

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0053785

Facility Name: Citadel Care Center Elgin

Address: 180 South State St Elgin 60123
Number City Zip Code

County: Kane

Telephone Number: (847) 742-3310 Fax # (847) 742-0924

HFS ID Number:

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

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/05/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Citadel Care Center Elgin

0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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 <u>N/A</u>					
	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	<u>88</u>	Skilled (SNF)	<u>88</u>	<u>32,208</u>	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	<u>88</u>	TOTALS	<u>88</u>	<u>32,208</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,463</u>	<u>1,791</u>	<u>6,414</u>	<u>27,668</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,463</u>	<u>1,791</u>	<u>6,414</u>	<u>27,668</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.90%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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 4,258

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		11,157	321,140	332,297		332,297		332,297			1
2	Food Purchase		158,413		158,413		158,413	(103)	158,310			2
3	Housekeeping		122	161,371	161,493		161,493	1,022	162,515			3
4	Laundry		468	107,581	108,049		108,049		108,049			4
5	Heat and Other Utilities			110,545	110,545		110,545	(4,210)	106,335			5
6	Maintenance	55,392	74,496	75,706	205,594		205,594	13	205,607			6
7	Other (specify):*											7
8	TOTAL General Services	55,392	244,656	776,343	1,076,391		1,076,391	(3,278)	1,073,113			8
	B. Health Care and Programs											
9	Medical Director			22,200	22,200		22,200		22,200			9
10	Nursing and Medical Records	2,001,551	236,148	70,678	2,308,377		2,308,377	(17,547)	2,290,830			10
10a	Therapy		20,828		20,828		20,828		20,828			10a
11	Activities	45,764	3,739	2,348	51,851		51,851		51,851			11
12	Social Services	114,271		1,654	115,925		115,925		115,925			12
13	CNA Training											13
14	Program Transportation			613	613		613		613			14
15	Other (specify):*							5,306	5,306			15
16	TOTAL Health Care and Programs	2,161,586	260,715	97,493	2,519,794		2,519,794	(12,241)	2,507,553			16
	C. General Administration											
17	Administrative	100,459		326,428	426,887		426,887	(277,837)	149,050			17
18	Directors Fees											18
19	Professional Services			89,777	89,777		89,777	97,379	187,156			19
20	Dues, Fees, Subscriptions & Promotions			72,178	72,178		72,178	(21,540)	50,638			20
21	Clerical & General Office Expenses	152,307	2,757	238,448	393,512		393,512	(118,313)	275,199			21
22	Employee Benefits & Payroll Taxes			413,649	413,649		413,649		413,649			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,357	1,357		1,357	309	1,666			24
25	Other Admin. Staff Transportation			3,112	3,112		3,112	692	3,804			25
26	Insurance-Prop.Liab.Malpractice			121,726	121,726		121,726	2,311	124,037			26
27	Other (specify):*							15,876	15,876			27
28	TOTAL General Administration	252,766	2,757	1,266,675	1,522,198		1,522,198	(301,123)	1,221,075			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,469,744	508,128	2,140,511	5,118,383		5,118,383	(316,641)	4,801,742			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,571	4,571		4,571	206,088	210,659			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,845	38,845		38,845	170,169	209,014			32
33	Real Estate Taxes							41,030	41,030			33
34	Rent-Facility & Grounds			504,000	504,000		504,000	(495,092)	8,908			34
35	Rent-Equipment & Vehicles			9,227	9,227		9,227	5,026	14,253			35
36	Other (specify):*											36
37	TOTAL Ownership			556,643	556,643		556,643	(72,778)	483,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,256	556,011	717,267		717,267	(3,009)	714,258			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,410	185,410		185,410		185,410			42
43	Other (specify):*	59,005		25,785	84,790		84,790	(84,790)				43
44	TOTAL Special Cost Centers	59,005	161,256	767,206	987,467		987,467	(87,799)	899,668			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,528,749	669,384	3,464,360	6,662,493		6,662,493	(477,219)	6,185,274			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,296)	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	(148,194)	30		9
10	Interest and Other Investment Income	(494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	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	(538)	21		18
19	Entertainment				19
20	Contributions	(1,000)	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	(148,508)	21		24
25	Fund Raising, Advertising and Promotional	(20,053)	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	(180,255)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (504,441)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,222		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,222		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (477,219)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Medicare Sequestration Expense	\$ (38,505)	21	1
2	Managed Care Sequestration Expense	(3,339)	21	2
3	Marketing Salary	(57,777)	43	3
4	Vacation - Marketing	(1,228)	43	4
5	Marketing Expense	(25,785)	43	5
6	Bank Charges	(1,647)	21	6
7	Credit Card Processing Fees	(1,306)	21	7
8	Additional R&M	2,606	06	8
9	Capitalized R&M	(3,618)	06	9
10	Building Company - Professional Fees	(7,750)	19	10
11	Building Company - Bank Charges	(863)	21	11
12	Building Company - Legal Fees	(32,098)	19	12
13	PAC Dues	(3,136)	20	13
14	Non-allowable Legal	(5,809)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(180,255)		49

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
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74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(103)											(103)	2
3	Housekeeping			1,022									1,022	3
4	Laundry													4
5	Heat and Other Utilities	(5,296)		1,086									(4,210)	5
6	Maintenance	(1,012)		1,025									13	6
7	Other (specify):*													7
8	TOTAL General Services	(6,411)		3,133									(3,278)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(17,547)									(17,547)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,306									5,306	15
16	TOTAL Health Care and Programs			(12,241)									(12,241)	16
	C. General Administration													
17	Administrative			(326,428)	48,591								(277,837)	17
18	Directors Fees													18
19	Professional Services	(45,657)	39,848	1,174	102,014								97,379	19
20	Fees, Subscriptions & Promotions	(24,189)		2,649									(21,540)	20
21	Clerical & General Office Expenses	(194,706)	863	75,530									(118,313)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			309									309	24
25	Other Admin. Staff Transportation			692									692	25
26	Insurance-Prop.Liab.Malpractice			2,311									2,311	26
27	Other (specify):*			15,876									15,876	27
28	TOTAL General Administration	(264,552)	40,711	(227,887)	150,605								(301,123)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(270,963)	40,711	(236,994)	150,605								(316,641)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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	(148,194)	351,812	2,470									206,088	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(494)	169,746	917									170,169	32
33	Real Estate Taxes		41,030										41,030	33
34	Rent-Facility & Grounds		(504,000)	8,908									(495,092)	34
35	Rent-Equipment & Vehicles			5,026									5,026	35
36	Other (specify):*													36
37	TOTAL Ownership	(148,688)	58,588	17,322									(72,778)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(3,009)							(3,009)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(84,790)											(84,790)	43
44	TOTAL Special Cost Centers	(84,790)				(3,009)							(87,799)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(504,441)	99,299	(219,673)	150,605	(3,009)							(477,219)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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:	
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)	
1	V	34	Rental Income	\$ 504,000	180 S. State Street	100.00%	\$	(504,000)	1
2	V	19	Professional Fees		180 S. State Street	100.00%	7,750	7,750	2
3	V	21	Bank Charges		180 S. State Street	100.00%	863	863	3
4	V	32	Interest Expense		180 S. State Street	100.00%	169,746	169,746	4
5	V	19	Legal Fees		180 S. State Street	100.00%	32,098	32,098	5
6	V	33	Real Estate Tax		180 S. State Street	100.00%	41,030	41,030	6
7	V	30	Depreciation Expense		180 S. State Street	100.00%	351,812	351,812	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 504,000			\$ 603,299	\$ * 99,299	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	5	UTILITIES	\$	DAMEN HEALTHCARE GROUP, LLC	100.00%	\$ 1,086	\$ 1,086	15
16	V	3	HOUSEKEEPING		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,022	1,022	16
17	V	6	MAINTENANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,025	1,025	17
18	V	10	NURSING	40,454	DAMEN HEALTHCARE GROUP, LLC	100.00%	22,907	(17,547)	18
19	V	15	NURSING PAYROLL TAXES		DAMEN HEALTHCARE GROUP, LLC	100.00%	5,306	5,306	19
20	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC	100.00%	1,174	1,174	20
21	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,649	2,649	21
22	V	21	OFFICE EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	75,530	75,530	22
23	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	309	309	23
24	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	692	692	24
25	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,311	2,311	25
26	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC	100.00%	15,876	15,876	26
27	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC	100.00%	2,470	2,470	27
28	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC	100.00%	917	917	28
29	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC	100.00%	8,908	8,908	29
30	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC	100.00%	570	570	30
31	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC	100.00%	4,456	4,456	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V	17	MANAGEMENT FEES	326,428	DAMEN HEALTHCARE GROUP, LLC	100.00%		(326,428)	36
37	V								37
38	V								38
39	Total			\$ 366,882			\$ 147,209	\$ * (219,673)	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 - JA	\$	JK MANAGEMENT GROUP, LLC	100.00%	\$ 23,381	\$ 23,381	15
16	V	17	MANAGEMENT FEES - KP		JK MANAGEMENT GROUP, LLC	100.00%	25,210	25,210	16
17	V	19	BOOKKEEPING SERVICES		JK MANAGEMENT GROUP, LLC	100.00%	101,935	101,935	17
18	V	19	DATA PROCESSING		JK MANAGEMENT GROUP, LLC	100.00%	79	79	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			\$			\$ 150,605	\$ * 150,605	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	39	DME & MEDICAL SUPPLIES	\$ 29,708	INTEGRA HEALTHCARE EQUIPMENT	100.00%	\$ 26,699	\$ (3,009)	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			\$ 29,708			\$ 26,699	\$ * (3,009)	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	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES

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	Kenneth Ripstein	30.00%	AMBERWOOD CARE CENTER	ROCKFORD, IL	180 S. STATE STREET		BUILDING COMPANY	1
2	Jonathan Aaron	25.00%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	JK MANAGEMENT GROUP LLC	MORTON GROVE, IL	MANAGEMENT COMPANY	2
3	Stern Family Investment Trust U/A/D 06/11/15	10.33%	CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	DAMEN HEALTHCARE GROUP	MORTON GROVE, IL	BOOKKEEPING	3
4	Berger Family Trust U/A/D 06/25/14	10.33%	CITADEL CARE CENTER-WILMETTE	WILMETTE, IL	MISTY MEADOWS	METROPOLIS, IL	ASSISTED LIVING	4
5	Israel Family Investment Trust U/A/D 05/20/15	5.17%	THE WATERFORD CARE CENTER	CHICAGO, IL	SEASONS HOSPICE	PARK RIDGE, IL	HOSPICE	5
6	Israel Investement Trust U/A/D 06/18/15	5.17%	CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	6
7	Illana Teller	5.00%			LIFELINE AMBULANCE	CHICAGO	AMBULANCE	7
8	Yakov Koeh	5.00%						8
9	Gabriel Kroll	1.00%						9
10	Stevel Nagel	1.00%						10
11	Jonathan Ollman	1.00%						11
12	David Mills	1.00%						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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	Shareholder	Administrative	25.00%	See Attached	4.68	11.70%	Alloc Mgmt Fee	\$ 23,381	17-7	1
2	Kenneth Ripstein	Shareholder	Administrative	30.00%	See Attached	6.19	15.48%	Alloc Mgmt Fee	25,210	17-7	2
3											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	\$ 48,591		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
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0053785

Report Period Beginning:

01/05/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

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

Facility Name & ID Number	Citadel Care Center Elgin
--------------------------------------	----------------------------------

0053785

Report Period Beginning:

01/05/16

Ending: 12/31/16

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

7

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	PATIENT DAYS	236,674	8	\$ 9,291	\$ 27,668	\$ 1,086	1
2	3	HOUSEKEEPING	PATIENT DAYS	236,674	8	8,740	27,668	1,022	2
3	6	MAINTENANCE	PATIENT DAYS	236,674	8	8,770	27,668	1,025	3
4	10	NURSING	PATIENT DAYS	236,674	8	195,949	27,668	22,907	4
5	15	NURSING PAYROLL TAXES	PATIENT DAYS	236,674	8	45,391	27,668	5,306	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	236,674	8	10,042	27,668	1,174	6
7	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	236,674	8	22,657	27,668	2,649	7
8	21	OFFICE EXPENSE	PATIENT DAYS	236,674	8	646,091	27,668	75,530	8
9	24	SEMINARS AND EDUCATION	PATIENT DAYS	236,674	8	2,647	27,668	309	9
10	25	AUTO EXPENSE	PATIENT DAYS	236,674	8	5,921	27,668	692	10
11	26	INSURANCE	PATIENT DAYS	236,674	8	19,769	27,668	2,311	11
12	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	236,674	8	135,801	27,668	15,876	12
13	30	DEPRECIATION	PATIENT DAYS	236,674	8	21,131	27,668	2,470	13
14	32	INTEREST EXPENSE	PATIENT DAYS	236,674	8	7,844	27,668	917	14
15	34	RENT	PATIENT DAYS	236,674	8	76,200	27,668	8,908	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	236,674	8	4,878	27,668	570	16
17	35	AUTO LEASE	PATIENT DAYS	236,674	8	38,115	27,668	4,456	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,259,237	\$ 782,192	\$ 147,209	25

Ending: 12/31/16

Facility Name & ID Number	Citadel Care Center Elgin
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0053785

Report Period Beginning:

01/05/16

Ending: 12/31/16

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		\$	\$		\$ 26,699	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				\$	\$		\$ 26,699	25

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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

Ending: 12/31/16

Ending: 12/31/16

Facility Name & ID Number Citadel Care Center Elgin # 0053785 Report Period Beginning: 01/05/16 Ending: 12/31/16

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: 01/05/16 Ending: 12/31/16

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

Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	MB Financial		X	Mortgage			\$	4,234,000			\$	169,746	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	MB Financial		X	Line of Credit				1,074,910				38,845	6
7													7
8					-								8
9	TOTAL Facility Related						\$	5,308,910			\$	208,591	9
	B. Non-Facility Related*												
10	Interest Income		X									(494)	10
11	Allocated - Damen Healthcare	X										917	11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	423	14
15	TOTALS (line 9+line14)						\$	5,308,910			\$	209,014	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 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 Steve Lavenda
TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <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 NO

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

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).

None

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	Facility		2016	\$ 464,185	1
2					2
3	TOTALS			\$ 464,185	3

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	\$ 351,812	39	\$ 89,723	\$ (262,089)	\$ 89,723	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	32,936	1,343		1,647	304	3,294	68
69	Financial Statement Depreciation		4,571			(4,571)		69
70	TOTAL (lines 4 thru 69)	\$ 3,532,143	\$ 357,726		\$ 91,370	\$ (266,356)	\$ 93,017	70

**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:

01/05/16

Ending:

12/31/16

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		\$ 3,532,143	\$ 357,726		\$ 91,370	\$ (266,356)	\$ 93,017	1
2	Signage - New Site Faces	2016	19,919		20	996	996	996	2
3	Installed 3 Pole Breakers And 2 Pump Motors	2016	3,618		20	181	181	181	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)		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	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)		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	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)		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	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)		\$ 3,555,679	\$ 357,726		\$ 92,547	\$ (265,179)	\$ 94,194	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:

01/05/16

Ending:

12/31/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1 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 - Damen Healthcare Group	2015	32,936	1,343	20	1,647	304	3,294	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 32,936	\$ 1,343		\$ 1,647	\$ 304	\$ 3,294	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:

01/05/16

Ending:

12/31/16

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		\$ 32,936	\$ 1,343		\$ 1,647	\$ 304	\$ 3,294	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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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 32,936	\$ 1,343		\$ 1,647	\$ 304	\$ 3,294	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	\$8,952	\$1,028	\$895	\$(133)	10	\$1,790	71
72	Current Year Purchases	1,172,174	100	117,218	117,118	10	117,218	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,181,126	\$1,128	\$118,113	\$116,985		\$119,008	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	2	
	Reference	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)	\$5,200,991	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$358,854	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$210,660	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(148,194)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$213,202	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?

YES

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated - Damen Healthcare Group				8,908			5
6								6
7	TOTAL				\$ 8,908			7

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

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

9. Option to Buy:

YES

NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$ 570

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	Facility	2012 Ford E-450	\$ 939	\$ 9,227	17
18	Allocated - Damen Healthcare Group			4,456	18
19					19
20					20
21	TOTAL		\$ 939	\$ 13,683	21

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. /2017 \$

13. /2018 \$

14. /2019 \$
- * 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.
- HFS 3745 (N-4-99)
- IL478-2471

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$		\$ 119,413	\$		\$ 119,413	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			21,611			21,611	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			373,779			373,779	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				161,256		161,256	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					41,208			41,208	13
14	TOTAL			\$		\$ 556,011	\$ 161,256		\$ 717,267	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 127,952	\$ 212,283	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,643,919	1,727,919	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,736	23,736	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	140,495	807,479	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,936,102	\$ 2,771,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		464,185	13
14	Buildings, at Historical Cost		3,499,207	14
15	Leasehold Improvements, at Historical Cost	20,850	20,850	15
16	Equipment, at Historical Cost	24,723	1,173,183	16
17	Accumulated Depreciation (book methods)	(4,571)	(356,383)	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>	18,431	35,627	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 59,433	\$ 4,836,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,995,535	\$ 7,608,086	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 899,719	\$ 899,718	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,074,910	1,169,510	29
30	Accrued Salaries Payable	137,106	137,106	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,270	12,270	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,584	32
33	Accrued Interest Payable	4,032	4,032	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	928	1,440,195	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,128,965	\$ 3,701,415	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,139,400	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,139,400	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,128,965	\$ 7,840,815	46
47	TOTAL EQUITY(page 18, line 24)	\$ (133,430)	\$ (232,729)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,995,535	\$ 7,608,086	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(133,430)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (133,430)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (133,430)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Citadel Care Center Elgin

0053785

Report Period Beginning:

01/05/16

Ending:

12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,367,790	1
2	Discounts and Allowances for all Levels	(2,657,106)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,710,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,643,750	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,643,750	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,649	19
20	Radiology and X-Ray	5,846	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,135	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	494	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 494	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,529,063	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,076,391	31
32	Health Care	2,519,794	32
33	General Administration	1,522,198	33
	B. Capital Expense		
34	Ownership	556,643	34
	C. Ancillary Expense		
35	Special Cost Centers	802,057	35
36	Provider Participation Fee	185,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,662,493	40
41	Income before Income Taxes (line 30 minus line 40)**	(133,430)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (133,430)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,108,089	44
45	Private Pay - Net Inpatient Revenue	463,948	45
46	Medicare - Net Inpatient Revenue	593,306	46
47	Other-(specify) <u>Managed Care</u>	344,927	47
48	Other-(specify) <u>Hospice</u>	200,414	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,710,684	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.

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	1,928	2,036	\$ 87,919	\$ 43.18	1
2	Assistant Director of Nursing	2,312	2,351	85,293	36.28	2
3	Registered Nurses	24,225	25,673	824,863	32.13	3
4	Licensed Practical Nurses	8,796	9,377	252,331	26.91	4
5	CNAs & Orderlies	50,910	53,448	722,077	13.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	146	149	1,790	12.01	9
10	Activity Assistants	3,867	4,072	43,974	10.80	10
11	Social Service Workers	4,347	4,726	114,271	24.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,224	2,357	55,392	23.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,007	2,151	100,459	46.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,634	1,757	37,637	21.42	23
24	Clerical	9,370	9,902	114,670	11.58	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	1,763	1,906	29,068	15.25	31
32	Other Health Care(specify)					32
33	Other(specify)	1,701	1,775	59,005	33.24	33
34	TOTAL (lines 1 - 33)	115,230	121,680	\$ 2,528,749 *	\$ 20.78	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		\$		35
36	Medical Director	Monthly	22,200	09-03	36
37	Medical Records Consultant	Monthly	2,000	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,988	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	40	2,348	11-03	44
45	Social Service Consultant	26	1,654	12-03	45
46	Other(specify)				46
47					47
48	Outside Dietary Services		321,140	01-03	48
49	TOTAL (lines 35 - 48)	66	\$ 354,330		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	668	\$ 36,747	10-03	50
51	Licensed Practical Nurses	595	26,787	10-03	51
52	Certified Nurse Assistants/Aides	6	156	10-03	52
53	TOTAL (lines 50 - 52)	1,270	\$ 63,690		53

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?
If YES, give association name and amount. ICLTC \$9,504
- (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?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,040 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. \$ 185,410
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. \$ None Has any meal income been offset against related costs? None 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