



Facility Name & ID Number Citadel Care Center Elgin

# 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	88	Skilled (SNF)	88	32,120	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	88	TOTALS	88	32,120	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,814	1,341	5,267	28,422	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,814	1,341	5,267	28,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.49%

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 01/05/16

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/05/16 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 88 and days of care provided 3,456

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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
	<b>A. General Services</b>										
1	Dietary	245,299	15,148	28,899	289,346		289,346		289,346		1
2	Food Purchase		195,415		195,415		195,415	(92)	195,323		2
3	Housekeeping	73,948	20,942		94,890		94,890	774	95,664		3
4	Laundry	36,164	3,898	2,243	42,305		42,305		42,305		4
5	Heat and Other Utilities			124,513	124,513		124,513	(9,826)	114,687		5
6	Maintenance	51,861	20,348	104,456	176,665		176,665	6,613	183,278		6
7	Other (specify):*							1,490	1,490		7
8	<b>TOTAL General Services</b>	407,272	255,751	260,111	923,134		923,134	(1,041)	922,093		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,400	24,400		24,400		24,400		9
10	Nursing and Medical Records	2,209,759	306,761	88,232	2,604,752		2,604,752	(54,084)	2,550,668		10
10a	Therapy		12,697		12,697		12,697	(12,697)			10a
11	Activities	61,805	3,056	936	65,797		65,797		65,797		11
12	Social Services	114,683		640	115,323		115,323		115,323		12
13	CNA Training										13
14	Program Transportation			13,717	13,717		13,717		13,717		14
15	Other (specify):*							9,203	9,203		15
16	<b>TOTAL Health Care and Programs</b>	2,386,247	322,514	127,925	2,836,686		2,836,686	(57,578)	2,779,108		16
	<b>C. General Administration</b>										
17	Administrative	94,921		366,245	461,166		461,166	(295,734)	165,432		17
18	Directors Fees										18
19	Professional Services			170,294	170,294	(750)	169,544	(18,605)	150,939		19
20	Dues, Fees, Subscriptions & Promotions			32,897	32,897		32,897	(2,910)	29,987		20
21	Clerical & General Office Expenses	131,957	3,253	393,133	528,343		528,343	(258,572)	269,771		21
22	Employee Benefits & Payroll Taxes			473,540	473,540		473,540		473,540		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,005	2,005		2,005	39	2,044		24
25	Other Admin. Staff Transportation			224	224		224	1,102	1,326		25
26	Insurance-Prop.Liab.Malpractice			247,734	247,734		247,734	1,211	248,945		26
27	Other (specify):*							18,801	18,801		27
28	<b>TOTAL General Administration</b>	226,878	3,253	1,686,072	1,916,203	(750)	1,915,453	(554,668)	1,360,785		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,020,397	581,518	2,074,108	5,676,023	(750)	5,675,273	(613,287)	5,061,986		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 &amp; ID Number

Citadel Care Center Elgin

#0053785

Report Period Beginning:

01/01/18

Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,913	24,913		24,913	193,272	218,185			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,911	50,911		50,911	145,511	196,422			32
33	Real Estate Taxes					750	750	36,833	37,583			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(491,876)	12,124			34
35	Rent-Equipment & Vehicles			18,396	18,396		18,396	5,202	23,598			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			598,220	598,220	750	598,970	(111,057)	487,913			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,596	638,706	764,302		764,302	(3,123)	761,179			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,888	195,888		195,888		195,888			42
43	Other (specify):*	75,427		66,160	141,587		141,587	(141,587)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	75,427	125,596	900,754	1,101,777		1,101,777	(144,710)	957,067			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,095,824	707,114	3,573,082	7,376,020		7,376,020	(869,055)	6,506,965			45

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

Facility Name & ID Number Citadel Care Center Elgin

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01/01/18

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**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(10,656)	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	(195,631)	30		9
10	Interest and Other Investment Income	(4,075)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	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	(26,123)	21		18
19	Entertainment				19
20	Contributions	(500)	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	(233,481)	21		24
25	Fund Raising, Advertising and Promotional	(1,880)	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	(252,368)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (724,806)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(144,249)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (144,249)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (869,055)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.**

**(See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veterans (OT & PT)	\$ (12,697)	10A	1
2	Veterans (Pharm., Rad., & W.C.)	(22,893)	10	2
3	Medicare Sequestration Expense	(38,652)	21	3
4	Managed Care Sequestration Expense	(3,139)	21	4
5	Patient Needs	(280)	10	5
6	Salaries - Marketing	(75,427)	43	6
7	Marketing	(66,160)	43	7
8	Bank Charges	(3,424)	21	8
9	Credit Card Processing Fees	(3,058)	21	9
10	Additional R&M	15,757	06	10
11	Building Company - Accounting Fees	(5,255)	19	11
12	Building Company - Professional Fees	(22,467)	19	12
13	Building Company - Bank Charges	(1,285)	21	13
14	PAC Dues	(484)	20	14
15	Non-allowable Legal	(9,038)	19	15
16	Annual Report Filing Fees	(225)	20	16
17	Capitalized R&M	(3,640)	06	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	<b>Total</b>	(252,368)		49

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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	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center Elgin# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(92)											(92)	2
3	Housekeeping			774									774	3
4	Laundry													4
5	Heat and Other Utilities	(10,656)		830									(9,826)	5
6	Maintenance	12,117		(5,504)									6,613	6
7	Other (specify):*			1,490									1,490	7
8	<b>TOTAL General Services</b>	<b>1,369</b>		<b>(2,410)</b>									<b>(1,041)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(23,173)		(30,911)									(54,084)	10
10a	Therapy	(12,697)											(12,697)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			9,203									9,203	15
16	<b>TOTAL Health Care and Programs</b>	<b>(35,870)</b>		<b>(21,708)</b>									<b>(57,578)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			17,409	(313,143)								(295,734)	17
18	Directors Fees													18
19	Professional Services	(36,760)	17,212	943									(18,605)	19
20	Fees, Subscriptions & Promotions	(3,089)		179									(2,910)	20
21	Clerical & General Office Expenses	(309,162)	1,285	49,305									(258,572)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			39									39	24
25	Other Admin. Staff Transportation			1,102									1,102	25
26	Insurance-Prop.Liab.Malpractice			1,211									1,211	26
27	Other (specify):*			18,801									18,801	27
28	<b>TOTAL General Administration</b>	<b>(349,011)</b>	<b>18,497</b>	<b>88,989</b>	<b>(313,143)</b>								<b>(554,668)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(383,512)</b>	<b>18,497</b>	<b>64,872</b>	<b>(313,143)</b>								<b>(613,287)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(195,631)	386,829	2,074									193,272	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,075)	149,077	509									145,511	32
33	Real Estate Taxes		36,833										36,833	33
34	Rent-Facility & Grounds		(504,000)	12,124									(491,876)	34
35	Rent-Equipment & Vehicles			5,202									5,202	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(199,706)</b>	<b>68,739</b>	<b>19,910</b>									<b>(111,057)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(3,123)							(3,123)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(141,587)											(141,587)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(141,587)</b>				<b>(3,123)</b>							<b>(144,710)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(724,806)</b>	<b>87,236</b>	<b>84,781</b>	<b>(313,143)</b>	<b>(3,123)</b>							<b>(869,055)</b>	<b>45</b>

**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 6-Supplemental		See 6-Supplemental		See 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	\$ 504,000	180 S. State Street	100.00%	\$	\$ (504,000)	1
2	V	19 Accounting Fees		180 S. State Street	100.00%	(5,255)	(5,255)	2
3	V	19 Professional Fees		180 S. State Street	100.00%	22,467	22,467	3
4	V	21 Bank Charges		180 S. State Street	100.00%	1,285	1,285	4
5	V	32 Interest Expense		180 S. State Street	100.00%	149,077	149,077	5
6	V	33 Real Estate Tax		180 S. State Street	100.00%	36,833	36,833	6
7	V	30 Depreciation Expense		181 S. State Street	100.00%	386,829	386,829	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 504,000			\$ 591,236	\$ * 87,236	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		\$ 774	\$ 774
16	V	5 UTILITIES		DAMEN HEALTHCARE GROUP, LLC		830	830
17	V	6 MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC		8,448	8,448
18	V	6 MAINTENANCE	15,112	DAMEN HEALTHCARE GROUP, LLC		1,160	(13,952)
19	V	7 MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC		1,490	1,490
20	V	10 NURSING	83,097	DAMEN HEALTHCARE GROUP, LLC		52,186	(30,911)
21	V	15 NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC		9,203	9,203
22	V	17 ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC		17,409	17,409
23	V	19 PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC		943	943
24	V	20 DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC		179	179
25	V	21 OFFICE EXPENSE - SALARIES		DAMEN HEALTHCARE GROUP, LLC		89,201	89,201
26	V	21 OFFICE EXPENSE - OTHER	48,661	DAMEN HEALTHCARE GROUP, LLC		8,765	(39,896)
27	V	24 SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC		39	39
28	V	25 AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC		1,102	1,102
29	V	26 INSURANCE		DAMEN HEALTHCARE GROUP, LLC		1,211	1,211
30	V	27 EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC		18,801	18,801
31	V	30 DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC		2,074	2,074
32	V	32 INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC		509	509
33	V	34 RENT		DAMEN HEALTHCARE GROUP, LLC		12,124	12,124
34	V	35 EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC		350	350
35	V	35 AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC		4,852	4,852
36	V						
37	V						
38	V						
39	Total		\$ 146,870			\$ 231,651	\$ * 84,781

\* 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	\$ 366,245	JK MANAGEMENT GROUP, LLC		\$	(366,245)
16	V	17 MGMT FEES - J. AARON				26,067	26,067
17	V	17 MGMT FEES - KEN RIPSTEIN				27,035	27,035
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		\$ 366,245			\$ 53,102	\$ * (313,143)

\* 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	\$ 20,090	Integra Healthcare Equipment		\$ 16,967	\$ (3,123)
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		\$ 20,090			\$ 16,967	\$ * (3,123)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	26 Insurance	\$ 123,319	Biltmore Incorporated Cell		\$ 123,319	\$
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		\$ 123,319			\$ 123,319	\$ *

\* 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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Citadel Opco Holding LLC	99.90%	AMBERWOOD CARE CENTER	ROCKFORD, IL	180 S. STATE STREET		BUILDING COMPANY	1
2	Jonathan Aaron	0.10%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	JK MANAGEMENT GROUP LLC	MORTON GROVE, IL	MANAGEMENT COMPANY	2
3			CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	DAMEN HEALTHCARE GROUP, LLC	MORTON GROVE, IL	BOOKKEEPING	3
4			CITADEL CARE CENTER-WILMETTE	WILMETTE, IL	MISTY MEADOWS	METROPOLIS, IL	ASSISTED LIVING	4
5			THE WATERFORD CARE CENTER	CHICAGO, IL	SEASONS HOSPICE	PARK RIDGE, IL	HOSPICE	5
6			CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	INTEGRA HEALTHCARE EQUIPMENT	ELMHURST	DME	6
7			PA PETERSON AT THE CITADEL	ROCKFORD, IL	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	7
8					BILTMORE INCORPORATED CELL	BURLINGTON, VT	INSURANCE	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 &amp; ID Number

Citadel Care Center Elgin

#

0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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	4.26	10.66%	Alloc. Mgmt Fee	\$ 26,067	17-3	1	
2	Kenneth Ripstein		Administrative		See Attached	4.33	7.71%	Alloc. Mgmt Fee	27,035	17-3	2	
3	Yakov Kohen		Clerical		See Attached	3.65	9.13%	Alloc. Mgmt Fee	11,082	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	\$ 64,184		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 Elgin

# 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization DAMEN HEALTHCARE GROUP, LLC  
 Street Address 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	3	HOUSEKEEPING	PATIENT DAYS	311,334	11	\$ 8,480	\$ 28,422	\$ 774	1	
2	5	UTILITIES	PATIENT DAYS	311,334	11	9,092	28,422	830	2	
3	6	MAINTENANCE SALARY	PATIENT DAYS	311,334	11	92,539	92,539	28,422	8,448	3
4	6	MAINTENANCE	PATIENT DAYS	311,334	11	12,710	28,422	1,160	4	
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	311,334	11	16,319	28,422	1,490	5	
6	10	NURSING	PATIENT DAYS	311,334	11	571,645	571,645	28,422	52,186	6
7	15	NURSING BENEFITS	PATIENT DAYS	311,334	11	100,808	28,422	9,203	7	
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	311,334	11	190,702	190,702	28,422	17,409	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	311,334	11	10,332	28,422	943	9	
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	311,334	11	1,963	28,422	179	10	
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	311,334	11	977,110	977,110	28,422	89,201	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	311,334	11	96,009	28,422	8,765	12	
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	311,334	11	425	28,422	39	13	
14	25	AUTO EXPENSE	PATIENT DAYS	311,334	11	12,076	28,422	1,102	14	
15	26	INSURANCE	PATIENT DAYS	311,334	11	13,262	28,422	1,211	15	
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	311,334	11	205,941	28,422	18,801	16	
17	30	DEPRECIATION	PATIENT DAYS	311,334	11	22,724	28,422	2,074	17	
18	32	INTEREST EXPENSE	PATIENT DAYS	311,334	11	5,571	28,422	509	18	
19	34	RENT	PATIENT DAYS	311,334	11	132,802	28,422	12,124	19	
20	35	EQUIPMENT RENTAL	PATIENT DAYS	311,334	11	3,837	28,422	350	20	
21	35	AUTO LEASE	PATIENT DAYS	311,334	11	53,145	28,422	4,852	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,537,492	\$ 1,831,996	\$ 231,651	25	

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

JK MANAGEMENT GROUP, LLC  
5611 DEMPSTER  
MORTON GROVE, IL 60053  
( 224) 470-2044  
( )

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	17	MGMT FEES - J. AARON	PATIENT DAYS	218,070	8	\$ 200,000	\$ 28,422	\$ 26,067	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	262,826	9	\$ 250,000	\$ 28,422	\$ 27,035	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					\$ 450,000	\$	\$ 53,102	25

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

INTEGRA HEALTHCARE EQUIPMENT  
747 CHURCH ROAD  
ELMHURST, IL 60126  
( 630) 834-3700  
( 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		\$	\$		\$ 16,967	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				\$	\$		\$ 16,967	25

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

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

Biltmore Incorporated Cell

Street Address

30 Main Street, Suite 330

City / State / Zip Code

Burlington, Vermont 05401

Phone Number

( )

Fax Number

( )

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	26	Insurance	Direct Allocation		\$	\$		\$ 123,319	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				\$	\$		\$ 123,319	25

Facility Name & ID Number Citadel Care Center Elgin

# 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Elgin

# 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Elgin

# 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

**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 Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	MB Financial		X	Mortgage			\$	\$ 3,550,000		\$ 149,077	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	MB Financial		X	Line of Credit				681,839		50,911	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 4,231,839		\$ 199,988	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(4,075)	10									
11	Allocated from Damen	X								509	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (3,566)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 4,231,839		\$ 196,422	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.)



**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Citadel Care Center Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0053785

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-14-476-028</u>	<u>Long Term Care Property</u>	\$ <u>38,686.56</u>	\$ <u>38,686.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>38,686.56</u></u>	\$ <u><u>38,686.56</u></u>

**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   X   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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Citadel Care Center Elgin COUNTY Kane  
 FACILITY IDPH LICENSE NUMBER 0053785  
 CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18 Ending:

12/31/18

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,117 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.  (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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

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

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>2016</u>	<u>\$ 464,185</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 464,185</b>	<b>3</b>

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	88		2016	1967	\$ 3,499,207	\$ 125,234	39	\$ 89,723	\$ (35,511)	\$ 269,169	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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 Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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								68			
69								69			
70								70			
Related Building Company (Pages 12F & 12G)											
Related Party Allocations (Pages 12H & 12I)			25,720		1,048		3,734				
Financial Statement Depreciation					24,913	(24,913)					
TOTAL (lines 4 thru 69)		\$	3,524,927	\$	151,195	\$	90,772	\$	(60,424)	\$	272,903

\*\*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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,524,927	\$ 151,195		\$ 90,772	\$ (60,424)	\$ 272,903	1
2	Signage - New Site Faces	2016	19,919		20	996	996	2,988	2
3	Installed 3 Pole Breakers And 2 Pump Motors	2016	3,618		20	181	181	543	3
4	New Camera System	2017	8,758		20	438	438	876	4
5	Wander Guard System	2017	5,121		20	256	256	512	5
6	Intersign Corportation	2017	2,868		20	143	143	287	6
7	Repair To Mixing Valve On Water Heater	2017	4,364		20	218	218	436	7
8	Chiller Repair On A/C	2017	4,646		20	232	232	465	8
9	Hc Dekor - Architectural Plans & Idph Submission/Demo/Doors,	2018	5,694		20	380	380	380	9
10	Geostar Mechanical - Domestic Water Storage Tank Replacement	2018	11,074		20	369	369	369	10
11	New Doors And Demo/Framing/Drywall In Memory Care	2018	9,970		20	332	332	332	11
12	Hot Water Tank	2018	3,640		20	182	182	182	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	34

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

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	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)		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	34

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

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	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
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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)		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	34

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

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,604,599	\$ 151,195		\$ 94,499	\$ (56,696)	\$ 280,272	34

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

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

**XI. OWNERSHIP COSTS (continued)**

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	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 Management	2015	25,720	1,048	20	1,048		3,734	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)		\$ 25,720	\$ 1,048		\$ 1,048	\$	\$ 3,734	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 25,720	\$ 1,048		\$ 1,048	\$	\$ 3,734	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)		\$ 25,720	\$ 1,048		\$ 1,048	\$	\$ 3,734	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	\$ 1,225,934	\$ 262,621	\$ 122,736	\$ (139,885)	10	\$ 368,095	71
72	Current Year Purchases	5,969		950	950	10	950	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,231,903	\$ 262,621	\$ 123,686	\$ (138,935)		\$ 369,045	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)	\$ 5,300,687	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 413,816	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,185	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (195,631)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 649,317	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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>12,124</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>12,124</b>			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. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2021                      \$ \_\_\_\_\_

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: \$ 7,478

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</u>	<u>2012 Ford E-450</u>	\$ <u>939.00</u>	\$ <u>11,269</u>	17
18	<u>Allocated from Damen Healthcare Group</u>			<u>4,852</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>939.00</b>	\$ <b>16,121</b>	21

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

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

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/01/18 Ending: 12/31/18  
 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs		\$			\$	210,277	\$			\$		210,277	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					\$	105,242						105,242	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						267,261						267,261	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 prescripts								125,045				125,045	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):								55,926		551				56,477	13
14	TOTAL				\$			\$	638,706	\$	125,596		\$		764,302	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Citadel Care Center Elgin

# 0053785

Report Period Beginning: 01/01/18

Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 228,276	\$ 232,719	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,320,078	1,320,078	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,016	26,016	6
7	Other Prepaid Expenses	6,075	6,075	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	18,659	169,812	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,599,104	\$ 1,754,700	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		511,185	13
14	Buildings, at Historical Cost		3,369,278	14
15	Leasehold Improvements, at Historical Cost	53,041	53,041	15
16	Equipment, at Historical Cost	108,582	1,373,327	16
17	Accumulated Depreciation (book methods)	(57,012)	(808,771)	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>	184,212	1,122,817	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 288,823	\$ 5,620,877	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,887,927	\$ 7,375,577	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 754,788	\$ 770,239	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	681,839	681,839	29
30	Accrued Salaries Payable	178,952	178,952	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,184	13,184	31
32	Accrued Real Estate Taxes(Sch.IX-B)		40,621	32
33	Accrued Interest Payable	3,554	3,554	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	8,304	53,433	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,640,621	\$ 1,741,822	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,550,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,550,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,640,621	\$ 5,291,822	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 247,306	\$ 2,083,755	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,887,927	\$ 7,375,577	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>298,336</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Depreciation</b>	(3,973)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>294,363</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(47,057)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(47,057)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>247,306</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,469,429	1
2	Discounts and Allowances for all Levels	(2,005,575)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,463,854	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,687,376	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,687,376	8
<b>C. Other Operating Revenue</b>			
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	142,681	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,245	19
20	Radiology and X-Ray	4,262	20
21	Other Medical Services	2,470	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 173,658	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,075	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,075	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,328,963	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	923,134	31
32	Health Care	2,836,686	32
33	General Administration	1,916,203	33
<b>B. Capital Expense</b>			
34	Ownership	598,220	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	905,889	35
36	Provider Participation Fee	195,888	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,376,020	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(47,057)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (47,057)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,825,728	44
45	Private Pay - Net Inpatient Revenue	335,100	45
46	Medicare - Net Inpatient Revenue	457,527	46
47	Other-(specify) <u>Managed Care</u>	339,592	47
48	Other-(specify) <u>Hospice/Veterans</u>	505,907	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,463,854	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 Elgin

# 0053785

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	2,136	2,136	\$ 100,701	\$ 47.14	1
2	Assistant Director of Nursing	1,405	1,480	58,204	39.33	2
3	Registered Nurses	19,316	21,424	831,733	38.82	3
4	Licensed Practical Nurses	13,181	15,570	456,363	29.31	4
5	CNAs & Orderlies	45,728	50,890	760,825	14.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,876	2,182	27,741	12.71	9
10	Activity Assistants	2,256	2,591	34,064	13.15	10
11	Social Service Workers	4,208	4,540	114,683	25.26	11
12	Dietician					12
13	Food Service Supervisor	2,078	2,142	41,560	19.40	13
14	Head Cook	5,409	5,721	87,079	15.22	14
15	Cook Helpers/Assistants	12,054	12,586	116,660	9.27	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,257	51,861	22.98	17
18	Housekeepers	6,732	7,041	73,948	10.50	18
19	Laundry	2,881	2,939	36,164	12.30	19
20	Administrator	2,225	2,351	94,921	40.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,889	2,157	70,709	32.78	23
24	Clerical	1,972	2,102	61,248	29.14	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	117	127	1,933	15.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	1,998	2,119	75,427	35.60	33
34	TOTAL (lines 1 - 33)	129,463	142,355	\$ 3,095,824 *	\$ 21.75	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	582	\$ 28,899	01-03	35
36	Medical Director	Monthly	24,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	6,071	10-03	38
39	Pharmacist Consultant	Monthly	14,790	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	16	936	11-03	44
45	Social Service Consultant	10	640	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	608	\$ 75,736		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	2,891	67,371	10-03	52
53	TOTAL (lines 50 - 52)	2,891	\$ 67,371		53



Facility Name & ID Number Citadel Care Center Elgin# 0053785

Report Period Beginning:

01/01/18Ending: 12/31/18**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 \$968
- (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. \$ 29,151 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. \$ 195,888  
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 benefit on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes 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% 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? Yes  
**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. Yes  
Attach invoices and a summary of services for all architect and appraisal fees