



Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793 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	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,857	2,105	7,913	30,875	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,857	2,105	7,913	30,875	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.06%

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 4,517

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

**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	187,979	19,600	11,103	218,682		218,682		218,682		1
2	Food Purchase		166,814		166,814		166,814	(114)	166,700		2
3	Housekeeping	110,827	22,666		133,493		133,493	841	134,334		3
4	Laundry	56,027	6,713	4,695	67,435		67,435		67,435		4
5	Heat and Other Utilities			133,248	133,248		133,248	(8,768)	124,480		5
6	Maintenance	48,719	13,985	112,557	175,261		175,261	(2,058)	173,203		6
7	Other (specify):*							1,618	1,618		7
8	<b>TOTAL General Services</b>	<b>403,552</b>	<b>229,778</b>	<b>261,603</b>	<b>894,933</b>		<b>894,933</b>	<b>(8,482)</b>	<b>886,451</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,991	22,991		22,991		22,991		9
10	Nursing and Medical Records	2,146,677	203,045	26,006	2,375,728		2,375,728	(27,525)	2,348,203		10
10a	Therapy										10a
11	Activities	83,227	2,828	3,290	89,345		89,345		89,345		11
12	Social Services	106,187		1,424	107,611		107,611		107,611		12
13	CNA Training										13
14	Program Transportation			11,360	11,360		11,360		11,360		14
15	Other (specify):*							9,997	9,997		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,336,091</b>	<b>205,873</b>	<b>65,071</b>	<b>2,607,035</b>		<b>2,607,035</b>	<b>(17,528)</b>	<b>2,589,507</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	112,400		371,005	483,405		483,405	(218,485)	264,920		17
18	Directors Fees										18
19	Professional Services			181,151	181,151		181,151	(9,499)	171,652		19
20	Dues, Fees, Subscriptions & Promotions			44,914	44,914		44,914	(11,624)	33,290		20
21	Clerical & General Office Expenses	96,271	3,919	401,201	501,391		501,391	(253,017)	248,374		21
22	Employee Benefits & Payroll Taxes			481,563	481,563		481,563		481,563		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,526	1,526		1,526	42	1,568		24
25	Other Admin. Staff Transportation			2,107	2,107		2,107	1,198	3,305		25
26	Insurance-Prop.Liab.Malpractice			246,014	246,014		246,014	1,315	247,329		26
27	Other (specify):*							20,423	20,423		27
28	<b>TOTAL General Administration</b>	<b>208,671</b>	<b>3,919</b>	<b>1,729,481</b>	<b>1,942,071</b>		<b>1,942,071</b>	<b>(469,647)</b>	<b>1,472,424</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,948,314</b>	<b>439,570</b>	<b>2,056,155</b>	<b>5,444,039</b>		<b>5,444,039</b>	<b>(495,656)</b>	<b>4,948,383</b>		<b>29</b>

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			33,373	33,373		33,373	199,496	232,869		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			44,611	44,611		44,611	292,860	337,471		32
33	Real Estate Taxes							79,893	79,893		33
34	Rent-Facility & Grounds			531,000	531,000		531,000	(517,830)	13,170		34
35	Rent-Equipment & Vehicles			34,273	34,273		34,273	5,651	39,924		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			643,257	643,257		643,257	60,069	703,326		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		114,538	599,578	714,116		714,116	(702)	713,414		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			213,261	213,261		213,261		213,261		42
43	Other (specify):*	83,984		54,865	138,849		138,849	(138,849)			43
44	<b>TOTAL Special Cost Centers</b>	83,984	114,538	867,704	1,066,226		1,066,226	(139,551)	926,675		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,032,298	554,108	3,567,116	7,153,522		7,153,522	(575,138)	6,578,384		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: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Sequestration Expense	\$ (37,343)	21	1
2	Managed Care Sequestration Exp	(3,592)	21	2
3	Patient Needs	(1,118)	10	3
4	Marketing Expense	(14,384)	43	4
5	Bank Charges	(4,501)	21	5
6	Additional R&M	5,609	06	6
7	Capitalize R&M	(2,993)	06	7
8	PAC Dues	(9,256)	20	8
9	Marketing Salary	(83,984)	43	9
10	Bldg Co -Other Professional Fees	(29,596)	19	10
11	Bldg Co - Bank Charges	(1,607)	21	11
12	Bldg Co - Licenses & Fees	(11,352)	20	12
13	Non-allowable Legal	(10,524)	19	13
14	Allocated Marketing	(40,481)	43	14
15	Misc Income	(1,033)	21	15
16	Bldg Co - Amortization Loan Fees	(4,155)	36	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	<b>Total</b>	(250,310)		49

Citadel Care Center- Kankakee

Report Period Beginning: ID# 0053793  
 Ending: 01/01/18  
 12/31/18

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- Kankakee# 0053793

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	(114)											(114)	2
3	Housekeeping			841									841	3
4	Laundry													4
5	Heat and Other Utilities	(9,670)		902									(8,768)	5
6	Maintenance	2,616		(4,674)									(2,058)	6
7	Other (specify):*			1,618									1,618	7
8	<b>TOTAL General Services</b>	<b>(7,168)</b>		<b>(1,314)</b>									<b>(8,482)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,118)		(26,407)									(27,525)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			9,997									9,997	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,118)</b>		<b>(16,410)</b>									<b>(17,528)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			18,912	(237,397)								(218,485)	17
18	Directors Fees													18
19	Professional Services	(40,120)	29,596	1,025									(9,499)	19
20	Fees, Subscriptions & Promotions	(23,171)	11,352	195									(11,624)	20
21	Clerical & General Office Expenses	(311,774)	1,607	57,150									(253,017)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			42									42	24
25	Other Admin. Staff Transportation			1,198									1,198	25
26	Insurance-Prop.Liab.Malpractice			1,315									1,315	26
27	Other (specify):*			20,423									20,423	27
28	<b>TOTAL General Administration</b>	<b>(375,065)</b>	<b>42,555</b>	<b>100,260</b>	<b>(237,397)</b>								<b>(469,647)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(383,351)</b>	<b>42,555</b>	<b>82,537</b>	<b>(237,397)</b>								<b>(495,656)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(290,855)	488,097	2,254									199,496	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,370)	295,678	552									292,860	32
33	Real Estate Taxes		79,893										79,893	33
34	Rent-Facility & Grounds		(531,000)	13,170									(517,830)	34
35	Rent-Equipment & Vehicles			5,651									5,651	35
36	Other (specify):*	(4,155)	4,155											36
37	<b>TOTAL Ownership</b>	<b>(298,380)</b>	<b>336,823</b>	<b>21,626</b>									<b>60,069</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(702)							(702)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(138,849)											(138,849)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(138,849)</b>				<b>(702)</b>							<b>(139,551)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(820,580)</b>	<b>379,378</b>	<b>104,163</b>	<b>(237,397)</b>	<b>(702)</b>							<b>(575,138)</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 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	\$ 531,000	900 West River Place			\$ (531,000)	1
2	V	19 Accounting Fees		900 West River Place				2
3	V	19 Other Professional Fees		900 West River Place		29,596	29,596	3
4	V	21 Bank Charges		900 West River Place		1,607	1,607	4
5	V	32 Interest Expense		900 West River Place		295,678	295,678	5
6	V	33 Real Estate Taxes		900 West River Place		79,893	79,893	6
7	V	20 Licenses & Fees		900 West River Place		11,352	11,352	7
8	V	30 Depreciation Expense		900 West River Place		488,097	488,097	8
9	V	36 Amortization - Loan fees		900 West River Place		4,155	4,155	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 531,000			\$ 910,378	\$ * 379,378	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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	\$ 841	\$ 841	15
16	V	5	UTILITIES		DAMEN HEALTHCARE GROUP, LLC	902	902	16
17	V	6	MAINTENANCE SALARY	15,112	DAMEN HEALTHCARE GROUP, LLC	9,177	(5,935)	17
18	V	6	MAINTENANCE		DAMEN HEALTHCARE GROUP, LLC	1,260	1,260	18
19	V	7	MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC	1,618	1,618	19
20	V	10	NURSING	83,097	DAMEN HEALTHCARE GROUP, LLC	56,690	(26,407)	20
21	V	15	NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC	9,997	9,997	21
22	V	17	ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC	18,912	18,912	22
23	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	1,025	1,025	23
24	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	195	195	24
25	V	21	OFFICE EXPENSE - SALARIES	49,271	DAMEN HEALTHCARE GROUP, LLC	96,900	47,629	25
26	V	21	OFFICE EXPENSE - OTHER		DAMEN HEALTHCARE GROUP, LLC	9,521	9,521	26
27	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	42	42	27
28	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	1,198	1,198	28
29	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC	1,315	1,315	29
30	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	20,423	20,423	30
31	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	2,254	2,254	31
32	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	552	552	32
33	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC	13,170	13,170	33
34	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	381	381	34
35	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	5,270	5,270	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 147,480			\$ 251,643	\$ * 104,163	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	\$ 371,005	JK MANAGEMENT GROUP, LLC		\$	(282,597)
16	V	17 MGMT FEES - J. AARON				28,317	22,188
17	V	17 MGMT FEES - KEN RIPSTEIN				29,366	23,012
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		\$ 371,005			\$ 57,683	\$ * (237,397)

\* 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	\$ 4,518	Integra Healthcare Equipment		\$ 3,816	\$ (702)
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	<b>Total</b>		\$ 4,518			\$ 3,816	\$ * (702)

\* 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	\$ 135,931	Biltmore Incorporated Cell		\$ 135,931	\$	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		\$ 135,931			\$ 135,931	\$ *	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 (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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 &amp; ID Number

Citadel Care Center- Kankakee

#

0053793

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	4.63	11.58%	Alloc. Mgmt Fee	\$ 28,317	17-3	1
2	Kenneth Ripstein		Administrative		See Attached	4.70	11.75%	Alloc. Mgmt Fee	29,368	17-3	2
3	Yakov Kohen		Clerical		See Attached	3.97	9.92%	Alloc Sal	12,039	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	\$ 69,724		13

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

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

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

Report Period Beginning:

01/01/18

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 ( ) \_\_\_\_\_

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					\$	\$		\$	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:

01/01/18

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 DAMEN HEALTHCARE GROUP, LLC  
 Street Address 5611 DEMPSTER  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 224) 470-2044  
 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	3	HOUSEKEEPING	PATIENT DAYS	311,334	11	\$ 8,480	\$ 30,875	\$ 841	1	
2	5	UTILITIES	PATIENT DAYS	311,334	11	9,092	30,875	902	2	
3	6	MAINTENANCE SALARY	PATIENT DAYS	311,334	11	92,539	92,539	30,875	9,177	3
4	6	MAINTENANCE	PATIENT DAYS	311,334	11	12,710	30,875	1,260	4	
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	311,334	11	16,319	30,875	1,618	5	
6	10	NURSING	PATIENT DAYS	311,334	11	571,645	571,645	30,875	56,690	6
7	15	NURSING BENEFITS	PATIENT DAYS	311,334	11	100,808	30,875	9,997	7	
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	311,334	11	190,702	190,702	30,875	18,912	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	311,334	11	10,332	30,875	1,025	9	
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	311,334	11	1,963	30,875	195	10	
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	311,334	11	977,110	977,110	30,875	96,900	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	311,334	11	96,009	30,875	9,521	12	
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	311,334	11	425	30,875	42	13	
14	25	AUTO EXPENSE	PATIENT DAYS	311,334	11	12,076	30,875	1,198	14	
15	26	INSURANCE	PATIENT DAYS	311,334	11	13,262	30,875	1,315	15	
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	311,334	11	205,941	30,875	20,423	16	
17	30	DEPRECIATION	PATIENT DAYS	311,334	11	22,724	30,875	2,254	17	
18	32	INTEREST EXPENSE	PATIENT DAYS	311,334	11	5,571	30,875	552	18	
19	34	RENT	PATIENT DAYS	311,334	11	132,802	30,875	13,170	19	
20	35	EQUIPMENT RENTAL	PATIENT DAYS	311,334	11	3,837	30,875	381	20	
21	35	AUTO LEASE	PATIENT DAYS	311,334	11	53,145	30,875	5,270	21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 2,537,492	\$ 1,831,996		\$ 251,643	25	

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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	\$ 30,875	\$ 28,317	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	262,826	9	\$ 250,000	\$ 30,875	\$ 29,368	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	\$	\$ 57,685	25

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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

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		\$	\$		\$ 3,816	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				\$	\$		\$ 3,816	25

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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		\$	\$		\$ 135,931	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				\$	\$		\$ 135,931	25

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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- Kankakee

# 0053793

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- Kankakee

# 0053793

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- Kankakee

# 0053793

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- Kankakee

# 0053793

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 Bank		X	Mortgage			\$	\$ 5,940,200		\$ 295,678	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	MB Financial Bank		X	Line of Credit				759,335		44,611	6									
7	Damen		X	Line of Credit				70,000		552	7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 6,769,535		\$ 340,841	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X							(3,370)	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (3,370)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 6,769,535		\$ 337,471	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- Kankakee COUNTY Kankakee  
 FACILITY IDPH LICENSE NUMBER 0053793  
 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>16-09-31-412-001</u>	<u>Long Term Care Property</u>	\$ <u>76,359.12</u>	\$ <u>76,359.12</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u><u>76,359.12</u></u>	\$ <u><u>76,359.12</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- Kankakee COUNTY Kankakee  
 FACILITY IDPH LICENSE NUMBER 0053793  
 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.**

**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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>101,930</u>	<u>2016</u>	<u>\$ 446,143</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 446,143</b>	<b>3</b>

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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	107		2016	1969	\$ 4,318,257	\$ 488,097	35	\$ 123,379	\$ (364,718)	\$ 370,137	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

**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
		\$	\$		\$	\$	\$	
67			27,940		1,139		4,057	67
68					1,139			68
69						(33,373)		69
70		\$	4,346,197	\$	522,609	124,518	(398,091)	374,193

\*\*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		\$ 4,346,197	\$ 522,609		\$ 124,518	\$ (398,091)	\$ 374,193	1
2	Repair Pipe Leak In Boiler Room	2016	3,532		20	177	177	530	2
3	Repair Signs/Flagpole & Renovate Courtyard	2016	8,132		20	407	407	1,220	3
4	Install Fencing Around Small Patio In Front	2016	2,950		20	148	148	443	4
5	Repair/Installation Roof Flashing	2016	5,496		20	275	275	975	5
6	Repair Damage Pipe From Ground Concrete Floor	2016	9,086		20	454	454	1,363	6
7	Fabricated/Installed New Signage Faces W/ Fco Graphics	2016	11,161		20	558	558	1,674	7
8	Cctv Installation/Secondary Intercom Stations In Housekeeping Ro	2016	4,752		20	238	238	713	8
9	Precision Piping Inc- Booster Heater	2017	3,305		20	165	165	331	9
10	Job 1 Fire Protection- Sprinkler Head Purchase And Protection	2017	3,740		20	187	187	374	10
11	Repairs On 1St Floor Hallway & Bathroom Wall	2017	3,919		20	196	196	392	11
12	Hc Dekor - Archictural Plans & Idph Submission	2018	12,947		20	863	863	863	12
13	Hc Dekor - Carpentry, Drywall, Framing, Paint	2018	3,447		20	57	57	57	13
14	Vestibule/Lobby/Lounge/Corridors/Dining/Therapy/Activity/ Resident Rms/showers: Ceilings/Floors/Wallcovering/Lighting/ Cabinetry/Window Treatments/Sinks/Shower Fixtures/Paint	2018	1,366,917		20	68,346	68,346	68,346	14
15									15
16									16
17	Wheelchair Lift Repair	2018	2,993		20	150	150	150	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)		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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 12B, Carried Forward		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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)		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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)		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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:

01/01/18

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		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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)		\$ 5,788,573	\$ 522,609		\$ 196,737	\$ (325,872)	\$ 451,622	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:

01/01/18

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.

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

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	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	27,940	1,139	20	1,139		4,057	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 27,940	\$ 1,139		\$ 1,139	\$	\$ 4,057	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		\$ 27,940	\$ 1,139		\$ 1,139	\$	\$ 4,057	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)		\$ 27,940	\$ 1,139		\$ 1,139	\$	\$ 4,057	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	\$ 55,757	\$ 1,115	\$ 5,731	\$ 4,616	10	\$ 17,533	71
72	Current Year Purchases	311,297		30,401	30,401	10	30,401	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 367,054	\$ 1,115	\$ 36,132	\$ 35,017		\$ 47,934	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,601,770	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 523,724	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,869	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (290,855)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 499,556	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		\$ 1,363,898	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>13,170</u>			5
6								6
7	<b>TOTAL</b>				\$ <b>13,170</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: \$ 23,502 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>5,270</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>929.36</b>	\$ <b>16,422</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.

**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**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
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	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	\$		\$ 219,192	\$		\$ 219,192	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			75,370			75,370	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			261,338			261,338	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				114,538		114,538	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					43,678			43,678	13
14	TOTAL			\$		\$ 599,578	\$ 114,538		\$ 714,116	14

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

Facility Name & ID Number Citadel Care Center- Kankakee

# 0053793

Report Period Beginning: 01/01/18

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	\$ 39,569	\$ 39,811	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,851,836	1,851,836	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,664	26,664	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	2,082	32,874	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,920,151	\$ 1,951,185	10
<b>B. Long-Term Assets</b>				
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	474,242	1,901,150	15
16	Equipment, at Historical Cost	82,358	1,523,634	16
17	Accumulated Depreciation (book methods)	(62,875)	(1,333,419)	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>	29,855	38,165	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 523,580	\$ 6,388,259	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,443,731	\$ 8,339,444	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 833,652	\$ 752,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	829,335	939,225	29
30	Accrued Salaries Payable	176,674	176,674	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,120	12,120	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,177	32
33	Accrued Interest Payable	4,088	4,088	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	155,671	155,671	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,011,540	\$ 2,120,687	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,830,310	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>	1,007,575	1,687,002	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,007,575	\$ 7,517,312	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,019,115	\$ 9,637,999	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (575,384)	\$ (1,298,555)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,443,731	\$ 8,339,444	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (849,482)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	3	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (849,479)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	274,095	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 274,095	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (575,384)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,577,534	1
2	Discounts and Allowances for all Levels	(2,059,947)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,517,587	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,760,400	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,760,400	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	127,636	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,485	19
20	Radiology and X-Ray	3,275	20
21	Other Medical Services	1,831	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 145,227	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,370	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,370	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	1,033	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,033	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,427,617	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	894,933	31
32	Health Care	2,607,035	32
33	General Administration	1,942,071	33
<b>B. Capital Expense</b>			
34	Ownership	643,257	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	852,965	35
36	Provider Participation Fee	213,261	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,153,522	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	274,095	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 274,095	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,633,388	44
45	Private Pay - Net Inpatient Revenue	436,200	45
46	Medicare - Net Inpatient Revenue	573,462	46
47	Other-(specify) <u>Managed Care</u>	380,270	47
48	Other-(specify) <u>Hospice</u>	494,267	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,517,587	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:

01/01/18

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	1,848	2,008	\$ 92,122	\$ 45.88	1
2	Assistant Director of Nursing	2,022	2,102	82,828	39.40	2
3	Registered Nurses	15,098	13,695	483,486	35.30	3
4	Licensed Practical Nurses	15,031	16,941	484,810	28.62	4
5	CNAs & Orderlies	58,145	65,357	924,533	14.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,962	2,061	31,003	15.04	9
10	Activity Assistants	4,970	5,139	52,224	10.16	10
11	Social Service Workers	3,238	3,545	77,956	21.99	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,096	40,347	19.25	13
14	Head Cook	4,425	4,813	51,323	10.66	14
15	Cook Helpers/Assistants	9,637	9,896	96,309	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,959	2,174	48,719	22.41	17
18	Housekeepers	9,895	10,142	110,827	10.93	18
19	Laundry	4,999	5,071	56,027	11.05	19
20	Administrator	1,931	2,016	112,400	55.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,561	1,561	36,302	23.26	23
24	Clerical	2,727	2,820	59,969	21.27	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	2,877	3,036	47,866	15.77	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	5,843	6,325	143,247	22.65	33
34	TOTAL (lines 1 - 33)	150,207	160,798	\$ 3,032,298 *	\$ 18.86	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	216	\$ 11,103	01-03	35
36	Medical Director	Monthly	22,991	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Per Visit	3,571	10-03	38
39	Pharmacist Consultant	Monthly	7,241	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	62	3,290	11-03	44
45	Social Service Consultant	22	1,424	12-03	45
46	Other(specify)				46
47	<u>Nurse Consultant</u>	Monthly	15,194	10-03	47
48					48
49	TOTAL (lines 35 - 48)	300	\$ 64,814		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jennifer Wright	Administrator	0.00%	\$ 112,400	Workers' Compensation Insurance	\$ 49,391	IDPH License Fee	\$	
				Unemployment Compensation Insurance	47,728	Advertising: Employee Recruitment	73	
				FICA Taxes	221,630	Health Care Worker Background Check	2,224	
				Employee Health Insurance	149,683	(Indicate # of checks performed <u>127</u> )		
				Employee Meals		Patient Background Checks	189 2,922	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	21,430	
				Employee Benefits - Other	5,818	Licenses and Fees	6,446	
				Holiday Expense	1,621	Allocated from Damen Healthcare Group	195	
				401K Employer Match Expense	5,692			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	( )	
			\$ 112,400			Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees - JK Management			\$ 371,005		\$ 481,563	\$ 33,290		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 371,005	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
Marcum LLP	Accounting Services		\$ 37,173				Out-of-State Travel	\$
See Attached	Legal Services		33,634					
Propay HR	Payroll Processing		19,678				In-State Travel	
Personnel Planners Inc	Unemployment Consulting		975					
Prescriptive Strategies	Management Consulting		4,556					
Greenberg & Associates	Insurance Services		2,133				Seminar Expense	1,526
Casamba Inc	Data Processing		1,700				Allocated from Damen Healthcare Group	42
Esolutions Inc	Data Processing		4,383					
IIT/SourceTech	Data Processing		1,993				Entertainment Expense	( )
National Datacare Corporation	Data Processing		1,457				(agree to Sch. V, line 24, col. 8)	
Point Click Care Technologies, Inc.	Data Processing		40,358				TOTAL	\$ 1,568
See Supplemental Schedule			34,085					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 182,125	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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 - \$18,511
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,208 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 213,261  
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. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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