

Facility Name & ID Number Citadel Care Center- Kankakee

0053793 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,156	4,224	6,531	30,911	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,156	4,224	6,531	30,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.15%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/05/2016

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 107 and days of care provided 4,113

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Citadel Care Center- Kankakee # 0053793 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	94,169	19,434	180,063	293,666	293,666		293,666			1
2	Food Purchase		87,628		87,628	87,628	(120)	87,508			2
3	Housekeeping	82,566	17,337	41,942	141,845	141,845	948	142,793			3
4	Laundry	25,957	5,375	37,279	68,611	68,611		68,611			4
5	Heat and Other Utilities			119,949	119,949	119,949	(7,763)	112,186			5
6	Maintenance	50,983	19,977	136,252	207,212	207,212	(1,189)	206,023			6
7	Other (specify):*						1,045	1,045			7
8	TOTAL General Services	253,675	149,751	515,485	918,911	918,911	(7,078)	911,833			8
	B. Health Care and Programs										
9	Medical Director			17,302	17,302	17,302		17,302			9
10	Nursing and Medical Records	2,079,576	247,488	14,626	2,341,690	2,341,690	(22,926)	2,318,764			10
10a	Therapy										10a
11	Activities	93,452	4,225	2,994	100,671	100,671		100,671			11
12	Social Services	116,123		1,552	117,675	117,675		117,675			12
13	CNA Training										13
14	Program Transportation			4,311	4,311	4,311		4,311			14
15	Other (specify):*						8,524	8,524			15
16	TOTAL Health Care and Programs	2,289,151	251,713	40,785	2,581,649	2,581,649	(14,402)	2,567,247			16
	C. General Administration										
17	Administrative	119,661		336,240	455,901	455,901	(263,713)	192,188			17
18	Directors Fees										18
19	Professional Services			143,225	143,225	143,225	(1,306)	141,919			19
20	Dues, Fees, Subscriptions & Promotions			66,689	66,689	66,689	(37,264)	29,425			20
21	Clerical & General Office Expenses	88,475	5,825	285,712	380,012	380,012	(181,292)	198,720			21
22	Employee Benefits & Payroll Taxes			434,294	434,294	434,294		434,294			22
23	Inservice Training & Education										23
24	Travel and Seminar			4,132	4,132	4,132	78	4,210			24
25	Other Admin. Staff Transportation			7,968	7,968	7,968	2,515	10,483			25
26	Insurance-Prop.Liab.Malpractice			103,976	103,976	103,976	1,913	105,889			26
27	Other (specify):*						18,714	18,714			27
28	TOTAL General Administration	208,136	5,825	1,382,236	1,596,197	1,596,197	(460,355)	1,135,842			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,750,962	407,289	1,938,506	5,096,757	5,096,757	(481,835)	4,614,922			29

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

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

Facility Name & ID Number

Citadel Care Center- Kankakee

#0053793

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,705	16,705		16,705	116,678	133,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,651	39,651		39,651	213,473	253,124			32
33	Real Estate Taxes							80,338	80,338			33
34	Rent-Facility & Grounds			516,000	516,000		516,000	(506,879)	9,121			34
35	Rent-Equipment & Vehicles			20,224	20,224		20,224	13,531	33,755			35
36	Other (specify):*											36
37	TOTAL Ownership			592,580	592,580		592,580	(82,859)	509,721			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,625	423,403	559,028		559,028	(817)	558,211			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,193	221,193		221,193		221,193			42
43	Other (specify):*	89,376		34,216	123,592		123,592	(123,592)				43
44	TOTAL Special Cost Centers	89,376	135,625	678,812	903,813		903,813	(124,409)	779,404			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,840,338	542,914	3,209,898	6,593,150		6,593,150	(689,103)	5,904,047			45

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

Citadel Care Center- Kankakee

ID# 0053793

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration Expense	\$ (26,687)	21	1
2	Managed Care Sequestration Expense	(2,654)	21	2
3	Patient Needs	(161)	10	3
4	Marketing	(126)	43	4
5	Bank Charges	(2,993)	21	5
6	Additional R&M	3,558	06	6
7	Non-Allowable Legal	(1,531)	19	7
8	Bldg Co -Accounting Fees	(5,516)	19	8
9	Bldg Co - Bank Charges	(1,192)	21	9
10	Bldg Co - Licenses & Fees	(2,948)	20	10
11	Bldg Co - Amortization Loan Fees	(4,155)	36	11
12	PAC Dues	(7,918)	20	12
13	Marketing Salary	(89,376)	43	13
14	Capitalized R&M	(3,919)	06	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	(145,618)		49

Citadel Care Center- Kankakee

Report Period Beginning: ID# 0053793
 Ending: 01/01/17
 12/31/17

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(120)											(120)	2
3	Housekeeping			948									948	3
4	Laundry													4
5	Heat and Other Utilities	(8,715)		952									(7,763)	5
6	Maintenance	(361)		(828)									(1,189)	6
7	Other (specify):*			1,045									1,045	7
8	TOTAL General Services	(9,196)		2,118									(7,078)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(161)		(22,765)									(22,926)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			8,524									8,524	15
16	TOTAL Health Care and Programs	(161)		(14,241)									(14,402)	16
	C. General Administration													
17	Administrative			(149,446)	(114,267)								(263,713)	17
18	Directors Fees													18
19	Professional Services	(7,047)	5,432	309									(1,306)	19
20	Fees, Subscriptions & Promotions	(42,559)	2,948	2,347									(37,264)	20
21	Clerical & General Office Expenses	(251,691)	1,192	69,207									(181,292)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			78									78	24
25	Other Admin. Staff Transportation			2,515									2,515	25
26	Insurance-Prop.Liab.Malpractice			1,913									1,913	26
27	Other (specify):*			18,714									18,714	27
28	TOTAL General Administration	(301,297)	9,572	(54,363)	(114,267)								(460,355)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(310,654)	9,572	(66,486)	(114,267)								(481,835)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(279,092)	393,185	2,585									116,678	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,735)	218,319	889									213,473	32
33	Real Estate Taxes		80,338										80,338	33
34	Rent-Facility & Grounds		(516,000)	9,121									(506,879)	34
35	Rent-Equipment & Vehicles			13,531									13,531	35
36	Other (specify):*	(4,155)	4,155											36
37	TOTAL Ownership	(288,982)	179,997	26,126									(82,859)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(817)							(817)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(89,502)		(34,090)									(123,592)	43
44	TOTAL Special Cost Centers	(89,502)		(34,090)		(817)							(124,409)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(689,138)	189,569	(74,450)	(114,267)	(817)							(689,103)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 516,000	900 West River Place	100.00%	\$	(516,000)	1
2	V	19 Accounting Fees		900 West River Place	100.00%	5,516	5,516	2
3	V	19 Other Professional Fees	84	900 West River Place	100.00%		(84)	3
4	V	21 Bank Charges		900 West River Place	100.00%	1,192	1,192	4
5	V	32 Interest Expense		900 West River Place	100.00%	218,319	218,319	5
6	V	33 Real Estate Taxes		900 West River Place	100.00%	80,338	80,338	6
7	V	20 Licenses & Fees		900 West River Place	100.00%	2,948	2,948	7
8	V	30 Depreciation Expense		900 West River Place	100.00%	393,185	393,185	8
9	V	36 Amortization - Loan fees		900 West River Place	100.00%	4,155	4,155	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 516,084			\$ 705,653	\$ * 189,569	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	DAMEN HEALTHCARE GROUP, LLC	100.00%	\$ 948	\$	948	15
16	V	5 UTILITIES		DAMEN HEALTHCARE GROUP, LLC	100.00%	952		952	16
17	V	6 MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC	100.00%	5,559		5,559	17
18	V	6 MAINTENANCE	7,686	DAMEN HEALTHCARE GROUP, LLC	100.00%	1,299		(6,387)	18
19	V	7 MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,045		1,045	19
20	V	10 NURSING	68,792	DAMEN HEALTHCARE GROUP, LLC	100.00%	46,027		(22,765)	20
21	V	15 NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC	100.00%	8,524		8,524	21
22	V	17 ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC	100.00%	20,794		20,794	22
23	V	19 PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	100.00%	309		309	23
24	V	20 DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,347		2,347	24
25	V	21 OFFICE EXPENSE - SALARIES		DAMEN HEALTHCARE GROUP, LLC	100.00%	78,809		78,809	25
26	V	21 OFFICE EXPENSE - OTHER	15,869	DAMEN HEALTHCARE GROUP, LLC	100.00%	6,267		(9,602)	26
27	V	24 SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	78		78	27
28	V	25 AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,515		2,515	28
29	V	26 INSURANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,913		1,913	29
30	V	27 EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	100.00%	18,714		18,714	30
31	V	30 DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,585		2,585	31
32	V	32 INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	889		889	32
33	V	34 RENT		DAMEN HEALTHCARE GROUP, LLC	100.00%	9,121		9,121	33
34	V	35 EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	100.00%	507		507	34
35	V	35 AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	100.00%	13,024		13,024	35
36	V	43 MARKETING	34,090	DAMEN HEALTHCARE GROUP, LLC	100.00%			(34,090)	36
37	V	17 MANAGEMENT FEES	170,240	DAMEN HEALTHCARE GROUP, LLC	100.00%			(170,240)	37
38	V								38
39	Total		\$ 296,677			\$ 222,227	\$ *	(74,450)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 166,000	JK MANAGEMENT GROUP LLC	100.00%	\$	(166,000)
16	V	17 MGMT FEES - J. AARON		JK MANAGEMENT GROUP LLC	100.00%	28,198	28,198
17	V	17 MGMT FEES - KEN RIPSTEIN		JK MANAGEMENT GROUP LLC	100.00%	23,535	23,535
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 166,000			\$ 51,733	\$ * (114,267)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 DME & Medical Supplies	\$ 3,841	Integra Healthcare Equipment		\$ 3,024	\$ (817)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,841			\$ 3,024	\$ * (817)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Citadel Care Center- Kankakee

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Report Period Beginning:

01/01/17

Ending:

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jonathan Aaron	Owner	Administrative	0.10%	See Attached	5.55	13.88%	Alloc. Mgmt Fee	\$ 28,198	17-7	1
2	Kenneth Ripstein	Relative	Administrative		See Attached	5.96	14.90%	Alloc. Mgmt Fee	23,535	17-7	2
3	Yakov Kohen	Relative	Clerical		See Attached	4.65	11.63%	Alloc. Mgmt Fee	13,683	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 65,416		13

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

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

Facility Name & ID Number Citadel Care Center- Kankakee

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Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization DAMEN HEALTHCARE GROUP, LLC
 Street Address 5611 DEMPSTER
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (224) 470-2044
 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	HOUSEKEEPING	PATIENT DAYS	265,967	9	\$ 8,160	\$ 30,911	\$ 948	1	
2	5	UTILITIES	PATIENT DAYS	265,967	9	8,194	30,911	952	2	
3	6	MAINTENANCE SALARY	PATIENT DAYS	265,967	9	47,832	47,832	30,911	5,559	3
4	6	MAINTENANCE	PATIENT DAYS	265,967	9	11,179	30,911	1,299	4	
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	265,967	9	8,991	30,911	1,045	5	
6	10	NURSING	PATIENT DAYS	265,967	9	396,029	390,195	30,911	46,027	6
7	15	NURSING BENEFITS	PATIENT DAYS	265,967	9	73,345	30,911	8,524	7	
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	265,967	9	178,914	178,914	30,911	20,794	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	265,967	9	2,661	30,911	309	9	
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	265,967	9	20,196	30,911	2,347	10	
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	265,967	9	678,098	678,098	30,911	78,809	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	265,967	9	53,921	30,911	6,267	12	
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	265,967	9	670	30,911	78	13	
14	25	AUTO EXPENSE	PATIENT DAYS	265,967	9	21,637	30,911	2,515	14	
15	26	INSURANCE	PATIENT DAYS	265,967	9	16,460	30,911	1,913	15	
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	265,967	9	161,021	30,911	18,714	16	
17	30	DEPRECIATION	PATIENT DAYS	265,967	9	22,241	30,911	2,585	17	
18	32	INTEREST EXPENSE	PATIENT DAYS	265,967	9	7,645	30,911	889	18	
19	34	RENT	PATIENT DAYS	265,967	9	78,480	30,911	9,121	19	
20	35	EQUIPMENT RENTAL	PATIENT DAYS	265,967	9	4,365	30,911	507	20	
21	35	AUTO LEASE	PATIENT DAYS	265,967	9	112,060	30,911	13,024	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,912,100	\$ 1,295,040	\$ 222,227	25	

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 JK MANAGEMENT GROUP, LLC
 Street Address 5611 DEMPSTER
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (224) 470-2044
 Fax Number (

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	MGMT FEES - J. AARON	PATIENT DAYS	164,430	6	\$ 150,000	\$ 30,911	\$ 28,198	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	207,521	7	158,000	30,911	23,535	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					\$ 308,000	\$	\$ 51,733	25

Facility Name & ID Number Citadel Care Center- Kankakee

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01/01/17

Ending: 12/31/17

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	DME & Medical Supplies	Direct		\$	\$		\$ 3,024	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 3,024	25

Facility Name & ID Number Citadel Care Center- Kankakee

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Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

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Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Citadel Care Center- Kankakee

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Report Period Beginning:

01/01/17

Ending:

12/31/17

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	MB Financial Bank		X	Mortgage			\$	\$ 4,588,600			\$	218,319						
2																		
3																		
4																		
5																		
Working Capital																		
6	MB Financial Bank		X	Line of Credit				784,335				39,651						
7																		
8																		
9	TOTAL Facility Related						\$	\$ 5,372,935			\$	257,970						
B. Non-Facility Related*																		
10	Interest Income		X									(5,735)						
11	Allocated from Damen Healthca	X										889						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$	(4,846)						
15	TOTALS (line 9+line14)						\$	\$ 5,372,935			\$	253,124						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	69,298	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.)		\$	72,993	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,695	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	76,643	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.)		\$		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.		\$	80,338	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	_____	8
	2013	_____	9
	2014	_____	10
	2015	69,099	11
	2016	72,993	12

2017 Accrual = \$72,993 x 1.05 = \$76,643 (Rounded)

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, 2016, \$446,143. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$446,143.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	107		2016	1969	\$ 4,318,257	\$ 393,185	35	\$ 123,379	\$ (269,806)	\$ 246,758	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68			32,744	1,335	1,335		3,419	68				
69				16,705		(16,705)		69				
70		\$	4,351,001	\$	411,225	\$	124,714	\$	(286,511)	\$	250,177	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,351,001	\$ 411,225		\$ 124,714	\$ (286,511)	\$ 250,177	1
2	Repair Pipe Leak In Boiler Room	2016	3,532		20	177	177	353	2
3	Repair Signs/Flagpole & Renovate Courtyard	2016	8,132		20	407	407	813	3
4	Install Fencing Around Small Patio In Front	2016	2,950		20	148	148	295	4
5	Repair/Installation Roof Flashing	2016	5,496		20	275	275	700	5
6	Repair Damage Pipe From Ground Concrete Floor	2016	9,086		20	454	454	909	6
7	Fabricated/Installed New Signage Faces W/ Fco Graphics	2016	11,161		20	558	558	1,116	7
8	Cctv Installation/Secondary Intercom Stations In Housekeeping R	2016	4,752		20	238	238	476	8
9	Precision Piping Inc- Booster Heater	2017	3,305		20	165	165	165	9
10	Job 1 Fire Protection- Sprinkler Head Purchase And Protection	2017	3,740		20	187	187	187	10
11	Repairs On 1St Floor Hallway & Bathroom Wall	2017	3,919		20	196	196	196	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)		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	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		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	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		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	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		\$ 4,407,074	\$ 411,225		\$ 127,517	\$ (283,708)	\$ 255,386	34

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Damen Healthcare Group	2015	32,744	1,335	20	1,335		3,419	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)		\$ 32,744	\$ 1,335		\$ 1,335	\$	\$ 3,419	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 32,744	\$ 1,335		\$ 1,335	\$	\$ 3,419	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)	\$ 32,744	\$ 1,335		\$ 1,335	\$	\$ 3,419	34

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

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 55,721	\$ 1,138	\$ 5,754	\$ 4,616	10	\$ 12,132	71
72	Current Year Purchases	1,686	112	112		10	112	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 57,407	\$ 1,250	\$ 5,866	\$ 4,616		\$ 12,244	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,910,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 412,475	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 133,383	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (279,092)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 267,630	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	CIP	\$ 408,129	92
93	CIP - Building Company	955,769	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 Citadel Care Center- Kankakee

0053793

Report Period Beginning: 01/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated from Damen Healthcare Group</u>				<u>9,121</u>			5
6								6
7	TOTAL				\$ 9,121			7

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.	<u> /2018</u>	\$ _____
13.	<u> /2019</u>	\$ _____
14.	<u> /2020</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,579 Description: See Attached Schedule

(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	<u>Facility Van</u>	<u>2012 Ford E-450 Super Du</u>	\$ <u>929</u>	\$ <u>11,152</u>	17
18	<u>Allocated from Damen Healthcare Group</u>			<u>13,024</u>	18
19					19
20					20
21	TOTAL		\$ 929	\$ 24,176	21

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 157,712	\$		\$ 157,712	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			44,550			44,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			189,610			189,610	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				135,625		135,625	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					31,531			31,531	13
14	TOTAL			\$		\$ 423,403	\$ 135,625		\$ 559,028	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 105,790	\$ 106,853	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,647,399	1,647,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,024	24,024	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	23,586	55,337	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,800,799	\$ 1,833,613	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		586,143	13
14	Buildings, at Historical Cost		3,672,586	14
15	Leasehold Improvements, at Historical Cost	49,718	211,141	15
16	Equipment, at Historical Cost	62,165	1,503,441	16
17	Accumulated Depreciation (book methods)	(29,501)	(811,948)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	421,049	1,699,974	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 503,431	\$ 6,861,337	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,304,230	\$ 8,694,950	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 929,506	\$ 762,975	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	784,335	904,505	29
30	Accrued Salaries Payable	182,924	182,924	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,801	14,801	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,643	32
33	Accrued Interest Payable	3,373	3,373	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	144,425	2,401,475	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,059,364	\$ 4,346,696	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,468,430	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	1,094,348	1,073,098	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,094,348	\$ 5,541,528	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,153,712	\$ 9,888,224	46
47	TOTAL EQUITY(page 18, line 24)	\$ (849,482)	\$ (1,193,274)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,304,230	\$ 8,694,950	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (978,242)	1
2	Restatements (describe):		2
3	Prior Year Pension Expense	(2,012)	3
4	Prior Year Depreciation Expense	(6,611)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (986,865)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	137,383	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)	\$ 137,383	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)	\$ (849,482)	24 *

* This must agree with page 17, line 47.

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

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,093,796	1
2	Discounts and Allowances for all Levels	(1,993,793)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,100,003	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,479,527	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,479,527	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,595	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,155	19
20	Radiology and X-Ray	1,740	20
21	Other Medical Services	778	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 145,268	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,735	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,735	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,730,533	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	918,911	31
32	Health Care	2,581,649	32
33	General Administration	1,596,197	33
B. Capital Expense			
34	Ownership	592,580	34
C. Ancillary Expense			
35	Special Cost Centers	682,620	35
36	Provider Participation Fee	221,193	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,593,150	40
41	Income before Income Taxes (line 30 minus line 40)**	137,383	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 137,383	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,358,333	44
45	Private Pay - Net Inpatient Revenue	844,100	45
46	Medicare - Net Inpatient Revenue	107,991	46
47	Other-(specify) <u>Managed Care</u>	393,392	47
48	Other-(specify) <u>Hospice</u>	396,187	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,100,003	49

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

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

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

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

Facility Name & ID Number Citadel Care Center- Kankakee

0053793

Report Period Beginning:

01/01/17

Ending:

12/31/17

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,092	2,273	\$ 97,652	\$ 42.96	1
2	Assistant Director of Nursing	2,106	2,189	75,612	34.54	2
3	Registered Nurses	16,853	18,579	570,630	30.71	3
4	Licensed Practical Nurses	13,642	15,375	397,050	25.82	4
5	CNAs & Orderlies	57,577	64,718	869,253	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,018	2,119	31,780	15.00	9
10	Activity Assistants	5,723	5,918	61,672	10.42	10
11	Social Service Workers	3,742	4,096	90,065	21.99	11
12	Dietician					12
13	Food Service Supervisor	1,023	1,052	20,305	19.30	13
14	Head Cook	1,546	1,682	19,699	11.71	14
15	Cook Helpers/Assistants	5,455	5,601	54,165	9.67	15
16	Dishwashers					16
17	Maintenance Workers	2,073	2,301	50,983	22.16	17
18	Housekeepers	7,494	7,681	82,566	10.75	18
19	Laundry	2,275	2,308	25,957	11.25	19
20	Administrator	2,105	2,198	119,661	54.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,745	6,384	88,475	13.86	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	2,283	2,410	38,131	15.82	31
32	Other Health Care(specify)					32
33	Other(specify)	5,784	6,268	146,682	23.40	33
34	TOTAL (lines 1 - 33)	139,536	153,152	\$ 2,840,338 *	\$ 18.55	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	116	\$ 5,949	01-03	35
36	Medical Director	Monthly	17,302	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,572	10-03	38
39	Pharmacist Consultant	Monthly	9,054	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,994	11-03	44
45	Social Service Consultant	24	1,552	12-03	45
46	Other(specify)				46
47					47
48	Outside Services - Dietary	Monthly	174,114	01-03	48
49	TOTAL (lines 35 - 48)	192	\$ 216,537		49

C. CONTRACT NURSES

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

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

Report Period Beginning:

01/01/17

Ending:

12/31/17**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. ICLTC: \$15,836
- (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. \$ 32,572 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. \$ 221,193
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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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% Ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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. No
Attach invoices and a summary of services for all architect and appraisal fees