		FOR BHF USE				

LL1

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.

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

I. IDPH License ID Number: 0053793

Facility Name: Citadel Care Center Kankakee

Address: 900 West River Place (Number) Kankakee (City) 60901 (Zip Code)

County: Kankakee

Telephone Number: (815) 933-1711 Fax # (815) 933-2065

HFS ID Number:

Date of Initial License for Current Owners: 1/5/2016

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) ________ (Date)
(Type or Print Name) ________
(Title) ________

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

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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	107	Skilled (SNF)	107	39,162	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,162	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	19,866	3,346	7,322	30,534	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,866	3,346	7,322	30,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.97%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 01/05/2016

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/05/2016 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 107 and days of care provided 4,566

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED 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: Citadel Care Center Kankakee # 0053793 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	214,973	26,514	9,001	250,488		250,488		250,488			1
2	Food Purchase		165,061		165,061		165,061	(183)	164,878			2
3	Housekeeping	116,579	23,618	4,000	144,197		144,197	1,109	145,306			3
4	Laundry	65,791	10,034	7,414	83,239		83,239		83,239			4
5	Heat and Other Utilities			144,379	144,379		144,379	(13,312)	131,067			5
6	Maintenance	48,559	17,382	122,720	188,661		188,661	1,410	190,071			6
7	Other (specify):*							1,844	1,844			7
8	**TOTAL General Services**	445,902	242,609	287,514	976,025		976,025	(9,132)	966,893			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,195,649	265,227	218,458	2,679,334		2,679,334	(23,374)	2,655,960			10
10a	Therapy	73,181			73,181		73,181		73,181			10a
11	Activities	108,814	6,036	1,638	116,488		116,488		116,488			11
12	Social Services	110,650		630	111,280		111,280		111,280			12
13	CNA Training											13
14	Program Transportation			13,988	13,988		13,988	(1,094)	12,894			14
15	Other (specify):*							15,517	15,517			15
16	**TOTAL Health Care and Programs**	2,488,294	271,263	258,714	3,018,271		3,018,271	(8,951)	3,009,320			16
	C. General Administration											
17	Administrative	129,000		426,953	555,953		555,953	(366,948)	189,005			17
18	Directors Fees											18
19	Professional Services			150,854	150,854	(771)	150,083	(10,544)	139,538			19
20	Dues, Fees, Subscriptions & Promotions			35,230	35,230		35,230	(3,792)	31,438			20
21	Clerical & General Office Expenses	222,583	7,298	377,087	606,968		606,968	(220,960)	386,008			21
22	Employee Benefits & Payroll Taxes			494,686	494,686		494,686		494,686			22
23	Inservice Training & Education											23
24	Travel and Seminar			767	767		767	33	800			24
25	Other Admin. Staff Transportation			6,878	6,878		6,878	1,983	8,861			25
26	Insurance-Prop.Liab.Malpractice			458,259	458,259		458,259	2,490	460,749			26
27	Other (specify):*							28,817	28,817			27
28	**TOTAL General Administration**	351,583	7,298	1,950,714	2,309,595	(771)	2,308,824	(568,921)	1,739,902			28
29	**TOTAL Operating Expense** (sum of lines 8, 16 & 28)	3,285,779	521,170	2,496,942	6,303,891	(771)	6,303,120	(587,004)	5,716,115			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 **Citadel Care Center Kankakee** **#0053793** **Report Period Beginning:** **01/01/20** **Ending:** **12/31/20**

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			108,254	108,254		108,254	131,585	239,839			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,274	25,274		25,274	223,857	249,131			32
33	Real Estate Taxes					771	771	153,497	154,268			33
34	Rent-Facility & Grounds			567,978	567,978		567,978	(556,894)	11,084			34
35	Rent-Equipment & Vehicles			31,277	31,277		31,277	2,125	33,402			35
36	Other (specify):*							51,798	51,798			36
37	**TOTAL Ownership**			732,783	732,783	771	733,554	5,968	739,522			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,508	620,963	742,471		742,471	(2,370)	740,101			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			213,190	213,190		213,190		213,190			42
43	Other (specify):*	88,863		58,430	147,293		147,293	(147,293)	(0)			43
44	**TOTAL Special Cost Centers**	88,863	121,508	892,583	1,102,954		1,102,954	(149,663)	953,291			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,374,642	642,678	4,122,308	8,139,628		8,139,628	(730,700)	7,408,928			45

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(14,229)	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	128,510	30		9
10	Interest and Other Investment Income	(3,751)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	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	(730)	21		18
19	Entertainment				19
20	Contributions	(3,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,476)	21		24
25	Fund Raising, Advertising and Promotional	(1,800)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(207,524)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (316,283)		$	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)	(414,417)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (414,417)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (730,700)		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

Citadel Care Center Kankakee

ID# 0053793

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (23,719)	21	1
2	Misc Income	(111)	21	2
3	Sequestration	(16,818)	21	3
4	Patient Needs	(782)	10	4
5	Marketing Salary	(88,863)	43	5
6	Marketing Expense	(58,175)	43	6
7	Credit Card/Pymt Process Fees	(269)	21	7
8	Bldg Co - Bank Charges	(1,159)	21	8
9	Additional R&M	15,942	06	9
10	Capitalized R&M	(9,480)	06	10
11	Non Allowable Auto Lease	(9,271)	35	11
12	Promotion Fees	(255)	43	12
13	Non Allowable Legal	(11,520)	19	13
14	Bldg Co - Accounting	(3,043)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(207,524)		49

Detail lines 29 and 35 of Page 5 starting in C12. **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 5B**

Citadel Care Center Kankakee

ID# 0053793

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V 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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(183)											(183)	2
3	Housekeeping			1,109									1,109	3
4	Laundry													4
5	Heat and Other Utilities	(14,229)		917									(13,312)	5
6	Maintenance	6,462		(5,206)	154								1,410	6
7	Other (specify):*			1,844									1,844	7
8	**TOTAL General Services**	(7,950)		(1,336)	154								(9,132)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(782)		(22,013)			(579)						(23,374)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							(1,094)					(1,094)	14
15	Other (specify):*			15,517									15,517	15
16	**TOTAL Health Care and Programs**	(782)		(6,496)			(579)	(1,094)					(8,951)	16
	C. General Administration													
17	Administrative			(366,948)									(366,948)	17
18	Directors Fees													18
19	Professional Services	(14,563)	3,043	205	771								(10,544)	19
20	Fees, Subscriptions & Promotions	(4,900)		1,108									(3,792)	20
21	Clerical & General Office Expenses	(256,282)	1,159	34,163									(220,960)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			33									33	24
25	Other Admin. Staff Transportation			1,983									1,983	25
26	Insurance-Prop.Liab.Malpractice			2,490									2,490	26
27	Other (specify):*			28,817									28,817	27
28	**TOTAL General Administration**	(275,745)	4,202	(298,149)	771								(568,921)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(284,477)	4,202	(305,981)	925		(579)	(1,094)					(587,004)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	128,510		1,828	1,247								131,585	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,751)	222,018	1,837	3,753								223,857	32
33	Real Estate Taxes		149,122		4,375								153,497	33
34	Rent-Facility & Grounds		(567,978)	16,742	(5,658)								(556,894)	34
35	Rent-Equipment & Vehicles	(9,271)		11,396									2,125	35
36	Other (specify):*		51,798										51,798	36
37	**TOTAL Ownership**	115,488	(145,040)	31,803	3,717								5,968	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,370)						(2,370)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(147,293)											(147,293)	43
44	**TOTAL Special Cost Centers**	(147,293)					(2,370)						(149,663)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(316,283)	(140,838)	(274,178)	4,642		(2,949)	(1,094)					(730,700)	45

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 567,978	900 West River Place, LLC		$	$ (567,978)	1
2	V	21	Bank Charges		900 West River Place, LLC		1,159	1,159	2
3	V	32	Interest	11	900 West River Place, LLC		222,029	222,018	3
4	V	33	Real Estate Taxes		900 West River Place, LLC		149,122	149,122	4
5	V	36	MIP Expense		900 West River Place, LLC		51,798	51,798	5
6	V	19	Accounting		900 West River Place, LLC		3,043	3,043	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 567,989			$ 427,151	$ * (140,838)	14

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

Facility Name & ID Number: Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JONATHAN AARON	0.10%	AMBERWOOD CARE CENTER	ROCKFORD, IL	900 WEST RIVER PLACE	KANKAKEE	BUILDING COMPANY	1
2	CITADEL OPCO HOLDINGS LLC	99.90%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3			CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4			CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5			THE WATERFORD CARE CENTER LLC	CHICAGO, IL	INTEGRA HEALTHCARE EQUI	ELMHURST	DME	5
6			CITADEL CARE CENTER-STERLING LLC	STERLING, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7			THE CITADEL OF NORTHBROOK LLC	NORTHBROOK, IL				7
8			PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				8
9			SKOKIE MEADOWS LLC	SKOKIE, IL				9
10			THE CITADEL OF SKOKIE LLC	SKOKIE, IL				10
11			THE CITADEL OF GLENVIEW LLC	GLENVIEW, IL				11
12			THE CITADEL OF BOURBONNAIS LLC	BOURBONNAIS				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	3	Housekeeping	$	Damen Healthcare Group, LLC		$ 1,109	$ 1,109	15
16	V	5	Utilities		Damen Healthcare Group, LLC		917	917	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		8,675	8,675	17
18	V	6	Maintenance	15,022	Damen Healthcare Group, LLC		1,141	(13,881)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		1,844	1,844	19
20	V	10	Nursing	96,693	Damen Healthcare Group, LLC		74,680	(22,013)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		15,517	15,517	21
22	V	17	Administrative	426,953	Damen Healthcare Group, LLC		19,246	(407,707)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		205	205	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		1,108	1,108	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		107,998	107,998	25
26	V	21	Office Expense - Other	81,687	Damen Healthcare Group, LLC		7,852	(73,835)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		33	33	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		1,983	1,983	28
29	V	26	Insurance		Damen Healthcare Group, LLC		2,490	2,490	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		28,817	28,817	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		1,828	1,828	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		1,837	1,837	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		11,084	11,084	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		5,658	5,658	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		612	612	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		10,784	10,784	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		21,512	21,512	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		19,246	19,246	38
39	Total			$ 620,355			$ 346,177	$ * (274,178)	39

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	3755 W Chase, LLC		$ 154	$ 154	15
16	V	30	Depreciation		3755 W Chase, LLC		1,247	1,247	16
17	V	32	Interest Expense		3755 W Chase, LLC		3,753	3,753	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		4,375	4,375	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		771	771	19
20	V								20
21	V	34	Rent	5,658	3755 W Chase, LLC			(5,658)	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			$ 5,658			$ 10,300	$ * 4,642	39

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 309,917	Biltmore Incorporated Cell		$ 309,917	$	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			$ 309,917			$ 309,917	$ *	39

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 3,738	Integra Healthcare Equipment		$ 3,159	$ (579)	15
16	V	39	Ancillary Expense	15,292	Integra Healthcare Equipment		12,922	(2,370)	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			$ 19,030			$ 16,081	$ * (2,949)	39

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	14	Patient Transportation	$ 5,787	Lifeline Ambulance LLC		$ 4,693	$ (1,094)	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			$ 5,787			$ 4,693	$ * (1,094)	39

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number: Citadel Care Center Kankakee # 0053793 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Jonathan Aaron	Owner	Administrative	0.10%	See Attached	3.44	8.60%	Alloc Mgt Fee	$ 21,512	17-7	1
2	Kenneth Ripstein	Administrative	Administrative		See Attached	3.08	7.70%	Alloc Mgt Fee	19,246	17-7	2
3	Yakov Kohen	Clerical	Clerical		See Attached	3.08	7.70%	Alloc Salary	10,555	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 51,313		13

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

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 [X]

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 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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	396,623	14	$ 14,400	$	30,534	$ 1,109	1
2	5	Utilities	Patient Days	396,623	14	11,913		30,534	917	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	30,534	8,675	3
4	6	Maintenance	Patient Days	396,623	14	14,821		30,534	1,141	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		30,534	1,844	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	30,534	74,680	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		30,534	15,517	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	30,534	19,246	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		30,534	205	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		30,534	1,108	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	30,534	107,998	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		30,534	7,852	12
13	24	Seminars & Education	Patient Days	396,623	14	431		30,534	33	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		30,534	1,983	14
15	26	Insurance	Patient Days	396,623	14	32,350		30,534	2,490	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		30,534	28,817	16
17	30	Depreciation	Patient Days	396,623	14	23,745		30,534	1,828	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		30,534	1,837	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		30,534	11,084	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		30,534	5,658	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		30,534	612	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		30,534	10,784	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		30,534	21,512	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		30,534	19,246	24
25	TOTALS					$ 4,467,270	$ 2,713,873		$ 346,177	25

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Patient Days	396,623	14	$ 2,000	$	30,534	$ 154	1
2	30	Depreciation	Patient Days	396,623	14	16,199		30,534	1,247	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		30,534	3,753	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		30,534	4,375	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		30,534	771	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	$		$ 10,300	25

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 X 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 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	26	Insurance	Direct Allocation			$	$		$ 309,917	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					$	$		$ 309,917	25

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 X NO

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

Name of Related Organization	Integra Healthcare Equipment, LLC
Street Address	747 Church Road
City / State / Zip Code	Elmhurst, IL 60126
Phone Number	(630) 834-3700
Fax Number	(630) 834-1500

	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	10	Medical Supplies/DME	Direct			$	$		$ 3,159	1
2	39	Ancillary Expense	Direct						12,922	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					$	$		$ 16,081	25

Facility Name & ID Number: Citadel Care Center Kankakee # 0053793 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 [X] NO [ ]

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

Name of Related Organization: Lifeline Ambulance
Street Address: 2424 S Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312) 949-9595
Fax Number: (312) 949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	14	Patient Transportation	Direct			$	$		$ 4,693	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					$	$		$ 4,693	25

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 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
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13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First American Capital Group		X	Mortgage			$	$ 6,772,981			$ 222,029	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit				616,740			25,274	6
7												7
8												8
9	TOTAL Facility Related						$	$ 7,389,721			$ 247,303	9
	B. Non-Facility Related*											
10	Interest Income		X								(3,751)	10
11	Interest Income - Bldg Co		X								(11)	11
12	Allocated from Damen HC	X									1,837	12
13	Allocated from 3755 Chase	X									3,753	13
14	TOTAL Non-Facility Related						$	$			$ 1,828	14
15	TOTALS (line 9+line14)						$	$ 7,389,721			$ 249,131	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 51,798 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.)

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	70,013	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.)	$	111,270	2
3. Under or (over) accrual (line 2 minus line 1).	$	41,257	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	112,240	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.)**	$	771	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.	$	154,268	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	69,099	8
	2016	72,993	9
	2017	76,359	10
	2018	66,679	11
	2019	106,895	12

2020 Accrual = $106,895 x 1.05 = $112,240
Allocated from 3755 Chase $4,375

	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 Citadel Care Center Kankakee COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0053793

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-09-31-412-001	Long Term Care Property	$ 106,895.10	$ 106,895.10
2.	10-26-318-023-0000	Allocated from Home Office	$ 172,792.10	$ 13,302.39
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 279,687.20	$ 120,197.49

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 Citadel Care Center Kankakee COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0053793

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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.

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,938 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	101,930	2016	$ 446,143	1
2	Allocated from 3755 W Chase, LLC		2019	51,749	2
3	TOTALS	101,930		$ 497,892	3

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	107		2016	1969	$ 4,318,257	$	35	123,379	$ 123,379	$ 616,895	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2016	45,109		20	2,257	2,257	11,428	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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)		20,855			1,043	1,043	1,043	67
68	Related Party Allocations (Pages 12H & 12I)		293,245	1,910		1,671	(239)	12,917	68
69	Financial Statement Depreciation			108,254			(108,254)		69
70	TOTAL (lines 4 thru 69)		$ 4,677,466	$ 110,164		$ 128,350	$ 18,185	$ 642,282	70

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 12A, Carried Forward		$ 4,677,466	$ 110,164		$ 128,350	$ 18,185	$ 642,282	1
2	Precision Piping Inc- Booster Heater	2017	3,305		20	165	165	661	2
3	Job 1 Fire Protection- Sprinker Head Purchse And Protection	2017	3,740		20	187	187	748	3
4	Repairs On 1St Floor Hallway & Bathroom Wall	2017	3,919		20	196	196	784	4
5	Hc Dekor - Architural Plans & Idph Submission	2018	12,947		20	647	647	2,373	5
6	Hc Dekor - Carpentry, Drywall, Framing, Paint	2018	3,447		20	172	172	286	6
7	Vestibule/Lobby/Lounge/Corridors/Dining/Therapy/Activity/	2018	1,366,917		20	68,346	68,346	205,038	7
8	Resident Rms/Showers: Ceilings/Floors/Wallcovering/Lighting/	2018			20				8
9	Cabinetry/Window Treatments/Sinks/Shower Fixtures/Paint	2018			20				9
10	Wheelchair Lift Repair	2018	2,993		20	150	150	449	10
11	Memory Care Doors	2019	3,600		20	180	180	360	11
12	Repair & Paint Trim & Doors/Remove Carpet-Business Office	2019	2,925		20	146	146	292	12
13	Zima Construction, Inc - Front Office And Nurse'S Room Rehab	2020	2,636		20	132	132	132	13
14	Sprinkler System Repair	2020	5,029		20	251	251	251	14
15	Repair Hot Water Pump	2020	4,451		20	223	223	223	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	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)		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 12C, Carried Forward		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	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)		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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 12D, Carried Forward		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	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)		$ 6,093,375	$ 110,164		$ 199,144	$ 88,980	$ 853,879	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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	Fire Sprinkler Dry Head	2019	17,825		20	891	891	891	9
10	Fire Sprinkler Dry Head	2020	3,030		20	152	152	152	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)		$ 20,855	$		$ 1,043	$ 1,043	$ 1,043	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 20,855	$		$ 1,043	$ 1,043	$ 1,043	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)		$ 20,855	$		$ 1,043	$ 1,043	$ 1,043	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 3737 Chase	2019	293,245	1,247	35	1,671	424	12,917	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		663			(663)		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)		$ 293,245	$ 1,910		$ 1,671	$ (239)	$ 12,917	34

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

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 293,245	$ 1,910		$ 1,671	$ (239)	$ 12,917	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)		$ 293,245	$ 1,910		$ 1,671	$ (239)	$ 12,917	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	$ 376,213	$ 633	$ 37,570	$ 36,937	10	$ 121,001	71
72	Current Year Purchases	31,171	430	3,023	2,593	10	3,023	72
73	Fully Depreciated Assets	874	102	102		10	874	73
74								74
75	TOTALS	$ 408,257	$ 1,165	$ 40,695	$ 39,530		$ 124,898	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 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)	$ 6,999,524	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,329	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 239,839	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 128,510	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 978,777	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	Various CIP	$ 29,929	92
93			93
94			94
95		$ 29,929	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.

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				11,084			5
6								6
7	TOTAL				$ 11,084 **			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: *

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	$

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: $ 11,465 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E-450 Super Du	$ 926	$ 11,152	17
18	Allocated from Damen HC			10,784	18
19					19
20					20
21	TOTAL		$ 926	$ 21,936	21

* 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.

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   [X] 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)	$			

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	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 194,042	$		$ 194,042	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			127,660			127,660	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			243,653			243,653	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				121,321		121,321	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					55,608	187		55,795	13
14	TOTAL			$		$ 620,963	$ 121,508		$ 742,471	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.

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,971,263	$ 2,003,475	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,958,569	1,958,569	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	355,469	355,469	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	2,031	307,804	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,287,332	$ 4,625,317	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		586,143	13
14	Buildings, at Historical Cost		3,672,586	14
15	Leasehold Improvements, at Historical Cost	490,048	1,937,811	15
16	Equipment, at Historical Cost	145,909	1,587,185	16
17	Accumulated Depreciation (book methods)	(281,781)	(2,072,059)	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	54,284	236,110	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 408,460	$ 5,947,776	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,695,792	$ 10,573,093	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 892,457	$ 892,456	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	616,740	616,740	29
30	Accrued Salaries Payable	126,419	126,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	155,414	155,414	31
32	Accrued Real Estate Taxes(Sch.IX-B)		112,240	32
33	Accrued Interest Payable	1,941	1,941	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,098,455	1,418,042	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,891,426	$ 3,323,252	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,772,981	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	814,823	492,892	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 814,823	$ 7,265,873	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,706,249	$ 10,589,125	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 989,543	$ (16,032)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,695,792	$ 10,573,093	48

*(See instructions.)

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (140,815)	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)**	$ (140,814)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,130,357	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)**	$ 1,130,357	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)**	$ 989,543	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,808,690	1
2	Discounts and Allowances for all Levels	(2,734,376)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,074,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	459,834	6
7	Oxygen	92	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 459,926	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(1)	19
20	Radiology and X-Ray		20
21	Other Medical Services	4,826	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,825	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,751	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,751	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	727,169	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 727,169	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,269,985	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	976,025	31
32	Health Care	3,018,271	32
33	General Administration	2,309,595	33
	B. Capital Expense		
34	Ownership	732,783	34
	C. Ancillary Expense		
35	Special Cost Centers	889,764	35
36	Provider Participation Fee	213,190	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,139,628	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,130,357	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,130,357	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,228,283	44
45	Private Pay - Net Inpatient Revenue	741,685	45
46	Medicare - Net Inpatient Revenue	2,352,029	46
47	Other-(specify) Managed Care	285,368	47
48	Other-(specify) Hospice	466,949	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,074,314	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.

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2,120	2,232	$ 91,802	$ 41.14	1
2	Assistant Director of Nursing	2,166	2,280	108,172	47.44	2
3	Registered Nurses	6,855	7,216	219,820	30.46	3
4	Licensed Practical Nurses	23,567	24,808	750,238	30.24	4
5	CNAs & Orderlies	58,909	62,009	988,947	15.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,062	2,170	73,181	33.72	8
9	Activity Director	2,111	2,222	38,806	17.47	9
10	Activity Assistants	6,117	6,439	70,008	10.87	10
11	Social Service Workers	2,157	2,271	92,798	40.86	11
12	Dietician					12
13	Food Service Supervisor	1,220	1,284	25,971	20.23	13
14	Head Cook	5,327	5,608	75,991	13.55	14
15	Cook Helpers/Assistants	9,651	10,159	113,011	11.12	15
16	Dishwashers					16
17	Maintenance Workers	2,096	2,207	48,559	22.00	17
18	Housekeepers	9,981	10,507	116,579	11.10	18
19	Laundry	5,492	5,782	65,791	11.38	19
20	Administrator	2,052	2,160	129,000	59.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,774	3,972	90,290	22.73	23
24	Clerical	6,159	6,483	132,293	20.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,391	5,675	143,384	25.27	33
34	TOTAL (lines 1 - 33)	157,208	165,483	$ 3,374,641 *	$ 20.39	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 9,001	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	Quarterly	2,982	10-03	37
38	Nurse Consultant	Per Visit	3,000	10-03	38
39	Pharmacist Consultant	Monthly	11,408	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	29	1,638	11-03	44
45	Social Service Consultant	10	630	12-03	45
46	Other(specify)				46
47	MDS Consultant	Monthly	15,194	10-03	47
48					48
49	TOTAL (lines 35 - 48)	230	$ 67,853		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	87	$ 7,375	10-03	50
51	Licensed Practical Nurses	266	16,747	10-03	51
52	Certified Nurse Assistants/Aides	4,384	161,752	10-03	52
53	TOTAL (lines 50 - 52)	4,737	$ 185,874		53

Facility Name & ID Number Citadel Care Center Kankakee # 0053793 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Jennifer Wright	Administrator	0	$	129,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	129,000

B. Administrative - Other

Description		Amount
Management Fees - Damen Healthcare Group, LLC	$	426,953
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	426,953

C. Professional Services

Vendor/Payee	Type		Amount
Marcum LLP	Accounting	$	29,035
ProPay HR	Payroll Services		20,378
Achieve Accreditation	Accreditation		4,856
Correll Co.	401K Services		1,093
MTS Consulting, LLC	Tax Consultant		626
Pendulum LLC	Healthcare Risk Consulting		1,190
Personnel Planners	Unemployment Consultant		1,500
eSolutions Inc.	Data Processing		2,428
IIT/SourceTech	Data Processing		2,565
National Datacare Corporation	Data Processing		1,739
See Attached	Legal		33,712
See Supplemental Schedule			51,731
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	150,854

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	43,318
Unemployment Compensation Insurance		12,062
FICA Taxes		258,160
Employee Health Insurance		147,816
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Life Insurance		4,340
Dental / Vision Insurance		2,238
Employee Benefits - Other		17,342
Holiday Expense		2,898
401K Employer Match Expense		6,512
TOTAL (agree to Schedule V, line 22, col.8)	$	494,687

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #		Amount
		$	
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description			Amount
IDPH License Fee		$	3,980
Advertising: Employee Recruitment			13,969
Health Care Worker Background Check			
(Indicate # of checks performed	80)		1,344
Patient Background Checks	183		1,830
Dues & Subscriptions			7,042
Licenses & Fees			2,165
See Supplemental Schedule			1,108
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)		$	31,438

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		767
See Supplemental Schedule		33
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	800

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,286** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **213,190**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ ____

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

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

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

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