		FOR BHF USE					

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053801

Facility Name: Citadel Care Center- Wilmette

Address: 432 Poplar Drive (Number) Wilmette (City) 60091 (Zip Code)

County: Cook

Telephone Number: (847) 256-5000 **Fax #** (847) 256-0225

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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- Wilmette # 0053801 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,384	3,842	8,028	20,254	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,384	3,842	8,028	20,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.36%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 5,968

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	262,647	25,792	89,004	377,443		377,443		377,443			1
2	Food Purchase		151,368		151,368		151,368	(287)	151,081			2
3	Housekeeping	121,446	12,327		133,773		133,773	552	134,325			3
4	Laundry	12,728	15	95,359	108,102		108,102	(2,222)	105,880			4
5	Heat and Other Utilities			90,788	90,788		90,788	(5,599)	85,189			5
6	Maintenance	54,400	14,490	136,607	205,497		205,497	(6,603)	198,894			6
7	Other (specify):*							1,062	1,062			7
8	**TOTAL General Services**	451,221	203,992	411,758	1,066,971		1,066,971	(13,097)	1,053,874			8
	B. Health Care and Programs											
9	Medical Director			65,500	65,500		65,500		65,500			9
10	Nursing and Medical Records	1,896,391	234,024	11,016	2,141,431		2,141,431	(50,474)	2,090,957			10
10a	Therapy											10a
11	Activities	86,111	10,220	399	96,730		96,730		96,730			11
12	Social Services	110,320		549	110,869		110,869		110,869			12
13	CNA Training											13
14	Program Transportation			17,764	17,764		17,764		17,764			14
15	Other (specify):*							6,558	6,558			15
16	**TOTAL Health Care and Programs**	2,092,822	244,244	95,228	2,432,294		2,432,294	(43,916)	2,388,378			16
	C. General Administration											
17	Administrative	105,294		352,405	457,699		457,699	(302,157)	155,542			17
18	Directors Fees											18
19	Professional Services			124,497	124,497		124,497	(3,360)	121,137			19
20	Dues, Fees, Subscriptions & Promotions			39,345	39,345		39,345	(9,465)	29,880			20
21	Clerical & General Office Expenses	87,594	1,460	310,646	399,700		399,700	(202,906)	196,794			21
22	Employee Benefits & Payroll Taxes			442,655	442,655		442,655		442,655			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,955	2,955		2,955	28	2,983			24
25	Other Admin. Staff Transportation			8,676	8,676		8,676	786	9,462			25
26	Insurance-Prop.Liab.Malpractice			159,090	159,090		159,090	863	159,953			26
27	Other (specify):*							13,398	13,398			27
28	**TOTAL General Administration**	192,888	1,460	1,440,269	1,634,617		1,634,617	(502,813)	1,131,804			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,736,931	449,696	1,947,255	5,133,882		5,133,882	(559,827)	4,574,055			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Citadel Care Center- Wilmette #0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			52,400	52,400		52,400	199,898	252,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,454	54,454		54,454	203,343	257,797			32
33	Real Estate Taxes							323,668	323,668			33
34	Rent-Facility & Grounds			624,000	624,000		624,000	(615,360)	8,640			34
35	Rent-Equipment & Vehicles			18,033	18,033		18,033	3,707	21,740			35
36	Other (specify):*											36
37	**TOTAL Ownership**			748,887	748,887		748,887	115,256	864,143			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,989	770,201	945,190		945,190	(997)	944,193			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,758	126,758		126,758		126,758			42
43	Other (specify):*	18,890		52,307	71,197		71,197	(71,197)				43
44	**TOTAL Special Cost Centers**	18,890	174,989	949,266	1,143,145		1,143,145	(72,194)	1,070,951			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,755,821	624,685	3,645,408	7,025,914		7,025,914	(516,765)	6,509,149			45

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(6,190)	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	(253,323)	30		9
10	Interest and Other Investment Income	(2,455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(287)	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				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(179,398)	21		24
25	Fund Raising, Advertising and Promotional	(2,173)	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	(165,148)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (609,474)		$	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)	92,709		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 92,709		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,765)		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

Citadel Care Center- Wilmette

ID# 0053801

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration Expense	$ (61,998)	21	1
2	Managed Care Sequestration Expense	468	21	2
3	Patient Needs	(4,566)	10	3
4	Allocated - Marketing	(31,581)	43	4
5	Bank Charges	(2,827)	21	5
6	Credit Card Processing Charges	(6,270)	21	6
7	Building Company - Accounting Fees	3,147	19	7
8	Building Company - Other Professional Fees	(6,250)	19	8
9	Building Company - Bank Charges	(1,328)	21	9
10	Building Company - Amortization - Loan Fees	(3,859)	36	10
11	Additional R&M	11,884	06	11
12	PAC Dues	(6,920)	20	12
13	Non-Allowable Legal	(2,944)	19	13
14	Non-Allowable other professional fee_	(1,088)	19	14
15	Salaries - Marketing	(18,890)	43	15
16	Marketing Expense - External	(6,559)	43	16
17	Marketing Expense - Internal	(14,167)	43	17
18	Capitalized R & M	(11,400)	06	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**	(165,148)		49

Citadel Care Center- Wilmette

ID# 0053801

Report Period Beginning: 01/01/18

Ending: 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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(287)											(287)	2
3	Housekeeping			552									552	3
4	Laundry					(2,222)							(2,222)	4
5	Heat and Other Utilities	(6,190)		591									(5,599)	5
6	Maintenance	484		(7,087)									(6,603)	6
7	Other (specify):*			1,062									1,062	7
8	**TOTAL General Services**	(5,993)		(4,882)		(2,222)							(13,097)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,566)		(45,908)									(50,474)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,558									6,558	15
16	**TOTAL Health Care and Programs**	(4,566)		(39,350)									(43,916)	16
	C. General Administration													
17	Administrative			12,406	(314,563)								(302,157)	17
18	Directors Fees													18
19	Professional Services	(7,135)	3,103	672									(3,360)	19
20	Fees, Subscriptions & Promotions	(9,593)		128									(9,465)	20
21	Clerical & General Office Expenses	(251,353)	1,328	47,119									(202,906)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			28									28	24
25	Other Admin. Staff Transportation			786									786	25
26	Insurance-Prop.Liab.Malpractice			863									863	26
27	Other (specify):*			13,398									13,398	27
28	**TOTAL General Administration**	(268,081)	4,431	75,400	(314,563)								(502,813)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(278,640)	4,431	31,168	(314,563)	(2,222)							(559,827)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(253,323)	451,743	1,478									199,898	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,455)	205,436	362									203,343	32
33	Real Estate Taxes		323,668										323,668	33
34	Rent-Facility & Grounds		(624,000)	8,640									(615,360)	34
35	Rent-Equipment & Vehicles			3,707									3,707	35
36	Other (specify):*	(3,859)	3,859											36
37	**TOTAL Ownership**	(259,637)	360,706	14,187									115,256	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(55)	(943)					(997)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(71,197)											(71,197)	43
44	**TOTAL Special Cost Centers**	(71,197)					(55)	(943)					(72,194)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(609,474)	365,137	45,355	(314,563)	(2,222)	(55)	(943)					(516,765)	45

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 624,000	432 Poplar Drive, LLC		$	$ (624,000)	1
2	V	19	Accounting Fees		432 Poplar Drive, LLC		(3,147)	(3,147)	2
3	V	19	Legal & Professional Fees		432 Poplar Drive, LLC		2,500	2,500	3
4	V	19	Other Professional Fees		432 Poplar Drive, LLC		3,750	3,750	4
5	V	21	Bank Charges		432 Poplar Drive, LLC		1,328	1,328	5
6	V	32	Interest Expense		432 Poplar Drive, LLC		205,436	205,436	6
7	V	33	Real Estate Taxes		432 Poplar Drive, LLC		323,668	323,668	7
8	V	30	Depreciation Expense		432 Poplar Drive, LLC		451,743	451,743	8
9	V	36	Amortization - Loan Fees		432 Poplar Drive, LLC		3,859	3,859	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 624,000			$ 989,137	$ * 365,137	14

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	DAMEN HEALTHCARE GROUP, LLC		$ 552	$ 552	15
16	V	5	UTILITIES		DAMEN HEALTHCARE GROUP, LLC		591	591	16
17	V	6	MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC		6,020	6,020	17
18	V	6	MAINTENANCE	13,934	DAMEN HEALTHCARE GROUP, LLC		827	(13,107)	18
19	V	7	MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC		1,062	1,062	19
20	V	10	NURSING	83,097	DAMEN HEALTHCARE GROUP, LLC		37,189	(45,908)	20
21	V	15	NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC		6,558	6,558	21
22	V	17	ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC		12,406	12,406	22
23	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC		672	672	23
24	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC		128	128	24
25	V	21	OFFICE EXPENSE - SALARIES	22,693	DAMEN HEALTHCARE GROUP, LLC		63,566	40,873	25
26	V	21	OFFICE EXPENSE - OTHER		DAMEN HEALTHCARE GROUP, LLC		6,246	6,246	26
27	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC		28	28	27
28	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC		786	786	28
29	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC		863	863	29
30	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC		13,398	13,398	30
31	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC		1,478	1,478	31
32	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC		362	362	32
33	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC		8,640	8,640	33
34	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC		250	250	34
35	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC		3,457	3,457	35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,724			$ 165,079	$ * 45,355	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 352,405	JK MANAGEMENT GROUP, LLC	100.00%	$	$ (352,405)	15
16	V	17	MGMT FEES - J. AARON			100.00%	18,576	18,576	16
17	V	17	MGMT FEES - KEN RIPSTEIN			100.00%	19,266	19,266	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			$ 352,405			$ 37,842	$ * (314,563)	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	04	Laundry Services	$ 95,359	EcoBrite Linen		$ 93,137	$ (2,222)	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			$ 95,359			$ 93,137	$ * (2,222)	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ambulance	$ 574	Lifeline Ambulance		$ 520	$ (55)	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			$ 574			$ 520	$ * (55)	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	DME & Medical Supplies	$ 6,071	Intergra Healthcare Equipment		$ 5,128	$ (943)	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			$ 6,071			$ 5,128	$ * (943)	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 86,884	Biltmore Incorporated Cell		$ 86,884	$	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			$ 86,884			$ 86,884	$ *	39

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jonathan Aaron	0.10%	AMBERWOOD CARE CENTER	ROCKFORD, IL	432 POPLAR DRIVE, LLC	WILMETTE, IL	BUILDING COMPANY	1
2	Citadel Opco Holdings LLC	99.90%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	JK MANAGEMENT GROUP LLC	MORTON GROVE, IL	MANAGEMENT COMPANY	2
3			CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	DAMEN HEALTHCARE GROUP,	MORTON GROVE, IL	BOOKKEEPING	3
4			CITADEL CARE CENTER-ELGIN	ELGIN, IL	MISTY MEADOWS	METROPOLIS, IL	ASSISTED LIVING	4
5			PA PETERSON AT THE CITADEL	ROCKFORD, IL	SEASONS HOSPICE	PARK RIDGE, IL	HOSPICE	5
6			THE WATERFORD CARE CENTER	CHICAGO, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST, IL	DME	6
7			CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	LIFELINE AMBULANCE	CHICAGO, IL	AMBULANCE	7
8			CITADEL OF STERLING	STERLING, IL	ECOBRITE LINEN	SKOKIE, IL	LAUNDRY SERVICE	8
9			CITADEL OF NORTHBROOK	NORTHBROOK, IL	BILTMORE INVESTMENT CELL	BURLINGTON, VT	INSURANCE	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jonathan Aaron	Owner	Administrative	0.10%	See Attached	3.04	7.60%	Alloc. Mgmt Fee	$ 18,576	17-3	1
2	Kenneth Ripstein		Administrative		See Attached	3.08	7.71%	Alloc. Mgmt Fee	19,266	17-3	2
3	Yakov Kohen		Clerical		See Attached	2.60	6.50%	Alloc. Mgmt Fee	7,897	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	$ 45,739		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- Wilmette # 0053801 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 [X]

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

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] NO [ ]

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

Name of Related Organization: DAMEN HEALTHCARE GROUP, LLC
Street Address: 5611 DEMPSTER
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (224) 470-2044
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	311,334	11	$ 8,480	$	20,254	$ 552	1
2	5	UTILITIES	PATIENT DAYS	311,334	11	9,092		20,254	591	2
3	6	MAINTENANCE SALARY	PATIENT DAYS	311,334	11	92,539	92,539	20,254	6,020	3
4	6	MAINTENANCE	PATIENT DAYS	311,334	11	12,710		20,254	827	4
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	311,334	11	16,319		20,254	1,062	5
6	10	NURSING	PATIENT DAYS	311,334	11	571,645	571,645	20,254	37,189	6
7	15	NURSING BENEFITS	PATIENT DAYS	311,334	11	100,808		20,254	6,558	7
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	311,334	11	190,702	190,702	20,254	12,406	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	311,334	11	10,332		20,254	672	9
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	311,334	11	1,963		20,254	128	10
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	311,334	11	977,110	977,110	20,254	63,566	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	311,334	11	96,009		20,254	6,246	12
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	311,334	11	425		20,254	28	13
14	25	AUTO EXPENSE	PATIENT DAYS	311,334	11	12,076		20,254	786	14
15	26	INSURANCE	PATIENT DAYS	311,334	11	13,262		20,254	863	15
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	311,334	11	205,941		20,254	13,398	16
17	30	DEPRECIATION	PATIENT DAYS	311,334	11	22,724		20,254	1,478	17
18	32	INTEREST EXPENSE	PATIENT DAYS	311,334	11	5,571		20,254	362	18
19	34	RENT	PATIENT DAYS	311,334	11	132,802		20,254	8,640	19
20	35	EQUIPMENT RENTAL	PATIENT DAYS	311,334	11	3,837		20,254	250	20
21	35	AUTO LEASE	PATIENT DAYS	311,334	11	53,145		20,254	3,457	21
22										22
23										23
24										24
25	TOTALS					$ 2,537,492	$ 1,831,996		$ 165,079	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] NO [ ]

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

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

	1 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	17	MGMT FEES - J. AARON	PATIENT DAYS	218,070	8	$ 200,000	$	20,254	$ 18,576	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	262,826	9	250,000		20,254	19,266	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	$		$ 37,842	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] NO [ ]

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

Name of Related Organization: EcoBrite Linen
Street Address: 3712 Jarvis Avenue
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 582-4000
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	4	Laundry Services	Direct			$	$		$ 93,137	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					$	$		$ 93,137	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] NO [ ]

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

Name of Related Organization: Lifeline Ambulance
Street Address: 2424 S Wabash Ave
City / State / Zip Code: Chicago, IL 60616
Phone Number: (312)949-9595
Fax Number: (312)949-9262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ambulance	Direct Allocation			$	$		$ 520	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					$	$		$ 520	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	DME & Medical Supplies	Direct			$	$		$ 5,128	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					$	$		$ 5,128	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 [X] NO [ ]

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

Name of Related Organization: Biltmore Incorporated Cell
Street Address: 30 Main Street, Suite 330
City / State / Zip Code: Burlington, Vermont 05401
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Allocation			$	$		$ 86,884	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					$	$		$ 86,884	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 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- Wilmette # 0053801 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 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
									2
									3
									4
									5
									6
									7
									8
									9
									10
									11
									12
									13
									14
									15
									16
									17
									18
									19
									20
									21
									22
									23
									24
TOTALS					$	$		$	25

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 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- Wilmette # 0053801 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB Financial		X	Mortgage			$	$ 3,605,400			$ 205,436	1
2	Ascentum Capital		X	Capital Lease				20,135			1,882	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				1,229,624			52,572	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,855,159			$ 259,890	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,455)	10
11	Allocated from Damen Healthca	X									362	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,093)	14
15	TOTALS (line 9+line14)						$	$ 4,855,159			$ 257,797	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # 36

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 200,608	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 255,744	2
3. Under or (over) accrual (line 2 minus line 1).		$ 55,136	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 268,531	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 323,667	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015	284,600	10
2016	191,055	11
2017	255,744	12

2018 Accrual = 2017 Accrual

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Citadel Care Center- Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053801

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-34-121-041-0000	Long Term Care Property	$ 7,771.22	$ 7,771.22
2.	05-34-121-042-0000	Long Term Care Property	$ 2,949.39	$ 2,949.39
3.	05-34-121-048-0000	Long Term Care Property	$ 6,252.80	$ 6,252.80
4.	05-34-121-050-0000	Long Term Care Property	$ 2,282.75	$ 2,282.75
5.	05-34-121-051-0000	Long Term Care Property	$ 2,939.48	$ 2,939.48
6.	05-34-121-056-0000	Long Term Care Property	$ 233,548.60	$ 233,548.60
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 255,744.24	$ 255,744.24

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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Citadel Care Center- Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053801

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,881 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	30,199	2016	$ 410,380	1
2					2
3	TOTALS			$ 410,380	3

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		2016	1969	$ 3,228,258	$ 451,743	39	$ 82,776	$ (368,967)	$ 248,328	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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	
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)		18,328	747		747		2,661	68
69	Financial Statement Depreciation			52,400			(52,400)		69
70	TOTAL (lines 4 thru 69)		$ 3,246,586	$ 504,890		$ 83,523	$ (421,367)	$ 250,989	70

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 12A, Carried Forward		$ 3,246,586	$ 504,890		$ 83,523	$ (421,367)	$ 250,989	1
2	High Pressure Urothane Injection - Passenger Elevator	2016	4,469		20	223	223	670	2
3	Signage - Installed New Faces And Parking Panels	2016	4,340		20	217	217	651	3
4	Installed 80 Ton Chiller	2016	69,842		20	3,492	3,492	10,476	4
5	Installed New Traveler For Elevator	2016	4,750		20	238	238	713	5
6	Installed Retractable Ladder For Elevator	2016	3,233		20	162	162	485	6
7	Installed New Air Chiller	2016	9,164		20	458	458	1,270	7
8	Surveilance Camera Installation	2017	4,680		20	234	234	468	8
9	Wall Coverings For Facility- 2Nd Floor Resident Rooms	2017	3,484		20	174	174	348	9
10	Planting Landscape	2017	15,500		20	775	775	1,550	10
11	Flooring For Facility- 2Nd Floor Resident Rooms	2017	13,953		20	698	698	1,395	11
12	Repaired Wallpaper-Mentor/Resident Rms/Kitch/1St-3Rd Floors	2017	54,699		20	2,898	2,898	5,796	12
13	1St Floor Shower Room Floor & Ceiling Repair	2018	9,500		20	950	950	1,188	13
14	Fire Sprinkler System Overhaul Repair	2018	4,505		20	300	300	300	14
15	1St & 2Nd Fl Shower Rooms, Restroom, Hallways - New Walls, Pai	2018	3,265		20	272	272	272	15
16	Resident Room #208 - New Walls, Floors, Paint	2018	3,186		20	239	239	239	16
17	Resident Room #205 - Walls, Paint, Flooring, Electrical, Toilet	2018	4,905		20	245	245	245	17
18	Resident Room #203 - Walls, Paint, Electrical	2018	2,897		20	48	48	48	18
19	Resident Room #201 - Walls, Paint, Flooring, Electrical	2018	3,719		20	31	31	31	19
20	Vestibule/Lobby/Corridor/Dining/Resident Rms/Bath Shower	2018	631,098		20	31,555	31,555	31,555	20
21	Rms/Therapy: Flooring/Lighting/Window Treatments/Handrails	2018			20				21
22	Wallcovering/Cabinetry/Shower Stalls/Paint	2018			20				22
23	Elevator #1 - Install New Overhead Oil Line	2018	11,400		20	570	570	570	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	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)		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	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)		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	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)		$ 4,109,176	$ 504,890		$ 127,302	$ (377,589)	$ 309,259	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 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- Wilmette # 0053801 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	18,328	747	20	747		2,661	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)		$ 18,328	$ 747		$ 747	$	$ 2,661	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 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 12H, Carried Forward		$ 18,328	$ 747		$ 747	$	$ 2,661	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)		$ 18,328	$ 747		$ 747	$	$ 2,661	34

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,035,041	$ 731	$ 103,606	$ 102,875	10	$ 307,626	71
72	Current Year Purchases	160,306		21,391	21,391	10	21,391	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,195,347	$ 731	$ 124,996	$ 124,265		$ 329,016	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,714,903	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 505,621	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 252,298	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (253,323)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 638,275	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Allocated from Damen Healthcare Group				8,640			5
6								6
7	TOTAL				$ 8,640 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,137 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 Van	2012 Ford E-450 Super Du	$ 928.81	$ 11,146	17
18	Allocated from Damen Healthcare Group			3,457	18
19					19
20					20
21	TOTAL		$ 928.81	$ 14,603	21

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

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 339,077	$		$ 339,077	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			43,285			43,285	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			345,998			345,998	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				174,989		174,989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					41,841			41,841	13
14	TOTAL			$		$ 770,201	$ 174,989		$ 945,190	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- Wilmette # 0053801 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,621	$ 23,409	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,095,347	1,095,347	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,384	21,384	6
7	Other Prepaid Expenses	4,250	4,250	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,221	126,552	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,144,823	$ 1,270,942	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		457,380	13
14	Buildings, at Historical Cost		3,722,655	14
15	Leasehold Improvements, at Historical Cost	328,894	328,894	15
16	Equipment, at Historical Cost	141,212	1,183,477	16
17	Accumulated Depreciation (book methods)	(85,111)	(1,208,797)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	23,220	30,938	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 408,215	$ 4,514,547	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,553,038	$ 5,785,489	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 832,346	$ 832,176	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,234,847	1,327,453	29
30	Accrued Salaries Payable	175,112	175,112	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,475	14,475	31
32	Accrued Real Estate Taxes(Sch.IX-B)		268,531	32
33	Accrued Interest Payable	2,824	2,824	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	49,875	925,423	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,309,479	$ 3,545,994	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,912	14,912	39
40	Mortgage Payable		3,512,794	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	362,077	362,077	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 376,989	$ 3,889,783	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,686,468	$ 7,435,777	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,133,430)	$ (1,650,288)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,553,038	$ 5,785,489	48

*(See instructions.)

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,165,825)	1	
2	Restatements (describe):		2	
3	**Prior Year Depreciation**	7,753	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,158,072)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	24,642	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)**	$ 24,642	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)**	$ (1,133,430)	24	*

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,873,257	1
2	Discounts and Allowances for all Levels	(1,381,595)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,491,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,311,500	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,311,500	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	171,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,745	19
20	Radiology and X-Ray	28,772	20
21	Other Medical Services	7,235	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 244,939	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,455	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,455	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)**	$ 7,050,556	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,066,971	31
32	Health Care	2,432,294	32
33	General Administration	1,634,617	33
	B. Capital Expense		
34	Ownership	748,887	34
	C. Ancillary Expense		
35	Special Cost Centers	1,016,387	35
36	Provider Participation Fee	126,758	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,025,914	40
41	**Income before Income Taxes (line 30 minus line 40)****	24,642	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 24,642	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,616,367	44
45	Private Pay - Net Inpatient Revenue	1,096,658	45
46	Medicare - Net Inpatient Revenue	1,232,924	46
47	Other-(specify) **Managed Care**	267,582	47
48	Other-(specify) **Hospice - Medicaid**	278,131	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,491,662	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- Wilmette # 0053801 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 97,034	$ 46.65	1
2	Assistant Director of Nursing	1,934	2,080	71,436	34.34	2
3	Registered Nurses	17,283	18,547	648,714	34.98	3
4	Licensed Practical Nurses	11,047	11,879	366,119	30.82	4
5	CNAs & Orderlies	44,603	47,960	713,088	14.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,018	2,080	43,685	21.00	9
10	Activity Assistants	3,198	3,439	42,426	12.34	10
11	Social Service Workers	3,869	4,160	110,320	26.52	11
12	Dietician					12
13	Food Service Supervisor	1,659	1,784	49,979	28.02	13
14	Head Cook	5,030	6,788	100,739	14.84	14
15	Cook Helpers/Assistants	8,738	9,396	111,929	11.91	15
16	Dishwashers					16
17	Maintenance Workers	2,023	2,175	54,400	25.01	17
18	Housekeepers	8,366	8,996	121,446	13.50	18
19	Laundry	877	943	12,728	13.50	19
20	Administrator	2,455	2,640	105,294	39.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,804	1,940	50,318	25.94	23
24	Clerical	2,595	2,791	37,276	13.36	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	440	440	18,890	42.93	33
34	TOTAL (lines 1 - 33)	119,883	130,118	$ 2,755,821 *	$ 21.18	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 17,301	01-03	35
36	Medical Director	Monthly	65,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	4,021	10-03	38
39	Pharmacist Consultant	Monthly	6,995	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	7	399	11-03	44
45	Social Service Consultant	9	549	12-03	45
46	Other(specify)				46
47	Outside Services - Dietary	Monthly	71,703	01-03	47
48					48
49	TOTAL (lines 35 - 48)	16	$ 166,468		49

C. CONTRACT NURSES

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

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cole Teller	Administrator	0	$ 105,294
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 105,294

B. Administrative - Other

Description	Amount
Management Fees - JK Management	$ 352,405
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 352,405

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fees	$ 33,641
See Schedule	Legal Fees	14,567
Prime Care Technologies	Managed Service Consulting	2,292
E-Solutions, Inc.	Business Service Consulting	4,427
Point Click Care Technologies, Inc.	Bookkeeping Software	31,964
National Data Care Corp	Financial Services	1,076
Telemedicine Solutions, LLC	Unemployment Consulting	2,340
Casamba Inc	Healthcare Software	1,700
IIT/Source Tech	Proprietory Software	1,330
Personnel Planners	Unemployment Consulting	1,125
Achieve Accreditation, LLC.	Accreditation Services	4,953
See Supplemental Schedule		25,081
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 124,496

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,030
Unemployment Compensation Insurance	41,907
FICA Taxes	205,157
Employee Health Insurance	135,315
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	4,420
Holiday Expense	2,929
401K Employer Match Expense	9,794
Dental / Vision Insurance	103
TOTAL (agree to Schedule V, line 22, col.8)	$ 442,655

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		91
Health Care Worker Background Check		
(Indicate # of checks performed	)	7,424
Patient Background Checks	88	880
License and Fees	495	4,952
Dues and Subscriptions		16,405
Allocated from Damen Healthcare Group		128
See Supplemental Schedule		
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 29,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,955
Allocated from Damen Healthcare	28
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,983

**See instructions.

Facility Name & ID Number Citadel Care Center- Wilmette # 0053801 Report Period Beginning: 01/01/18 Ending: 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. **ICLTC/HCCI $13,840**

(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 Yes**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,431** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **126,758**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
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. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.