

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0054635</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																																				
Facility Name: <u>PA Peterson at the Citadel</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																																				
Address: <u>1311 Parkview Avenue</u> <u>Rockford</u> <u>61107</u>																																																																																						
Number City Zip Code																																																																																						
County: <u>Winnebago</u>																																																																																						
Telephone Number: <u>(815) 399-8832</u> Fax # <u>(815) 399-8342</u>																																																																																						
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ <u>05/23/2021</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>* Subject to the attached Accountants' Consulting Report (Date)</td></tr><tr><td>(Print Name <u>Steven N. Lavenda, CPA</u></td></tr><tr><td>and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u></td></tr><tr><td>& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>7/1/2017</u></td><td colspan="2">(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td colspan="2">Type of Ownership:</td><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td colspan="2"><table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Steven N. Lavenda</u></td><td colspan="2">Telephone Number: <u>(847) 282-6300</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/23/2021</u>	Paid Preparer	* Subject to the attached Accountants' Consulting Report (Date)	(Print Name <u>Steven N. Lavenda, CPA</u>	and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u>	& Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	Date of Initial License for Current Owners: <u>7/1/2017</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>		Type of Ownership:		MAIL TO: BUREAU OF HEALTH FINANCE		<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☒</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____					In the event there are further questions about this report, please contact:				Name: <u>Steven N. Lavenda</u>		Telephone Number: <u>(847) 282-6300</u>		Email Address: _____			
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Facility Name & ID Number PA Peterson at the Citadel

0054635 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	129	Skilled (SNF)	129	47,214	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,828	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	25,959	2,498	13,484	41,941	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		8,485		8,485	12
13	DD 16 OR LESS					13
14	TOTALS	25,959	10,983	13,484	50,426	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.20%

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)

Outpatient Therapy

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO X

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

YES NO X

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

Date started 07/01/2017

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

YES X Date 07/01/2017 NO

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

YES X NO If YES, enter number of beds certified 129 and days of care provided 6,243

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

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

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

Facility Name & ID Number PA Peterson at the Citadel # 0054635 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	374,632	55,083	11,468	441,183		441,183		441,183			1
2	Food Purchase		315,558		315,558		315,558	(689)	314,869			2
3	Housekeeping	316,687	52,317	27,804	396,808		396,808	1,831	398,639			3
4	Laundry	27,796	2,805	150,231	180,832		180,832		180,832			4
5	Heat and Other Utilities			203,474	203,474		203,474	(6,696)	196,778			5
6	Maintenance	95,824	77,612	235,363	408,799		408,799	(9,239)	399,560			6
7	Other (specify):*							3,045	3,045			7
8	TOTAL General Services	814,939	503,375	628,340	1,946,654		1,946,654	(11,748)	1,934,906			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,716,316	465,509	50,345	4,232,170		4,232,170	(58,997)	4,173,173			10
10a	Therapy	98,781			98,781		98,781		98,781			10a
11	Activities	135,821	4,472	3,493	143,786		143,786		143,786			11
12	Social Services	173,578		2,740	176,318		176,318		176,318			12
13	CNA Training											13
14	Program Transportation			8,709	8,709		8,709		8,709			14
15	Other (specify):*							25,626	25,626			15
16	TOTAL Health Care and Programs	4,124,496	469,981	101,287	4,695,764		4,695,764	(33,371)	4,662,393			16
	C. General Administration											
17	Administrative	143,815		639,117	782,932		782,932	(540,021)	242,911			17
18	Directors Fees											18
19	Professional Services			176,293	176,293	(1,274)	175,019	(6,128)	168,891			19
20	Dues, Fees, Subscriptions & Promotions			65,693	65,693		65,693	(16,766)	48,927			20
21	Clerical & General Office Expenses	219,254	2,799	543,792	765,845		765,845	(302,978)	462,867			21
22	Employee Benefits & Payroll Taxes			710,223	710,223		710,223		710,223			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,192	4,192		4,192	55	4,247			24
25	Other Admin. Staff Transportation			9,207	9,207		9,207	3,275	12,482			25
26	Insurance-Prop.Liab.Malpractice			495,153	495,153		495,153	4,113	499,266			26
27	Other (specify):*							47,591	47,591			27
28	TOTAL General Administration	363,069	2,799	2,643,670	3,009,538	(1,274)	3,008,264	(810,858)	2,197,406			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,302,504	976,155	3,373,297	9,651,956	(1,274)	9,650,682	(855,978)	8,794,704			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.

Facility Name & ID Number PA Peterson at the Citadel #0054635 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			84,142	84,142		84,142	(34,913)	49,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,303	42,303		42,303	8,953	51,256			32
33	Real Estate Taxes					1,274	1,274	7,225	8,499			33
34	Rent-Facility & Grounds			1,045,706	1,045,706		1,045,706	18,305	1,064,011			34
35	Rent-Equipment & Vehicles			33,766	33,766		33,766	18,820	52,586			35
36	Other (specify):*											36
37	TOTAL Ownership			1,205,917	1,205,917	1,274	1,207,191	18,391	1,225,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		253,864	890,087	1,143,951		1,143,951	(7,035)	1,136,916			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,482	266,482		266,482		266,482			42
43	Other (specify):*	158,974		105,885	264,859		264,859	(264,859)	(0)			43
44	TOTAL Special Cost Centers	158,974	253,864	1,262,454	1,675,292		1,675,292	(271,894)	1,403,398			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,461,478	1,230,019	5,841,668	12,533,165		12,533,165	(1,109,481)	11,423,684			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(8,211)	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	(39,991)	30		9
10	Interest and Other Investment Income	(278)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(689)	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	(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	(319,558)	21		24
25	Fund Raising, Advertising and Promotional	(3,000)	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	(343,997)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (718,824)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	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)	(390,657)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (390,657)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,109,481)		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	2	3	4	
		Yes	No	Amount	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	\$ (10,811)	21	1
2	Sequestration	(47,064)	21	2
3	Patient Needs	(3,889)	10	3
4	Marketing Salary	(93,656)	43	4
5	Guest Services Salary	(57,132)	43	5
6	Wellness Coordinator Salaries	(8,186)	43	6
7	Marketing Expense	(105,630)	43	7
8	Telephone Revenue	(600)	21	8
9	Credit Card/Pymt Process Fees	(1,122)	21	9
10	Additional R&M	53,025	06	10
11	Capitalized R&M	(48,375)	06	11
12	PAC Dues	(12,496)	20	12
13	Promotion Fees	(255)	43	13
14	Non Allowable Legal	(7,741)	19	14
15	Misc Income	(65)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(343,997)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PA Peterson at the Citadel

0054635

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	(689)											(689)	2
3	Housekeeping			1,831									1,831	3
4	Laundry													4
5	Heat and Other Utilities	(8,211)		1,515									(6,696)	5
6	Maintenance	4,650		(14,143)	254								(9,239)	6
7	Other (specify):*			3,045									3,045	7
8	TOTAL General Services	(4,250)		(7,752)	254								(11,748)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,889)		(53,255)			(1,853)						(58,997)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			25,626									25,626	15
16	TOTAL Health Care and Programs	(3,889)		(27,629)			(1,853)						(33,371)	16
	C. General Administration													
17	Administrative			(540,021)									(540,021)	17
18	Directors Fees													18
19	Professional Services	(7,741)		339	1,274								(6,128)	19
20	Fees, Subscriptions & Promotions	(18,596)		1,830									(16,766)	20
21	Clerical & General Office Expenses	(379,220)		76,242									(302,978)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			55									55	24
25	Other Admin. Staff Transportation			3,275									3,275	25
26	Insurance-Prop.Liab.Malpractice			4,113									4,113	26
27	Other (specify):*			47,591									47,591	27
28	TOTAL General Administration	(405,557)		(406,575)	1,274								(810,858)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(413,696)		(441,957)	1,528		(1,853)						(855,978)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PA Peterson at the Citadel # 0054635 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(39,991)		3,019	2,060								(34,913)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(278)		3,034	6,197								8,953	32
33	Real Estate Taxes				7,225								7,225	33
34	Rent-Facility & Grounds			27,650	(9,345)								18,305	34
35	Rent-Equipment & Vehicles			18,820									18,820	35
36	Other (specify):*													36
37	TOTAL Ownership	(40,269)		52,523	6,137								18,391	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,035)						(7,035)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(264,859)											(264,859)	43
44	TOTAL Special Cost Centers	(264,859)					(7,035)						(271,894)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(718,824)		(389,434)	7,665		(8,888)						(1,109,481)	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

X 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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	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	43.01%	AMBERWOOD CARE CENTER	ROCKFORD, IL				1
2	Kenneth Ripstein	43.01%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3	Marcella Graf	4.99%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Yakov Kohen	4.50%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Tsipporah Kohen	4.50%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	5
6			THE WATERFORD CARE CENTER LLC	CHICAGO, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7			CITADEL CARE CENTER-STERLING LLC	STERLING, IL				7
8			THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				8
9			SKOKIE MEADOWS LLC	SKOKIE, IL				9
10			THE CITADEL OF SKOKIE LLC	SKOKIE, IL				10
11			THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				11
12			THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	\$	Damen Healthcare Group, LLC		\$ 1,831	\$ 1,831	15
16	V	5	Utilities		Damen Healthcare Group, LLC		1,515	1,515	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		14,327	14,327	17
18	V	6	Maintenance	30,354	Damen Healthcare Group, LLC		1,884	(28,470)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		3,045	3,045	19
20	V	10	Nursing	176,587	Damen Healthcare Group, LLC		123,332	(53,255)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		25,626	25,626	21
22	V	17	Administrative	639,117	Damen Healthcare Group, LLC		31,785	(607,332)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		339	339	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		1,830	1,830	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		178,355	178,355	25
26	V	21	Office Expense - Other	115,080	Damen Healthcare Group, LLC		12,967	(102,113)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		55	55	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		3,275	3,275	28
29	V	26	Insurance		Damen Healthcare Group, LLC		4,113	4,113	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		47,591	47,591	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		3,019	3,019	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		3,034	3,034	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		18,305	18,305	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		9,345	9,345	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		1,011	1,011	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		17,809	17,809	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		35,527	35,527	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		31,785	31,785	38
39	Total			\$ 961,138			\$ 571,704	\$ * (389,434)	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		\$ 254	\$ 254	15
16	V	30	Depreciation		3755 W Chase, LLC		2,060	2,060	16
17	V	32	Interest Expense		3755 W Chase, LLC		6,197	6,197	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		7,225	7,225	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		1,274	1,274	19
20	V								20
21	V	34	Rent	9,345	3755 W Chase, LLC			(9,345)	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			\$ 9,345			\$ 17,010	\$ * 7,665	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	\$ 401,455	Biltmore Incorporated Cell		\$ 401,455	\$	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			\$ 401,455			\$ 401,455	\$ *	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	10	Medical Supplies/DME	\$ 11,954	Integra Healthcare Equipment		\$ 10,101	\$ (1,853)	15
16	V	39	Ancillary Expense	45,386	Integra Healthcare Equipment		38,351	(7,035)	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			\$ 57,340			\$ 48,452	\$ * (8,888)	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.

YESNO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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 PA Peterson at the Citadel # 0054635 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	43.01 %	See Attached	5.68	14.20 %	Alloc Mgt Fee	\$ 35,527	17-7	1
2	Kenneth Ripstein	Owner	Administrative	43.01 %	See Attached	5.09	12.73 %	Alloc Mgt Fee	31,785	17-7	2
3	Yakov Kohen	Owner	Clerical	4.50 %	See Attached	5.09	12.73 %	Alloc Salary	17,431	21-7	3
4	Marcella Graf	Owner	Administrative	4.99 %	See Attached	5.09	12.73 %	Alloc Salary	31,785	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 116,528		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 PA Peterson at the Citadel # 0054635 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 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	\$	50,426	\$ 1,831	1
2	5	Utilities	Patient Days	396,623	14	11,913		50,426	1,515	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	50,426	14,327	3
4	6	Maintenance	Patient Days	396,623	14	14,821		50,426	1,884	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		50,426	3,045	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	50,426	123,332	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		50,426	25,626	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	50,426	31,785	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		50,426	339	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		50,426	1,830	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	50,426	178,355	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		50,426	12,967	12
13	24	Seminars & Education	Patient Days	396,623	14	431		50,426	55	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		50,426	3,275	14
15	26	Insurance	Patient Days	396,623	14	32,350		50,426	4,113	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		50,426	47,591	16
17	30	Depreciation	Patient Days	396,623	14	23,745		50,426	3,019	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		50,426	3,034	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		50,426	18,305	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		50,426	9,345	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		50,426	1,011	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		50,426	17,809	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		50,426	35,527	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		50,426	31,785	24
25	TOTALS					\$ 4,467,270	\$ 2,713,873		\$ 571,704	25

Facility Name & ID Number PA Peterson at the Citadel # 0054635 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	\$	50,426	\$ 254	1
2	30	Depreciation	Patient Days	396,623	14	16,199		50,426	2,060	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		50,426	6,197	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		50,426	7,225	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		50,426	1,274	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	\$		\$ 17,010	25

Facility Name & ID Number PA Peterson at the Citadel # 0054635 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			\$	\$		\$ 401,455	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					\$	\$		\$ 401,455	25

Ending: 12/31/20

(630) 834-1500

Ending: 12/31/20

Ending: 12/31/20

Ending: 12/31/20

Facility Name & ID Number PA Peterson at the Citadel # 0054635 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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	First Midwest Bank		X	Line Of Credit				931,367				42,303	6
7													7
8													8
9	TOTAL Facility Related						\$	931,367			\$	42,303	9
	B. Non-Facility Related*												
10	Interest Income		X									(278)	10
11	Allocated from Damen HC	X										3,034	11
12	Allocated from 3755 Chase	X										6,197	12
13													13
14	TOTAL Non-Facility Related						\$				\$	8,953	14
15	TOTALS (line 9+line14)						\$	931,367			\$	51,256	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	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.)			\$171,649	2
3. Under or (over) accrual (line 2 minus line 1).			\$171,649	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.)			\$1,274	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.			\$172,923	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	186,030	8	
	2016	183,715	9	
	2017	173,073	10	
	2018	173,941	11	
	2019	164,424	12	
Facility did not accrue for taxes				
Allocated from 3755 Chase \$7,225				

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PA Peterson at the Citadel COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0054635

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 12-19-101-001	Long Term Care Property	\$ 164,424.26	\$ 164,424.26
2. 10-26-318-023-0000	Allocated from Home Office	\$ 172,792.10	\$ 21,968.51
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 337,216.36	\$ 186,392.77

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

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

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

PA Peterson at the Citadel

COUNTY

Winnebago

FACILITY IDPH LICENSE NUMBER

0054635

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 Index Number	Property Description	Total Tax	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: 110,000

B. General Construction Type: ExteriorMasonryFrameSteel Grids

Number of Stories3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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				\$	1
2	Allocated from 3755 W Chase		2019	85,462	2
3	TOTALS			\$ 85,462	3

HFS 3745 (N-4-99)

IL478-2471

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					\$	\$		\$	\$		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 PA Peterson at the Citadel

0054635

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		484,286	3,155		2,760	(395)	21,332	68
69	Financial Statement Depreciation			84,142			(84,142)		69
70	TOTAL (lines 4 thru 69)		\$ 484,286	\$ 87,297		\$ 2,760	\$ (84,537)	\$ 21,332	70

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

Facility Name & ID Number PA Peterson at the Citadel

0054635

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		\$ 484,286	\$ 87,297		\$ 2,760	\$ (84,537)	\$ 21,332	1
2	Removed & Installed New Carpet - Therapy	2017	9,500		20	475	475	1,623	2
3	Installed New Surveillance System - Front Desk	2017	9,827		20	491	491	1,597	3
4	Swaped Door Closure Hardware, Removed/Cleaned Flame Sensor	2017	3,494		20	175	175	539	4
5	Hc Dekor - Design And Preconstruction/Drawing/Rendering	2018	9,625		20	481	481	1,444	5
6	Suburban Elevator Company - Down Payment On Two Elevators	2018	22,913		20	1,146	1,146	3,342	6
7	Lm Sheet Metal & Service, Inc - Replaced Broken Condenser Fan	2018	4,253		20	213	213	550	7
8	Zima Construction - Basement Elevator Hallway Remodeling	2018	2,650		20	133	133	398	8
9	Zima Construction, Inc - 2Nd Fl - Resident Room #209-Paint/Ceili	2018	2,990		20	150	150	437	9
10	Lobby Lvt, Carpet Tile, Millwork Base, Fireplace Wall, Electrical W	2018	18,750		20	938	938	2,188	10
11	Hc Dekor - Lobby Installations, Fireplace Wall, Ceiling Work	2018	94,760		20	4,738	4,738	10,661	11
12	Zima Construction - Repair Walls/Repaint 3Rd Fl: Rooms 311, 30	2018	3,200		20	160	160	387	12
13	Zima Construction - Repair Carpet, Walls, Tile 2B Apt On 2Nd Fl	2018	2,890		20	145	145	326	13
14	Zima Construction - Remove Carpet & Insert Tile, Rooms 217, 22	2018	6,250		20	313	313	704	14
15	Zima Construction - Repair Walls & Flooring Apt #106	2018	3,660		20	183	183	397	15
16	Repaired/Replaced Broken Condensor Fan Motors, Blades, Capaci	2018	3,508		20	175	175	423	16
17	1St Flr Elevator Hallway/Resident Rm-Paint/Ceiling/Carpet/Walls	2018	5,380		20	269	269	583	17
18	2Nd/4Th Floor Resident Rm-Remove Wp And Paint Elv. Hallway	2018	4,120		20	206	206	618	18
19	Repaired Elevators	2018	68,739		20	3,437	3,437	8,592	19
20	Zima Construction - Repair Ceiling/Walls/Carpet-2Nd Flr Rm #20	2018	4,755		20	238	238	595	20
21	Replaced Cold Water Supply	2018	2,792		20	140	140	280	21
22	Rplcd 2 Alrm Panels-Serv To Door Alarm System	2019	3,200		20	160	160	307	22
23	4 New Electric Panels	2019	7,700		20	385	385	674	23
24	Rebuilt Catch Basin And Sidewalk	2019	4,500		20	225	225	356	24
25	Replaced Broken Actuators / Installed Erv Motor	2019	5,322		20	266	266	532	25
26	Condensor Fan Motor, Diaphragm, Replaced Fuses	2019	3,076		20	154	154	308	26
27	Applied Roof Patch 25' Of 6" Epdm & Calked Joints	2019	4,200		20	210	210	420	27
28	Repair Of Leaky Waterline	2019	4,732		20	237	237	474	28
29	Repair Ac Kitchen Cond Fans & Pneumatic Unit In Therapy	2019	8,740		20	437	437	874	29
30	Life Safety Electrical Work On Generator	2019	2,660		20	133	133	266	30
31	Dialysis Carpentry Plumbing, Electrical, Millwork	2020	82,044		20	4,102	4,102	4,102	31
32	Dialysis Plumbing, Flooring, Ceiling, Paint	2020	60,253		20	3,013	3,013	3,013	32
33	Chilled Water Piping Replacement	2020	4,246		20	212	212	212	33
34	TOTAL (lines 1 thru 33)		\$ 959,016	\$ 87,297		\$ 26,500	\$ (60,797)	\$ 68,554	34

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

Facility Name & ID Number PA Peterson at the Citadel

0054635

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 959,016	\$ 87,297		\$ 26,500	\$ (60,797)	\$ 68,554	1
2	Repair Aeon Unit	2020	3,689		20	184	184	184	2
3	Repair Condenser Motor On Chiller	2020	3,533		20	177	177	177	3
4	Repair Condenser Fan Motors On A/C Units	2020	3,575		20	179	179	179	4
5	Repair 2Nd Fl Office And Atrium A/C Units	2020	4,261		20	213	213	213	5
6	Repair Boiler	2020	6,034		20	302	302	302	6
7	Repair Compressor Pumps	2020	2,657		20	133	133	133	7
8	Ceiling Tile And Therapy Flooring	2020	20,380		20	1,019	1,019	1,019	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)		\$ 1,003,144	\$ 87,297		\$ 28,706	\$ (58,590)	\$ 70,760	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		\$1,003,144	\$87,297		\$28,706	\$(58,590)	\$70,760	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)		\$1,003,144	\$87,297		\$28,706	\$(58,590)	\$70,760	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		\$1,003,144	\$87,297		\$28,706	\$(58,590)	\$70,760	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)		\$1,003,144	\$87,297		\$28,706	\$(58,590)	\$70,760	34

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

Facility Name & ID Number PA Peterson at the Citadel

0054635

Report Period Beginning:

01/01/20

Ending:

12/31/20

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									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	484,286	2,060	35	2,760	700	21,332	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Damen Management	2015		1,095			(1,095)		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)		\$ 484,286	\$ 3,155		\$ 2,760	\$ (395)	\$ 21,332	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		\$484,286	\$3,155		\$2,760	\$(395)	\$21,332	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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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)		\$484,286	\$3,155		\$2,760	\$(395)	\$21,332	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	\$142,271	\$1,045	\$14,142	\$13,097	10	\$44,583	71
72	Current Year Purchases	30,715	709	2,916	2,206	10	2,916	72
73	Fully Depreciated Assets	1,443	169	169		10	1,443	73
74								74
75	TOTALS	\$174,429	\$1,924	\$17,227	\$15,303		\$48,941	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		2004 Chevrolet Silverado Plow T	2020	\$16,480	\$	\$3,296	\$3,296	5	\$3,296	76
77										77
78										78
79										79
80	TOTALS			\$16,480	\$	\$3,296	\$3,296		\$3,296	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	\$1,279,515	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$89,220	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$49,229	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(39,991)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$122,998	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:PA Peterson Realty
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:				\$1,045,706			3
4	Additions							4
5	Allocated from Damen Healthcare				18,305			5
6								6
7	TOTAL				\$1,064,011			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: \$20,629
- 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	2019 E350 Elkhart Coach	\$1,179	\$14,148	17
18	Allocated from Damen Healthcare			17,809	18
19					19
20					20
21	TOTAL		\$1,179	\$31,957	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	\$		\$ 241,103	\$		\$ 241,103	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			104,505			104,505	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			347,288			347,288	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				252,466		252,466	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					197,191	1,398		198,589	13
14	TOTAL			\$		\$ 890,087	\$ 253,864		\$ 1,143,951	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.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,215,583	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,257,424		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	502,474		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	12,950		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,988,431	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	441,359		15
16	Equipment, at Historical Cost	278,902		16
17	Accumulated Depreciation (book methods)	(195,811)		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	24,249		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 548,699	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,537,130	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 525,223	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	931,367		29
30	Accrued Salaries Payable	354,194		30
31	Accrued Taxes Payable (excluding real estate taxes)	270,176		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,609		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,622,927		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,707,496	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,707,496	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,829,634	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,537,130	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 654,402	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 654,401	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,175,233	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)	\$ 1,175,233	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,829,634	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PA Peterson at the Citadel

0054635

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	\$ 17,035,826	1
2	Discounts and Allowances for all Levels	(4,616,289)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,419,537	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	353,548	6
7	Oxygen	137	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 353,685	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	1,206	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,813	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	625	20
21	Other Medical Services	3,874	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,518	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	278	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 278	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	927,380	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 927,380	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,708,398	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,946,654	31
32	Health Care	4,695,764	32
33	General Administration	3,009,538	33
	B. Capital Expense		
34	Ownership	1,205,917	34
	C. Ancillary Expense		
35	Special Cost Centers	1,408,810	35
36	Provider Participation Fee	266,482	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,533,165	40
41	Income before Income Taxes (line 30 minus line 40)**	1,175,233	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,175,233	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,899,195	44
45	Private Pay - Net Inpatient Revenue	651,882	45
46	Medicare - Net Inpatient Revenue	3,760,274	46
47	Other-(specify) <u>Managed Care</u>	1,583,005	47
48	Other-(specify) <u>Private AL & IL/Hospice</u>	1,525,181	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,419,537	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,245	2,363	\$ 118,551	\$ 50.18	1
2	Assistant Director of Nursing	2,057	2,165	94,176	43.50	2
3	Registered Nurses	18,811	19,801	798,969	40.35	3
4	Licensed Practical Nurses	36,122	38,023	1,392,173	36.61	4
5	CNAs & Orderlies	70,848	74,577	1,270,810	17.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,415	2,542	98,781	38.86	8
9	Activity Director	2,044	2,152	41,863	19.45	9
10	Activity Assistants	5,984	6,299	93,958	14.92	10
11	Social Service Workers	6,959	7,325	173,578	23.70	11
12	Dietician					12
13	Food Service Supervisor	2,071	2,180	61,600	28.25	13
14	Head Cook	5,668	5,966	86,469	14.49	14
15	Cook Helpers/Assistants	18,256	19,217	226,563	11.79	15
16	Dishwashers					16
17	Maintenance Workers	4,292	4,518	95,824	21.21	17
18	Housekeepers	19,434	20,457	316,687	15.48	18
19	Laundry	2,070	2,179	27,796	12.76	19
20	Administrator	2,014	2,120	138,518	65.34	20
21	Assistant Administrator	105	110	5,297	48.15	21
22	Other Administrative					22
23	Office Manager	3,557	3,744	95,583	25.53	23
24	Clerical	7,548	7,946	123,671	15.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,926	2,027	41,637	20.54	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	4,817	5,072	158,974	31.34	33
34	TOTAL (lines 1 - 33)	219,243	230,784	\$ 5,461,478 *	\$ 23.66	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	244	\$ 11,468	01-03	35
36	Medical Director	Monthly	36,000	09-03	36
37	Medical Records Consultant	Quarterly	2,381	10-03	37
38	Nurse Consultant	Per Visit	5,000	10-03	38
39	Pharmacist Consultant	Monthly	15,964	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	52	3,493	11-03	44
45	Social Service Consultant	41	2,740	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	27,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	337	\$ 104,046		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.

STATE OF ILLINOIS

Facility Name & ID Number

PA Peterson at the Citadel

0054635

Report Period Beginning:

01/01/20

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Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Travas Tucker	Administrator	0	\$ 133,277
Mike Rhoe	Administrator	0	5,241
Ben Kramer	Asst. Admin.	0	5,297
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 143,815

B. Administrative - Other

Description	Amount
Management Fees -Damen Healthcare Group, LLC	\$ 639,117
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 639,117

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 27,883
ProPay HR	Payroll Services	29,854
Achieve Accreditation	Accreditation	4,863
Correll Co.	401K Planning	1,093
MTS Consulting LLC	Tax Consultants	2,509
Personnel Planners	Unemployment Consultant	2,050
eSolutions Inc.	Data Processing	2,590
IIT/SourceTech	Data Processing	2,170
National Datacare Corporation	Data Processing	2,718
Point Click Care Technologies, Inc.	Clinical Software	55,431
See Attached	Legal	30,109
See Supplemental Schedule		15,021
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 176,292

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 70,235
Unemployment Compensation Insurance	45,167
FICA Taxes	417,803
Employee Health Insurance	143,471
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	6,217
Employee Benefits - Other	21,551
Holiday Expense	1,693
401K Employer Match Expense	4,086
TOTAL (agree to Schedule V, line 22, col.8)	\$ 710,224

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	\$ 1,990
Advertising: Employee Recruitment	8,051
Health Care Worker Background Check (Indicate # of checks performed 198)	8,866
Patient Background Checks 474	5,645
Dues & Subscriptions	19,811
Licenses & Fees	2,734
See Supplemental Schedule	1,830
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,927

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	4,192
See Supplemental Schedule	55
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 4,247

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

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

HCCI \$24,992
- (3)

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

Yes

Yes
- (4)

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

No

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

10 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 30,040

Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

N/A
- (11)

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

\$ 266,482
- (12)

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

No
- (13)

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

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15)

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

\$ N/A

Indicate the amount. \$
- (16)

Travel and Transportation

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

No

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

No

\$ N/A

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

100% Ln 14

d. Have vehicle usage logs been maintained?

No

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

Yes

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

N/A

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

No

\$ N/A
- (17)

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

No

N/A
- (18)

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

Yes
- (19)

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

Yes