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: 0055020

Facility Name: The Citadel of Northbrook

Address: 3300 Milwaukee Ave (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 795-9700 Fax # (847) 795-9600

HFS ID Number:

Date of Initial License for Current Owners: 12/28/2018

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
	IRS Exemption Code		Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 The Citadel of Northbrook # 0055020 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	158	Skilled (SNF)	158	57,828	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	158	TOTALS	158	57,828	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	30,694	6,075	11,916	48,685	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,694	6,075	11,916	48,685	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.19%

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 12/28/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/28/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 8,108

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: The Citadel of Northbrook # 0055020 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	469,436	66,479	20,078	555,993		555,993		555,993			1
2	Food Purchase		326,140		326,140		326,140	(407)	325,733			2
3	Housekeeping	350,838	57,700	10,000	418,538		418,538	1,768	420,306			3
4	Laundry	46,612	12,299	14,811	73,722		73,722		73,722			4
5	Heat and Other Utilities			200,820	200,820		200,820	(8,473)	192,347			5
6	Maintenance	67,500	25,261	171,594	264,355		264,355	2,916	267,271			6
7	Other (specify):*							2,940	2,940			7
8	**TOTAL General Services**	934,386	487,879	417,303	1,839,568		1,839,568	(1,256)	1,838,312			8
	B. Health Care and Programs											
9	Medical Director			52,200	52,200		52,200		52,200			9
10	Nursing and Medical Records	4,330,546	536,259	252,884	5,119,689		5,119,689	(32,165)	5,087,524			10
10a	Therapy	104,542			104,542		104,542		104,542			10a
11	Activities	181,854	8,361	798	191,013		191,013		191,013			11
12	Social Services	281,536		2,988	284,524		284,524		284,524			12
13	CNA Training											13
14	Program Transportation			16,037	16,037		16,037	(1,538)	14,499			14
15	Other (specify):*							24,741	24,741			15
16	**TOTAL Health Care and Programs**	4,898,478	544,620	324,907	5,768,005		5,768,005	(8,961)	5,759,044			16
	C. General Administration											
17	Administrative	149,698		822,673	972,371		972,371	(726,999)	245,372			17
18	Directors Fees											18
19	Professional Services			227,294	227,294	(21,315)	205,979	(5,383)	200,596			19
20	Dues, Fees, Subscriptions & Promotions			83,899	83,899		83,899	(27,764)	56,135			20
21	Clerical & General Office Expenses	239,088	4,144	598,801	842,033		842,033	(362,019)	480,014			21
22	Employee Benefits & Payroll Taxes			1,009,283	1,009,283		1,009,283		1,009,283			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,204	1,204		1,204	53	1,257			24
25	Other Admin. Staff Transportation			10,763	10,763		10,763	3,162	13,925			25
26	Insurance-Prop.Liab.Malpractice			389,890	389,890		389,890	3,971	393,861			26
27	Other (specify):*							45,948	45,948			27
28	**TOTAL General Administration**	388,786	4,144	3,143,807	3,536,737	(21,315)	3,515,422	(1,069,030)	2,446,392			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,221,650	1,036,643	3,886,017	11,144,310	(21,315)	11,122,995	(1,079,247)	10,043,748			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,752	63,752		63,752	(28,361)	35,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,147	91,147		91,147	(43,740)	47,407			32
33	Real Estate Taxes					21,315	21,315	6,976	28,291			33
34	Rent-Facility & Grounds			1,347,203	1,347,203		1,347,203	17,673	1,364,876			34
35	Rent-Equipment & Vehicles			21,103	21,103		21,103	18,170	39,273			35
36	Other (specify):*											36
37	TOTAL Ownership			1,523,205	1,523,205	21,315	1,544,520	(29,282)	1,515,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	84,260	317,426	1,628,272	2,029,958		2,029,958	(3,673)	2,026,285			39
40	Barber and Beauty Shops			2,192	2,192		2,192		2,192			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,263	326,263		326,263		326,263			42
43	Other (specify):*	140,830		90,691	231,521		231,521	(231,521)	0			43
44	TOTAL Special Cost Centers	225,090	317,426	2,047,418	2,589,934		2,589,934	(235,194)	2,354,740			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,446,740	1,354,069	7,456,640	15,257,449		15,257,449	(1,343,722)	13,913,727			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 The Citadel of Northbrook # 0055020 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	(9,935)	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	(33,264)	30		9
10	Interest and Other Investment Income	(1,682)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(407)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,078)	21		18
19	Entertainment				19
20	Contributions	(6,100)	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	(357,298)	21		24
25	Fund Raising, Advertising and Promotional	(17,900)	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	(353,588)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (781,252)		$	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)	(562,471)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (562,471)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,343,723)		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

STATE OF ILLINOIS

The Citadel of Northbrook

ID# 0055020

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (7,284)	21	1
2	Medicare Sequestration Expense	(30,483)	21	2
3	Managed Care Sequestration Exp	(4,863)	21	3
4	Patient Needs	(4,214)	10	4
5	Salaries - Marketing	(140,830)	43	5
6	Marketing Expense	(90,435)	43	6
7	Credit Card/Pymt Process Fees	(21,622)	21	7
8	Additional R&M	19,379	06	8
9	Capitalized R&M	(9,537)	06	9
10	PAC Dues	(5,530)	20	10
11	Non Allowable Legal	(6,941)	19	11
12	Promotional Fees	(255)	43	12
13	Shareholder Interest	(50,972)	32	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
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**	(353,588)		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**

The Citadel of Northbrook

ID# 0055020
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 The Citadel of Northbrook # 0055020 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	(407)											(407)	2
3	Housekeeping			1,768									1,768	3
4	Laundry													4
5	Heat and Other Utilities	(9,935)		1,462									(8,473)	5
6	Maintenance	9,842		(7,171)	245								2,916	6
7	Other (specify):*			2,940									2,940	7
8	**TOTAL General Services**	(500)		(1,001)	245								(1,256)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,214)		(27,832)			(119)						(32,165)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation							(1,538)					(1,538)	14
15	Other (specify):*			24,741									24,741	15
16	**TOTAL Health Care and Programs**	(4,214)		(3,090)			(119)	(1,538)					(8,961)	16
	C. General Administration													
17	Administrative			(726,999)									(726,999)	17
18	Directors Fees													18
19	Professional Services	(6,941)		328	1,230								(5,383)	19
20	Fees, Subscriptions & Promotions	(29,530)		1,766									(27,764)	20
21	Clerical & General Office Expenses	(422,628)		60,609									(362,019)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			53									53	24
25	Other Admin. Staff Transportation			3,162									3,162	25
26	Insurance-Prop.Liab.Malpractice			3,971									3,971	26
27	Other (specify):*			45,948									45,948	27
28	**TOTAL General Administration**	(459,099)		(611,161)	1,230								(1,069,030)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(463,813)		(615,253)	1,475		(119)	(1,538)					(1,079,247)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Citadel of Northbrook # 0055020 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(33,264)		2,915	1,988								(28,361)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(52,654)		2,930	5,984								(43,740)	32
33	Real Estate Taxes				6,976								6,976	33
34	Rent-Facility & Grounds			26,695	(9,022)								17,673	34
35	Rent-Equipment & Vehicles			18,170									18,170	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(85,918)		50,710	5,926								(29,282)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,673)						(3,673)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(231,521)											(231,521)	43
44	**TOTAL Special Cost Centers**	(231,521)					(3,673)						(235,194)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(781,252)		(564,543)	7,402		(3,792)	(1,538)					(1,343,722)	45

Facility Name & ID Number The Citadel of Northbrook # 0055020 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. [ ] YES [X] NO

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

1 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

STATE OF ILLINOIS

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	30.03%	AMBERWOOD CARE CENTER	ROCKFORD, IL				1
2	Kenneth Ripstein	30.03%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	DAMEN HEALTHCARE GROUP	SKOKIE, IL	BOOKKEEPING	2
3	Stern Family Investment Trust	4.99%	CITADEL CARE CENTER-KANKAKEE LLC	KANKAKEE, IL	3755 CHASE, LLC	SKOKIE	BUILDING COMPANY	3
4	Todd Stern	4.99%	CITADEL CARE CENTER-ELGIN LLC	ELGIN, IL	BILTMORE INC. CELL	BURLINGTON, VT	INSURANCE	4
5	Chananel Teller	4.99%	CITADEL CARE CENTER-WILMETTE LLC	WILMETTE, IL	INTEGRA HEALTHCARE EQUII	ELMHURST	DME	5
6	Ilana Teller	4.99%	THE WATERFORD CARE CENTER LLC	CHICAGO, IL	LIFELINE AMBULANCE	SKOKIE	AMBULANCE	6
7	Maurice Aaron	4.99%	CITADEL CARE CENTER-STERLING LLC	STERLING, IL				7
8	Abraham Stern	4.99%	PA PETERSON AT THE CITADEL LLC	ROCKFORD, IL				8
9	Susan Stern	4.99%	SKOKIE MEADOWS LLC	SKOKIE, IL				9
10	Marcella Graf	4.00%	THE CITADEL OF SKOKIE LLC	SKOKIE, IL				10
11	Yakov Kohen	1.01%	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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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		$ 1,768	$ 1,768	15
16	V	5	Utilities		Damen Healthcare Group, LLC		1,462	1,462	16
17	V	6	Maintenance Salary		Damen Healthcare Group, LLC		13,833	13,833	17
18	V	6	Maintenance	22,823	Damen Healthcare Group, LLC		1,819	(21,004)	18
19	V	7	Maintenance Benefits		Damen Healthcare Group, LLC		2,940	2,940	19
20	V	10	Nursing	146,905	Damen Healthcare Group, LLC		119,073	(27,832)	20
21	V	15	Nursing Benefits		Damen Healthcare Group, LLC		24,741	24,741	21
22	V	17	Administrative	822,673	Damen Healthcare Group, LLC		30,687	(791,986)	22
23	V	19	Professional Fees		Damen Healthcare Group, LLC		328	328	23
24	V	20	Dues, Fees, Subscriptions		Damen Healthcare Group, LLC		1,766	1,766	24
25	V	21	Office Expense - Salaries		Damen Healthcare Group, LLC		172,197	172,197	25
26	V	21	Office Expense - Other	124,108	Damen Healthcare Group, LLC		12,520	(111,588)	26
27	V	24	Seminars & Education		Damen Healthcare Group, LLC		53	53	27
28	V	25	Auto Expense		Damen Healthcare Group, LLC		3,162	3,162	28
29	V	26	Insurance		Damen Healthcare Group, LLC		3,971	3,971	29
30	V	27	Employee Ben. - Gen. Admin.		Damen Healthcare Group, LLC		45,948	45,948	30
31	V	30	Depreciation		Damen Healthcare Group, LLC		2,915	2,915	31
32	V	32	Interest Expense		Damen Healthcare Group, LLC		2,930	2,930	32
33	V	34	Rent-Unrelated		Damen Healthcare Group, LLC		17,673	17,673	33
34	V	34	Rent-3755 W. Chase		Damen Healthcare Group, LLC		9,022	9,022	34
35	V	35	Equipment Rental		Damen Healthcare Group, LLC		976	976	35
36	V	35	Auto Lease		Damen Healthcare Group, LLC		17,194	17,194	36
37	V	17	Admin Fees-J Aaron		Damen Healthcare Group, LLC		34,300	34,300	37
38	V	17	Admin Fees-K Ripstein		Damen Healthcare Group, LLC		30,687	30,687	38
39	Total			$ 1,116,509			$ 551,966	$ * (564,543)	39

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 245	$ 245	15
16	V	30	Depreciation		3755 W Chase, LLC		1,988	1,988	16
17	V	32	Interest Expense		3755 W Chase, LLC		5,984	5,984	17
18	V	33	Real Estate Taxes		3755 W Chase, LLC		6,976	6,976	18
19	V	19	Real Estate Tax Protest Fees		3755 W Chase, LLC		1,230	1,230	19
20	V								20
21	V	34	Rent	9,022	3755 W Chase, LLC			(9,022)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,022			$ 16,424	$ * 7,402	39

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	26	Insurance	$ 353,400	Biltmore Incorporated Cell		$ 353,400	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 353,400			$ 353,400	$ *	39

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	39	Ancillary Expenses	$ 23,696	Integra Healthcare Equipment, LLC		$ 20,023	$ (3,673)	15
16	V	10	Medical Supplies/DME	770	Integra Healthcare Equipment, LLC		651	(119)	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			$ 24,466			$ 20,674	$ * (3,792)	39

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	14	Patient Transportation	$ 8,138	Lifeline Ambulance LLC		$ 6,600	$ (1,538)	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			$ 8,138			$ 6,600	$ * (1,538)	39

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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	30.03%	See Attached	5.49	13.73%	Alloc Mgt Fee	$ 34,300	17-7	1
2	Kenneth Ripstein	Owner	Administrative	30.03%	See Attached	4.91	12.28%	Alloc Mgt Fee	30,687	17-7	2
3	Yakov Kohen	Owner	Clerical	1.01%	See Attached	4.91	12.28%	Alloc Salary	16,829	21-7	3
4	Marcella Graf	Owner	Administrative	4.00%	See Attached	4.91	12.28%	Alloc Salary	30,687	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 112,503		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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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	$	48,685	$ 1,768	1
2	5	Utilities	Patient Days	396,623	14	11,913		48,685	1,462	2
3	6	Maintenance Salary	Patient Days	396,623	14	112,690	112,690	48,685	13,833	3
4	6	Maintenance	Patient Days	396,623	14	14,821		48,685	1,819	4
5	7	Maintenance Benefits	Patient Days	396,623	14	23,951		48,685	2,940	5
6	10	Nursing	Patient Days	396,623	14	970,057	948,342	48,685	119,073	6
7	15	Nursing Benefits	Patient Days	396,623	14	201,561		48,685	24,741	7
8	17	Administrative	Patient Days	396,623	14	250,000	250,000	48,685	30,687	8
9	19	Professional Fees	Patient Days	396,623	14	2,669		48,685	328	9
10	20	Dues, Fees, Subscriptions	Patient Days	396,623	14	14,390		48,685	1,766	10
11	21	Office Expense - Salaries	Patient Days	396,623	14	1,402,841	1,402,841	48,685	172,197	11
12	21	Office Expense - Other	Patient Days	396,623	14	101,995		48,685	12,520	12
13	24	Seminars & Education	Patient Days	396,623	14	431		48,685	53	13
14	25	Auto Expense	Patient Days	396,623	14	25,762		48,685	3,162	14
15	26	Insurance	Patient Days	396,623	14	32,350		48,685	3,971	15
16	27	Employee Ben. - Gen. Admin.	Patient Days	396,623	14	374,325		48,685	45,948	16
17	30	Depreciation	Patient Days	396,623	14	23,745		48,685	2,915	17
18	32	Interest Expense	Patient Days	396,623	14	23,867		48,685	2,930	18
19	34	Rent-Unrelated	Patient Days	396,623	14	143,975		48,685	17,673	19
20	34	Rent-3755 W. Chase	Patient Days	396,623	14	73,500		48,685	9,022	20
21	35	Equipment Rental	Patient Days	396,623	14	7,954		48,685	976	21
22	35	Auto Lease	Patient Days	396,623	14	140,073		48,685	17,194	22
23	17	Admin Fees-J Aaron	Patient Days	354,845	13	250,000		48,685	34,300	23
24	17	Admin Fees-K Ripstein	Patient Days	396,623	14	250,000		48,685	30,687	24
25	TOTALS					$ 4,467,270	$ 2,713,873		$ 551,966	25

Facility Name & ID Number The Citadel of Northbrook # 0055020 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: 3755 W Chase, LLC
Street Address: 3755 W. Chase Ave.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (224) 470-2044
Fax Number: (224) 470-2952

	1 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	$	48,685	$ 245	1
2	30	Depreciation	Patient Days	396,623	14	16,199		48,685	1,988	2
3	32	Interest Expense	Patient Days	396,623	14	48,746		48,685	5,984	3
4	33	Real Estate Taxes	Patient Days	396,623	14	56,831		48,685	6,976	4
5	33	Real Estate Tax Protest Fees	Patient Days	396,623	14	10,020		48,685	1,230	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	$		$ 16,424	25

Facility Name & ID Number: The Citadel of Northbrook # 0055020 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			$	$		$ 353,400	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 353,400	25

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	39	Ancillary Expenses	Direct			$	$		$ 20,023	1
2	10	Medical Supplies/DME	Direct						651	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					$	$		$ 20,674	25

Facility Name & ID Number The Citadel of Northbrook # 0055020 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			$	$		$ 6,600	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					$	$		$ 6,600	25

Facility Name & ID Number The Citadel of Northbrook # 0055020 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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.

	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
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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 The Citadel of Northbrook # 0055020 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 The Citadel of Northbrook # 0055020 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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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 The Citadel of Northbrook # 0055020 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 [ ]

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	VAR Technology/Ascentium		X	Capitalized Lease			$	$ 35,932			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC Bank USA		X	Line of Credit				1,000,000			40,175	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,035,932			$ 40,175	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,682)	10
11	Allocated from Damen Healthca	X									2,930	11
12	Allocated from 3755 Chase	X									5,984	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,232	14
15	TOTALS (line 9+line14)						$	$ 1,035,932			$ 47,407	15

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

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

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	756,222	2
3. Under or (over) accrual (line 2 minus line 1).	$	756,222	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	21,315	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.	$	777,537	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	545,051	8
2016	560,490	9
2017	602,564	10
2018	652,377	11
2019	749,246	12

Facility does not accrue real estate taxes.
Allocated from 3755 Chase $6,976

FOR BHF USE ONLY

Line	Description	Amount	Line
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 The Citadel of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055020

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.	04-30-200-029-0000	Long Term Care Property	$ 519,315.44	$ 519,315.44
2.	04-30-200-030-0000	Long Term Care Property	$ 229,930.28	$ 229,930.28
3.	10-26-318-023-0000	Allocated from Home Office	$ 172,792.00	$ 21,210.02
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 922,037.72	$ 770,455.74

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 The Citadel of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055020

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

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

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,393 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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 [ ] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocated from 3755 W Chase		2019	82,512	2
3	TOTALS			$ 82,512	3

Facility Name & ID Number The Citadel of Northbrook # 0055020 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Citadel of Northbrook # 0055020 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
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		467,566	3,046		2,665	(381)	20,595	68
69	Financial Statement Depreciation			63,752			(63,752)		69
70	TOTAL (lines 4 thru 69)		$ 467,566	$ 66,798		$ 2,665	$ (64,133)	$ 20,595	70

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 467,566	$ 66,798		$ 2,665	$ (64,133)	$ 20,595	1
2	Signs & Banner For Facility	2018	21,884		20	1,094	1,094	3,282	2
3	Outdoor Condensing Unit	2019	4,848		20	242	242	484	3
4	Safety Viewer & Audio Video-24 Cameras & 2 Monitors Installati	2019	12,668		20	633	633	1,266	4
5	Fast Signs - Installation Of Led Spot Lights	2019	2,979		20	149	149	298	5
6	3S Group Db - Lvt, Ceramic Tile, Carpet, Wall Finishes, Wallcove	2020	158,875		20	7,944	7,944	7,944	6
7	3S Group Db - Lvt, Ceramic Tile, And Carpet	2020	20,850		20	1,043	1,043	1,043	7
8	Repair Phone System	2020	4,718		20	236	236	236	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)		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	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)		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	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)		$ 694,388	$ 66,798		$ 14,005	$ (52,793)	$ 35,147	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	467,566	1,989	35	2,665	676	20,595	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Management	2015		1,057			(1,057)		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)		$ 467,566	$ 3,046		$ 2,665	$ (381)	$ 20,595	34

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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		$ 467,566	$ 3,046		$ 2,665	$ (381)	$ 20,595	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 467,566	$ 3,046		$ 2,665	$ (381)	$ 20,595	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	$ 143,985	$ 1,009	$ 14,316	$ 13,307	10	$ 32,367	71
72	Current Year Purchases	38,750	685	3,724	3,040	10	3,724	72
73	Fully Depreciated Assets	1,393	163	163		10	1,393	73
74								74
75	TOTALS	$ 184,128	$ 1,857	$ 18,204	$ 16,347		$ 37,485	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		2001 Chevrolet Silverado 2500 Pl	2019	$ 15,914	$	$ 3,183	$ 3,183	5	$ 6,366	76
77										77
78										78
79										79
80	TOTALS			$ 15,914	$	$ 3,183	$ 3,183		$ 6,366	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)	$ 976,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,392	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (33,264)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 78,998	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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: Paradox Northbrook Property, LLC
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:		158		$ 1,347,203			3
4	Additions							4
5	Allocated from Damen Healthcare Group				17,673			5
6								6
7	TOTAL		158		$ 1,364,876 **			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: $ 7,823 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	Ford Elkhart Coach 2019	$ 1,188	$ 14,256	17
18	Allocated from Damen Healthcare Group			17,194	18
19					19
20					20
21	TOTAL		$ 1,188	$ 31,450	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** <u>This amount plus any amortization of lease expense must agree with page 4, line 34.</u>

Facility Name & ID Number The Citadel of Northbrook # 0055020 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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 594,510	$		$ 594,510	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			271,798			271,798	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			666,442			666,442	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				316,842		316,842	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			84,260		95,522	584		180,366	13
14	TOTAL			$ 84,260		$ 1,628,272	$ 317,426		$ 2,029,958	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: The Citadel of Northbrook # 0055020 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	$ 2,718,361	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,943,884		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	451,972		6
7	Other Prepaid Expenses	1,268		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,115,485	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	206,320		15
16	Equipment, at Historical Cost	253,037		16
17	Accumulated Depreciation (book methods)	(100,137)		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	756,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,115,220	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,230,705	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 563,500	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,026,132		29
30	Accrued Salaries Payable	418,808		30
31	Accrued Taxes Payable (excluding real estate taxes)	341,972		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,741		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,971,490		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,324,643	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,800		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	1,212,575		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,222,375	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,547,018	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,683,687	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,230,705	$	48

*(See instructions.)

Facility Name & ID Number The Citadel of Northbrook # 0055020 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**	$ 105,569	1
2	Restatements (describe):		2
3	Depreciation	(30,017)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 75,552	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,608,135	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)**	$ 2,608,135	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)**	$ 2,683,687	24 *

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

Facility Name & ID Number The Citadel of Northbrook # 0055020 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	$ 20,052,739	1
2	Discounts and Allowances for all Levels	(5,041,881)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,010,858	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,442,864	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,442,864	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	2,688	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	76	20
21	Other Medical Services	(251)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,514	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,682	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,682	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	1,407,666	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,407,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,865,584	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,839,568	31
32	Health Care	5,768,005	32
33	General Administration	3,536,737	33
	B. Capital Expense		
34	Ownership	1,523,205	34
	C. Ancillary Expense		
35	Special Cost Centers	2,263,671	35
36	Provider Participation Fee	326,263	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,257,449	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,608,135	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,608,135	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,950,685	44
45	Private Pay - Net Inpatient Revenue	1,928,860	45
46	Medicare - Net Inpatient Revenue	4,931,974	46
47	Other-(specify) Managed Care	591,606	47
48	Other-(specify) Hospice	607,733	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,010,858	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 The Citadel of Northbrook # 0055020 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,996	2,079	$ 129,962	$ 62.50	1
2	Assistant Director of Nursing	115	120	4,212	35.10	2
3	Registered Nurses	45,151	47,033	1,823,457	38.77	3
4	Licensed Practical Nurses	24,279	25,291	782,866	30.95	4
5	CNAs & Orderlies	79,565	82,880	1,534,073	18.51	5
6	CNA Trainees					6
7	Licensed Therapist	2,235	2,329	84,260	36.19	7
8	Rehab/Therapy Aides	2,520	2,625	104,542	39.83	8
9	Activity Director	1,971	2,053	47,288	23.04	9
10	Activity Assistants	9,530	9,927	134,566	13.56	10
11	Social Service Workers	8,976	9,350	281,536	30.11	11
12	Dietician	1,954	2,035	42,018	20.65	12
13	Food Service Supervisor	1,361	1,418	41,724	29.42	13
14	Head Cook	11,086	11,548	198,925	17.23	14
15	Cook Helpers/Assistants	13,122	13,669	186,769	13.66	15
16	Dishwashers					16
17	Maintenance Workers	1,997	2,080	67,500	32.45	17
18	Housekeepers	22,644	23,587	350,838	14.87	18
19	Laundry	3,344	3,483	46,612	13.38	19
20	Administrator	1,997	2,080	149,698	71.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,997	2,080	91,012	43.76	23
24	Clerical	6,704	6,984	148,076	21.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,083	2,170	42,061	19.38	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	3,269	3,405	154,745	45.45	33
34	TOTAL (lines 1 - 33)	247,896	258,225	$ 6,446,740 *	$ 24.97	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	410	$ 20,078	01-03	35
36	Medical Director	Monthly	52,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	5,500	10-03	38
39	Pharmacist Consultant	Monthly	17,321	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	14	798	11-03	44
45	Social Service Consultant	47	2,988	12-03	45
46	Other(specify) MDS Consultant	Monthly	48,581	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	470	$ 147,466		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 400	10-03	50
51	Licensed Practical Nurses	8	330	10-03	51
52	Certified Nurse Assistants/Aides	5,839	180,752	10-03	52
53	TOTAL (lines 50 - 52)	5,855	$ 181,482		53

Facility Name & ID Number: The Citadel of Northbrook # 0055020 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Kanter	Administrator	0	$ 149,698
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 149,698

B. Administrative - Other

Description	Amount
Management Fees - Damen Healthcare Group, LLC	$ 822,673
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 822,673

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 25,579
ProPay HR	Payroll Services	28,512
Esolutions Inc.	Data Processing	2,547
IIT/SourceTech	Data Processing	2,565
National Datacare	Data Processing	1,656
Point Click Care	Data Processing	61,067
Prime Care Technologies	Data Processing	2,345
Telemedicine Solutions	Woundcare Mgmt	5,688
Third Eye Health, Inc.	Data Processing	12,419
Reside Admissions LLC	Data Processing	4,876
See Attached	Legal	70,865
See Supplemental Schedule		9,175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 227,294

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,492
Unemployment Compensation Insurance	80,609
FICA Taxes	493,176
Employee Health Insurance	271,174
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance - Involuntary	7,112
Dental / Vision Insurance	1,996
Employee Benefits - Other	31,998
Holiday Expense	3,192
401K Employer Match Expense	32,534
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,009,284

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	$ 2,443
Advertising: Employee Recruitment	25,159
Health Care Worker Background Check (Indicate # of checks performed 208)	12,089
Patient Background Checks 293	2,932
Dues & Subscriptions	10,736
Licenses & Fees	1,010
See Supplemental Schedule	1,766
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,204
See Supplemental Schedule	53
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,257

**See instructions.

Facility Name & ID Number **The Citadel of Northbrook** **#** **0055020** **Report Period Beginning:** **01/01/20** **Ending:** **12/31/20**

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? **Yes**
If YES, give association name and amount. **HCCI $11,060**

(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. $ **52,305** 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. $ **326,263**
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? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **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.