 02/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jonathan Aaron	Owner	Administrative	27.04%	See Attached	2.83	7.08%	Alloc Mgt Fee	\$ 17,689	17-7	1
2	Kenneth Ripstein	Administrative	Administrative	27.04%	See Attached	2.53	6.33%	Alloc Mgt Fee	15,825	17-7	2
3	Yakov Kohen	Clerical	Clerical	2.00%	See Attached	2.53	6.33%	Alloc Salary	8,679	21-7	3
4	Marcella Graf	Administrative	Administrative	2.00%	See Attached	2.53	6.33%	Alloc Salary	15,825	17-7	4
5	Lisa Trudeau	VP Clinical Op.	Nsg Admin	2.00%	See Attached	2.53	6.33%	Alloc Salary	18,349	10-7	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	\$ 76,367		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 The Citadel of Skokie# 0055988

Report Period Beginning:

02/01/20Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

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

Name of Related Organization

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		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	3	Housekeeping	Patient Days	396,623	14	\$ 14,400	\$ 25,107	\$ 912	1
2	5	Utilities	Patient Days	396,623	14	11,913	25,107	754	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	25,107	7,134	3
4	6	Maintenance	Patient Days	396,623	14	14,821	25,107	938	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951	25,107	1,516	5
6	10	Nursing	Patient Days	396,623	14	970,057	25,107	61,407	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561	25,107	12,759	7
8	17	Administrative	Patient Days	396,623	14	250,000	25,107	15,825	8
9	19	Professional Fees	Patient Days	396,623	14	2,669	25,107	169	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390	25,107	911	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	25,107	88,803	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995	25,107	6,456	12
13	24	Seminars & Education	Patient Days	396,623	14	431	25,107	27	13
14	25	Auto Expense	Patient Days	396,623	14	25,762	25,107	1,631	14
15	26	Insurance	Patient Days	396,623	14	32,350	25,107	2,048	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325	25,107	23,695	16
17	30	Depreciation	Patient Days	396,623	14	23,745	25,107	1,503	17
18	32	Interest Expense	Patient Days	396,623	14	23,867	25,107	1,511	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975	25,107	9,114	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500	25,107	4,653	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954	25,107	504	21
22	35	Auto Lease	Patient Days	396,623	14	140,073	25,107	8,867	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000	25,107	17,689	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000	25,107	15,825	24
25	TOTALS					\$ 4,467,270	\$ 2,713,873	\$ 284,650	25

Ending: 12/31/20

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

IL478-2471

Ending: 12/31/20

Ending: 12/31/20

()

IL478-2471

Ending: 12/31/20

(630) 834-1500

Ending: 12/31/20

(312) 949-9262

Ending: 12/31/20

Ending: 12/31/20

	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						\$	\$		\$	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

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	Cambridge Realty Capital Ltd of IL		X	Mortgage			\$	6,693,556			\$	135,984	1
2													2
3													3
4													4
5													5
	Working Capital												
6	CIBC		X	Line of Credit				225,000				21,472	6
7													7
8													8
9	TOTAL Facility Related						\$	6,918,556			\$	157,456	9
	B. Non-Facility Related*												
10	Interest Income		X									(1,165)	10
11	Interest Income - Bldg Co		X									(21)	11
12	Allocated from Damen HC	X										1,511	12
13	Allocated from 3755 Chase	X										3,086	13
14	TOTAL Non-Facility Related						\$				\$	3,411	14
15	TOTALS (line 9+line14)						\$	6,918,556			\$	160,867	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 37,290 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	402,581	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.)				\$	342,750	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(59,831)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	308,800	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.)				\$	32,134	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.				\$	281,103	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	289,430	8	FOR BHF USE ONLY	
		2016	290,110	9		
		2017	307,771	10	13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
		2018	305,561	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2019	339,152	12	15	LESS REFUND FROM LINE 6 \$ 15
2020 Accrual = \$339,152 x .91 = \$308,800					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Allocated from 3755 Chase \$3,598						
Beginning Accrual Adjusted						

- 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.

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 The Citadel of Skokie COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055988

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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

B. **Real Estate Tax Cost Allocations**

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

C. Tax Bills

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

A. Square Feet:

32,048

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 607,239	1
2	Allocated from 3755 W Chase		2019	42,551	2
3	TOTALS			\$ 649,791	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	113		2020	1977	\$ 7,640,313	\$	35	\$ 218,295	\$ 218,295	\$ 200,103	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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 The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		8,234			412	412	412	67
68	Related Party Allocations (Pages 12H & 12I)		241,125	1,571		1,374	(197)	10,621	68
69	Financial Statement Depreciation			26,902			(26,902)		69
70	TOTAL (lines 4 thru 69)		\$ 7,889,672	\$ 28,473		\$ 220,080	\$ 191,608	\$ 211,136	70

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

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1	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		\$ 7,889,672	\$ 28,473		\$ 220,080	\$ 191,608	\$ 211,136	1
2	Replace 8 Indoor/Outdoor Cameras & Setup System	2020	4,889		20	244	244	244	2
3	On-Line Communications, Inc - 12/24Vdc Mag Lock,Keypad,Fire	2020	2,946		20	147	147	147	3
4	Safety Viewer & Audio Video, Llc - Replace And Install 13 Indoor	2020	8,615		20	431	431	431	4
5	2Nd Fl Flooring Install,All Wall Demo,Electrical Labor	2020	36,551		20	1,828	1,828	1,828	5
6	3S Group Db - Resident Room Bathroom Materials	2020	8,670		20	434	434	434	6
7	Repaint Resident Rooms On 1St Fl	2020	10,680		20	534	534	534	7
8	2Nd Fl Flooring Install - Lvt, Base, Accent Strips And Fl	2020	12,638		20	632	632	632	8
9	3S Group Db - Resident Room Bathroom Materials	2020	19,464		20	973	973	973	9
10	3S Group Db - Flooring Install - Lvt, Base, Accent Strips And Fl	2020	29,250		20	1,463	1,463	1,463	10
11	2Nd Fl Bathroom Flooring, Plumbing	2020	13,650		20	683	683	683	11
12	3S Group Db - Bathroom Labor Progress Billing	2020	27,300		20	1,365	1,365	1,365	12
13	Floor Install In Laundry & Basement Rooms	2020	3,400		20	170	170	170	13
14	Total Elevator Service - Repair Sump Pump Issues To Avoid Seal	2020	3,213		20	161	161	161	14
15	Repair The Walls Of The 9 Remaining Resident Rms	2020	17,609		20	880	880	880	15
16	3S Group Db - Skokie - Bathroom Labor	2020	13,650		20	683	683	683	16
17	Paragon Mechanical, Inc. - 18651-18650-18884-Roof Top Unit Ins	2020	16,968		20	848	848	848	17
18	Installation Of 6 Banners	2020	2,683		20	134	134	134	18
19	Repair Water Heater In Main Kitchen	2020	2,581		20	129	129	129	19
20	Repair Hvac	2020	7,292		20	365	365	365	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)		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	34

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

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	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		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	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)		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	34

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

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	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
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)		\$ 8,131,721	\$ 28,473		\$ 232,183	\$ 203,710	\$ 223,239	34

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

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Install of RTU 03 Cooling Rooftop Unit (14,249)	2020	8,234		20	412	412	412	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)		\$ 8,234	\$		\$ 412	\$ 412	\$ 412	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		\$ 8,234	\$		\$ 412	\$ 412	\$ 412	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)		\$ 8,234	\$		\$ 412	\$ 412	\$ 412	34

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

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 3737 Chase	2019	241,125	1,025	35	1,374	349	10,621	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		545			(545)		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)		\$ 241,125	\$ 1,571		\$ 1,374	\$ (197)	\$ 10,621	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		\$ 241,125	\$ 1,571		\$ 1,374	\$ (197)	\$ 10,621	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)		\$ 241,125	\$ 1,571		\$ 1,374	\$ (197)	\$ 10,621	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	\$ 5,630	\$ 520	\$ 520	\$	10	\$ 2,967	71
72	Current Year Purchases	855,575	353	78,986	78,633	10	78,986	72
73	Fully Depreciated Assets	718	84	84		10	718	73
74								74
75	TOTALS	\$ 861,923	\$ 958	\$ 79,591	\$ 78,633		\$ 82,672	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	9,643,435
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	29,431
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	311,774
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	282,343
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	305,910

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Damen HC				9,114			5
6								6
7	TOTAL				\$ 9,114			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 4,026
- Description:
- See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Damen HC		\$	\$ 8,867	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 8,867	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	\$		\$ 202,574	\$		\$ 202,574	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			41,558			41,558	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			291,279			291,279	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				139,994		139,994	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					55,644	68		55,712	13
14	TOTAL			\$		\$ 591,055	\$ 140,062		\$ 731,117	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	\$ 648,843	\$ 648,843	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,640,396	2,640,396	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,864	168,864	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached		289,625	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,458,103	\$ 3,747,728	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		607,239	13
14	Buildings, at Historical Cost		7,648,547	14
15	Leasehold Improvements, at Historical Cost	215,397	994,628	15
16	Equipment, at Historical Cost	123,523	123,523	16
17	Accumulated Depreciation (book methods)	(26,900)	(26,900)	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	73,432	166,230	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 385,452	\$ 9,513,267	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,843,555	\$ 13,260,995	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 407,267	\$ 407,267	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	225,000	225,000	29
30	Accrued Salaries Payable	182,765	182,765	30
31	Accrued Taxes Payable (excluding real estate taxes)	186,459	186,459	31
32	Accrued Real Estate Taxes(Sch.IX-B)		308,800	32
33	Accrued Interest Payable	2,193	2,193	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,490,551	1,490,551	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,494,235	\$ 2,803,035	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,693,556	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	807,992	1,009,922	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 807,992	\$ 7,703,478	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,302,227	\$ 10,506,513	46
47	TOTAL EQUITY(page 18, line 24)	\$ 541,328	\$ 2,754,482	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,843,555	\$ 13,260,995	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	541,328	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)	\$ 541,328	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)	\$ 541,328	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Citadel of Skokie

0055988

Report Period Beginning:

02/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,711,596	1
2	Discounts and Allowances for all Levels	(2,902,780)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,808,816	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	401,409	6
7	Oxygen	212	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 401,621	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	50	15
16	Rental of Facility Space		16
17	Sale of Drugs	28,717	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,844	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,611	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,165	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,165	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	463,899	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 463,899	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,710,112	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,385,004	31
32	Health Care	2,867,787	32
33	General Administration	1,758,003	33
	B. Capital Expense		
34	Ownership	1,120,433	34
	C. Ancillary Expense		
35	Special Cost Centers	817,969	35
36	Provider Participation Fee	219,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,168,784	40
41	Income before Income Taxes (line 30 minus line 40)**	541,328	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 541,328	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,975,252	44
45	Private Pay - Net Inpatient Revenue	402,325	45
46	Medicare - Net Inpatient Revenue	2,975,148	46
47	Other-(specify) <u>Managed Care</u>	474,093	47
48	Other-(specify) <u>Hospice/Veterans</u>	981,998	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,808,816	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	1,858	1,956	\$ 101,802	\$ 52.05	1
2	Assistant Director of Nursing	1,934	2,035	101,216	49.73	2
3	Registered Nurses	18,507	19,481	751,365	38.57	3
4	Licensed Practical Nurses	8,780	9,242	383,929	41.54	4
5	CNAs & Orderlies	39,214	41,277	816,467	19.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	586	617	17,035	27.61	8
9	Activity Director	833	877	19,522	22.25	9
10	Activity Assistants	3,605	3,794	58,256	15.35	10
11	Social Service Workers	4,243	4,467	129,956	29.09	11
12	Dietician					12
13	Food Service Supervisor	1,665	1,753	54,479	31.09	13
14	Head Cook	4,895	5,153	87,586	17.00	14
15	Cook Helpers/Assistants	14,437	15,197	257,331	16.93	15
16	Dishwashers					16
17	Maintenance Workers	2,105	2,216	54,414	24.56	17
18	Housekeepers	14,404	15,162	294,936	19.45	18
19	Laundry	3,449	3,631	67,478	18.59	19
20	Administrator	1,748	1,840	112,446	61.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,839	1,936	51,800	26.76	23
24	Clerical	3,564	3,752	67,401	17.96	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	2,104	2,215	46,363	20.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,378	2,503	66,930	26.74	33
34	TOTAL (lines 1 - 33)	132,148	139,104	\$ 3,540,712 *	\$ 25.45	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	335	\$ 16,749	01-03	35
36	Medical Director	Monthly	22,120	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,000	10-03	38
39	Pharmacist Consultant	Monthly	10,534	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	8,085	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	5	288	11-03	44
45	Social Service Consultant	321	21,174	12-03	45
46	Other(specify) Psychiatric	Monthly	1,590	12-03	46
47	MDS Consultant	Monthly	15,987	10-03	47
48					48
49	TOTAL (lines 35 - 48)	661	\$ 98,527		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

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

** See instructions.

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	
Andrea Martinez	Administrator	0	\$ 112,446	Workers' Compensation Insurance	\$	22,988	IDPH License Fee	\$	
				Unemployment Compensation Insurance		60,345	Advertising: Employee Recruitment	1,605	
				FICA Taxes		270,864	Health Care Worker Background Check		
				Employee Health Insurance		134,849	(Indicate # of checks performed 43)	431	
				Employee Meals			Patient Background Checks	262 2,623	
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	7,622	
				Pension Expense		21,829	Licenses & Fees	2,645	
				Life Insurance - Involuntary		4,743			
				Dental / Vision Insurance		28			
				Employee Benefits - Other		12,583			
				Holiday Expense		1,618			
				401K Employer Match Expense		788			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$	112,446	See Supplemental Schedule	911	
B. Administrative - Other							Less: Public Relations Expense	()	
Description			Amount				Non-allowable advertising	()	
Management Fees - Damen Healthcare Group, LLC			\$ 412,210				Yellow page advertising	()	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 15,837		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 412,210			G. Schedule of Travel and Seminar**		
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Marcum LLP	Accounting	\$	5,417			\$	Out-of-State Travel	\$	
ProPay HR	Payroll Services		20,181						
Madison Specs	Cost Segregation Study		4,200						
Pendulum, LLC	Risk Assessment		3,750				In-State Travel		
Personnel Planners	Unemployment Consultant		639						
Stout Risius Ross, LLC	Advisory Consulting		5,014						
Telemedicine Solutions, LLC	Woundcare Mgmt Consult		3,746						
eSolutions Inc.	Data Processing		1,066				Seminar Expense	788	
IIT/SourceTech	Data Processing		1,626						
National Datacare Corporation	Data Processing		2,203						
See Attached	Legal		44,704				See Supplemental Schedule	27	
See Supplemental Schedule			55,210				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 147,755			(agree to Sch. V, line 24, col. 8)		
				TOTAL			TOTAL	\$ 815	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>Yes</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>No</u> <u>N/A</u>
(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?	<u>Yes</u> <u>Yes</u>
(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?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 Years</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>6,139</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	
(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.	\$ <u>219,588</u>
(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.	<u>No</u>
(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?	<u>Yes</u>
(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.	<u>No</u>
(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?	\$ <u>N/A</u> Indicate the amount. \$
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. 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. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>N/A</u> <u>N/A</u> <u>100% Ln 14</u> <u>N/A</u> <u>N/A</u>
	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.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?	<u>Yes</u>
(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.	<u>Yes</u>