		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: 0054882

Facility Name: CITADEL OF STERLING THE

Address: 105 E. 23Rd Street (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-4264 **Fax #** (815) 626-0021

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1993

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 OF STERLING THE # 0054882 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	121	Skilled (SNF)	121	44,165	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	121	TOTALS	121	44,165	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	1,158	1,329	4,236	6,723	8
9	SNF/PED					9
10	ICF	14,122	3,742	2,031	19,895	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,280	5,071	6,267	26,618	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.27%

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 2/1/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 4,203

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	246,991	29,696	12,167	288,854		288,854		288,854			1
2	Food Purchase		165,226		165,226		165,226	(566)	164,660			2
3	Housekeeping	132,243	24,389		156,632		156,632	659	157,291			3
4	Laundry	76,402	11,893	5,586	93,881		93,881		93,881			4
5	Heat and Other Utilities			155,667	155,667		155,667	(6,678)	148,989			5
6	Maintenance	88,740	19,184	80,758	188,682		188,682	674	189,356			6
7	Other (specify):*							1,282	1,282			7
8	**TOTAL General Services**	544,376	250,388	254,178	1,048,942		1,048,942	(4,630)	1,044,312			8
	B. Health Care and Programs											
9	Medical Director			26,300	26,300		26,300		26,300			9
10	Nursing and Medical Records	1,647,277	174,455	12,253	1,833,985		1,833,985	(31,181)	1,802,804			10
10a	Therapy	10,061	199		10,260		10,260		10,260			10a
11	Activities	111,471	2,967	704	115,142		115,142		115,142			11
12	Social Services	85,849		6,866	92,715		92,715		92,715			12
13	CNA Training											13
14	Program Transportation			10,104	10,104		10,104		10,104			14
15	Other (specify):*							7,834	7,834			15
16	**TOTAL Health Care and Programs**	1,854,658	177,621	56,227	2,088,506		2,088,506	(23,347)	2,065,159			16
	C. General Administration											
17	Administrative	86,325		282,597	368,922		368,922	(218,237)	150,685			17
18	Directors Fees											18
19	Professional Services			171,545	171,545		171,545	(67,482)	104,063			19
20	Dues, Fees, Subscriptions & Promotions			31,509	31,509		31,509	(12,606)	18,903			20
21	Clerical & General Office Expenses	69,016	1,071	251,107	321,194		321,194	(116,718)	204,476			21
22	Employee Benefits & Payroll Taxes			421,826	421,826		421,826		421,826			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,297	2,297		2,297	56	2,353			24
25	Other Admin. Staff Transportation			4,114	4,114		4,114	1,169	5,283			25
26	Insurance-Prop.Liab.Malpractice			192,607	192,607		192,607	1,302	193,909			26
27	Other (specify):*							17,932	17,932			27
28	**TOTAL General Administration**	155,341	1,071	1,357,602	1,514,014		1,514,014	(394,585)	1,119,429			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,554,375	429,080	1,668,007	4,651,462		4,651,462	(422,562)	4,228,900			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 OF STERLING THE #0054882 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			20,683	20,683		20,683	228,168	248,851			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,821	28,821		28,821	297,684	326,505			32
33	Real Estate Taxes			2,583	2,583		2,583	25,725	28,308			33
34	Rent-Facility & Grounds			560,100	560,100		560,100	(549,780)	10,320			34
35	Rent-Equipment & Vehicles			34,465	34,465		34,465	5,275	39,740			35
36	Other (specify):*											36
37	**TOTAL Ownership**			646,652	646,652		646,652	7,071	653,723			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,837	687,182	859,019		859,019	(268)	858,751			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,632	181,632		181,632		181,632			42
43	Other (specify):*	45,049		65,590	110,639		110,639	(110,639)				43
44	**TOTAL Special Cost Centers**	45,049	171,837	934,404	1,151,290		1,151,290	(110,907)	1,040,383			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,599,424	600,917	3,249,063	6,449,404		6,449,404	(526,397)	5,923,007			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 OF STERLING THE # 0054882 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	(7,452)	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	58,372	30		9
10	Interest and Other Investment Income	(792)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(315)	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	(101,874)	21		24
25	Fund Raising, Advertising and Promotional	(6,169)	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	(267,877)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (326,607)		$	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)	(199,790)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (199,790)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (526,397)		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 OF STERLING THE

ID# 0054882

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare Sequestration Expense	$ (40,211)	21	1
2	Managed Care Sequestration Expense	(129)	21	2
3	Patient Needs	(290)	10	3
4	Salaries - Marketing	(44,300)	43	4
5	Vacation - Marketing	(749)	43	5
6	Bank Charges	(1,708)	21	6
7	PAC Dues	(5,757)	20	7
8	Additional R&M	5,744	06	8
9	State Replacement Tax	(261)	21	9
10	Allocated - Marketing	(43,334)	43	10
11	Marketing Expense - External	(10,657)	43	11
12	Marketing Expense - Internal	(10,999)	43	12
13	Chamber of Commerce Dues	(500)	20	13
14	Vending Revenue	(251)	02	14
15	Annual Report Filing Fees	(75)	20	15
16	Non Allowable Legal Fees	(29,930)	19	16
17	Marketing Consultant	(600)	43	17
18	Intercompany Interest	(3,279)	32	18
19	Prior Period Expense	(13,094)	21	19
20	Dynamic Depreciation	(189)	30	20
21	Building Company - Professional Fees	(2,649)	19	21
22	Building Company - Bank Charges	(1,379)	21	22
23	Building Company - Amortization	(52,593)	36	23
24	Building Company - Accounting Fees	(3,813)	19	24
25	Building Company - Legal Fees	(2,583)	19	25
26	Building Company - Franchise Taxes	(75)	21	26
27	Adjust Real Estate Tax to Actual	(4,216)	33	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**	(267,877)		49

CITADEL OF STERLING THE

ID# 0054882

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 OF STERLING THE # 0054882 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	(566)											(566)	2
3	Housekeeping			659									659	3
4	Laundry													4
5	Heat and Other Utilities	(7,452)		707			67						(6,678)	5
6	Maintenance	5,744		(5,592)			522						674	6
7	Other (specify):*			1,268			14						1,282	7
8	**TOTAL General Services**	(2,274)		(2,959)			603						(4,630)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(290)		(30,891)									(31,181)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,834									7,834	15
16	**TOTAL Health Care and Programs**	(290)		(23,057)									(23,347)	16
	C. General Administration													
17	Administrative			14,819	(237,397)			4,342					(218,237)	17
18	Directors Fees													18
19	Professional Services	(38,975)	9,045	803			(38,355)						(67,482)	19
20	Fees, Subscriptions & Promotions	(13,001)		153			242						(12,606)	20
21	Clerical & General Office Expenses	(158,731)	(2,746)	38,495			6,264						(116,718)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			33			23						56	24
25	Other Admin. Staff Transportation			938			231						1,169	25
26	Insurance-Prop.Liab.Malpractice			1,031			271						1,302	26
27	Other (specify):*			16,003			997	932					17,932	27
28	**TOTAL General Administration**	(210,707)	6,299	72,275	(237,397)		(30,328)	5,274					(394,585)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(213,271)	6,299	46,259	(237,397)		(29,725)	5,274					(422,562)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	58,183	168,030	1,766			189						228,168	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,071)	301,206	433			116						297,684	32
33	Real Estate Taxes	(4,216)	29,731				210						25,725	33
34	Rent-Facility & Grounds		(560,100)	10,320									(549,780)	34
35	Rent-Equipment & Vehicles			4,428			847						5,275	35
36	Other (specify):*	(52,593)	52,593											36
37	TOTAL Ownership	(2,697)	(8,540)	16,947			1,361						7,071	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(268)							(268)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(110,639)											(110,639)	43
44	TOTAL Special Cost Centers	(110,639)				(268)							(110,907)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(326,607)	(2,241)	63,206	(237,397)	(268)	(28,364)	5,274					(526,397)	45

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	Rent	$ 560,100	Sterling Building LLC		$	$ (560,100)	1
2	V	30	Depreciation		Sterling Building LLC		168,030	168,030	2
3	V	19	Professional Fees		Sterling Building LLC		2,649	2,649	3
4	V	21	Bank Charges		Sterling Building LLC		1,379	1,379	4
5	V	36	Amortization		Sterling Building LLC		52,593	52,593	5
6	V	32	Interest Expense		Sterling Building LLC		301,206	301,206	6
7	V	19	Accounting Fees		Sterling Building LLC		3,813	3,813	7
8	V	19	Legal Fees		Sterling Building LLC		2,583	2,583	8
9	V	21	Taxes - Franchise		Sterling Building LLC		75	75	9
10	V	33	Taxes-Real Estate		Sterling Building LLC		29,731	29,731	10
11	V	21	Misc Income	4,200	Sterling Building LLC			(4,200)	11
12	V								12
13	V								13
14	Total			$ 564,300			$ 562,059	$ * (2,241)	14

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 659	$ 659	15
16	V	5	UTILITIES		DAMEN HEALTHCARE GROUP, LLC		707	707	16
17	V	6	MAINTENANCE SALARY		DAMEN HEALTHCARE GROUP, LLC		7,191	7,191	17
18	V	6	MAINTENANCE	13,771	DAMEN HEALTHCARE GROUP, LLC		988	(12,783)	18
19	V	7	MAINTENANCE BENEFITS		DAMEN HEALTHCARE GROUP, LLC		1,268	1,268	19
20	V	10	NURSING	75,312	DAMEN HEALTHCARE GROUP, LLC		44,421	(30,891)	20
21	V	15	NURSING BENEFITS		DAMEN HEALTHCARE GROUP, LLC		7,834	7,834	21
22	V	17	ADMINISTRATIVE SALARY		DAMEN HEALTHCARE GROUP, LLC		14,819	14,819	22
23	V	19	PROFESSIONAL FEES		DAMEN HEALTHCARE GROUP, LLC		803	803	23
24	V	20	DUES FEES, SUBSCRIPTIONS		DAMEN HEALTHCARE GROUP, LLC		153	153	24
25	V	21	OFFICE EXPENSE - SALARIES		DAMEN HEALTHCARE GROUP, LLC		75,929	75,929	25
26	V	21	OFFICE EXPENSE - OTHER	44,895	DAMEN HEALTHCARE GROUP, LLC		7,461	(37,434)	26
27	V	24	SEMINARS AND EDUCATION		DAMEN HEALTHCARE GROUP, LLC		33	33	27
28	V	25	AUTO EXPENSE		DAMEN HEALTHCARE GROUP, LLC		938	938	28
29	V	26	INSURANCE		DAMEN HEALTHCARE GROUP, LLC		1,031	1,031	29
30	V	27	EMPLOYEE BEN. GEN ADMIN.		DAMEN HEALTHCARE GROUP, LLC		16,003	16,003	30
31	V	30	DEPRECIATION		DAMEN HEALTHCARE GROUP, LLC		1,766	1,766	31
32	V	32	INTEREST EXPENSE		DAMEN HEALTHCARE GROUP, LLC		433	433	32
33	V	34	RENT		DAMEN HEALTHCARE GROUP, LLC		10,320	10,320	33
34	V	35	EQUIPMENT RENTAL		DAMEN HEALTHCARE GROUP, LLC		298	298	34
35	V	35	AUTO LEASE		DAMEN HEALTHCARE GROUP, LLC		4,130	4,130	35
36	V								36
37	V								37
38	V								38
39	Total			$ 133,978			$ 197,184	$ * 63,206	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$ 282,597	JK MANAGEMENT GROUP, LLC		$	$ (282,597)	15
16	V	17	MGMT FEES - J. AARON				22,188	22,188	16
17	V	17	MGMT FEES - KEN RIPSTEIN				23,012	23,012	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			$ 282,597			$ 45,200	$ * (237,397)	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$ 2,820	Integra Healthcare Equipment		$ 2,552	$ (268)	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			$ 2,820			$ 2,552	$ * (268)	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.		$ 67	$ 67	15
16	V	6	REPAIRS & MAINT. - SALARIES		DYNAMIC HEALTH CARE CONS.		204	204	16
17	V	6	REPAIRS & MAINT. - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.		318	318	17
18	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.		14	14	18
19	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		39	39	19
20	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		242	242	20
21	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTH CARE CONS.		4,468	4,468	21
22	V	21	CLERICAL & GENERAL - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.		1,796	1,796	22
23	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		23	23	23
24	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.		231	231	24
25	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.		271	271	25
26	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		997	997	26
27	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.		189	189	27
28	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.		116	116	28
29	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		210	210	29
30	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.		17	17	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.		812	812	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		35	35	32
33	V								33
34	V	19	HOME OFFICE	38,411	DYNAMIC HEALTH CARE CONS.			(38,411)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,411			$ 10,047	$ * (28,364)	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.		873	$ 873	15
16	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.		1,902	1,902	16
17	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.		1,566	1,566	17
18	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.		234	234	18
19	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.		517	517	19
20	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.		181	181	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			$			$ 5,274	$ * 5,274	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$ 138,733	Biltmore Incorporated Cell		$ 138,733	$	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			$ 138,733			$ 138,733	$ *	39

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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	36.10%	AMBERWOOD CARE CENTER	ROCKFORD, IL				1
2	Kenneth Ripstein	36.10%	WARREN PARK HEALTH AND LIVING CENTER	CHICAGO, IL	JK MANAGEMENT GROUP LLC	MORTON GROVE, IL	MANAGEMENT COMPANY	2
3	Stern Family Investment Trust u/a/d June 11, 2015	4.95%	CITADEL CARE CENTER-KANKAKEE	KANKAKEE, IL	DAMEN HEALTHCARE GROUP,	MORTON GROVE, IL	BOOKKEEPING	3
4	Raphaela Stern	4.95%	CITADEL CARE CENTER-ELGIN	ELGIN, IL	MISTY MEADOWS		ASSISTED LIVING	4
5	Fred Aaron	4.95%	CITADEL CARE CENTER-WILMETTE	WILMETTE, IL	PHARMORE DRUGS	SKOKIE	PHARMACY	5
6	Adina Aaron	4.95%	CITADEL ESTATES-HAZEL CREST	HAZEL CREST, IL	LIFELINE AMBULANCE	CHICAGO	AMBULANCE	6
7	Lisa Trudeau	3.33%	PA PETERSON AT THE CITADEL	ROCKFORD, IL	LIFESCAN LABORATORY, INC	SKOKIE	LABORATORY CO	7
8	Marcella Graf	3.33%	CITADEL OF NORTHBROOK	NORTHBROOK, IL	INTEGRA HEALTHCARE EQUIP	ELMHURST	DME	8
9	Yakov Kohen	1.34%	THE WATERFORD CARE CENTER	CHICAGO, IL	BILTMORE INCORPORATED CE	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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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	36.10%	See Attached	3.63	9.08%	Alloc. Mgmt Fe	$ 22,188	17-7	1
2	Kenneth Ripstein	Owner	Administrative	36.10%	See Attached	3.68	9.20%	Alloc. Mgmt Fee	23,012	17-7	2
3	Yakov Kohen	Owner	Clerical	1.34%	See Attached	3.11	7.77%	Alloc. Salary	9,433	21-7	3
4	Lisa Trudeau	Owner	Nursing	3.33%	See Attached	3.11	7.77%	Alloc. Salary	15,197	10-7	4
5	Marcella Graf	Owner	Administrative	3.33%	See Attached	3.11	7.77%	Alloc. Salary	14,819	17-7	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	$ 84,649		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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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	$	24,193	$ 659	1
2	5	UTILITIES	PATIENT DAYS	311,334	11	9,092		24,193	707	2
3	6	MAINTENANCE SALARY	PATIENT DAYS	311,334	11	92,539	92,539	24,193	7,191	3
4	6	MAINTENANCE	PATIENT DAYS	311,334	11	12,710		24,193	988	4
5	7	MAINTENANCE BENEFITS	PATIENT DAYS	311,334	11	16,319		24,193	1,268	5
6	10	NURSING	PATIENT DAYS	311,334	11	571,645	571,645	24,193	44,421	6
7	15	NURSING BENEFITS	PATIENT DAYS	311,334	11	100,808		24,193	7,834	7
8	17	ADMINISTRATIVE SALARY	PATIENT DAYS	311,334	11	190,702	190,702	24,193	14,819	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	311,334	11	10,332		24,193	803	9
10	20	DUES FEES, SUBSCRIPTIONS	PATIENT DAYS	311,334	11	1,963		24,193	153	10
11	21	OFFICE EXPENSE - SALARIES	PATIENT DAYS	311,334	11	977,110	977,110	24,193	75,929	11
12	21	OFFICE EXPENSE - OTHER	PATIENT DAYS	311,334	11	96,009		24,193	7,461	12
13	24	SEMINARS AND EDUCATION	PATIENT DAYS	311,334	11	425		24,193	33	13
14	25	AUTO EXPENSE	PATIENT DAYS	311,334	11	12,076		24,193	938	14
15	26	INSURANCE	PATIENT DAYS	311,334	11	13,262		24,193	1,031	15
16	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	311,334	11	205,941		24,193	16,003	16
17	30	DEPRECIATION	PATIENT DAYS	311,334	11	22,724		24,193	1,766	17
18	32	INTEREST EXPENSE	PATIENT DAYS	311,334	11	5,571		24,193	433	18
19	34	RENT	PATIENT DAYS	311,334	11	132,802		24,193	10,320	19
20	35	EQUIPMENT RENTAL	PATIENT DAYS	311,334	11	3,837		24,193	298	20
21	35	AUTO LEASE	PATIENT DAYS	311,334	11	53,145		24,193	4,130	21
22										22
23										23
24										24
25	TOTALS					$ 2,537,492	$ 1,831,996		$ 197,184	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$	24,193	$ 22,188	1
2	17	MGMT FEES - KEN RIPSTEIN	PATIENT DAYS	262,826	9	250,000		24,193	23,012	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	$		$ 45,200	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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			$	$		$ 2,552	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					$	$		$ 2,552	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	5	UTILITIES	DIRECT ALLOCATION			$	$		$ 67	1
2	6	REPAIRS & MAINT. - SALARIES	DIRECT ALLOCATION						204	2
3	6	REPAIRS & MAINT. - OTHER E	DIRECT ALLOCATION						318	3
4	7	EMP. BEN-GEN SERV.	DIRECT ALLOCATION						14	4
5	19	PROFESSIONAL FEES	DIRECT ALLOCATION						39	5
6	20	DUES AND SUBSCRIPTIONS	DIRECT ALLOCATION						242	6
7	21	CLERICAL & GENERAL - SALA	DIRECT ALLOCATION						4,468	7
8	21	CLERICAL & GENERAL - OTHI	DIRECT ALLOCATION						1,796	8
9	24	SEMINARS AND TRAVEL	DIRECT ALLOCATION						23	9
10	25	AUTO EXP.	DIRECT ALLOCATION						231	10
11	26	INSURANCE	DIRECT ALLOCATION						271	11
12	27	EMP.BEN. - GEN. ADMIN.	DIRECT ALLOCATION						997	12
13	30	DEPRECIATION	DIRECT ALLOCATION						189	13
14	32	INTEREST	DIRECT ALLOCATION						116	14
15	33	REAL ESTATE TAXES	DIRECT ALLOCATION						210	15
16	19	REAL ESTATE TAX PROTEST F	DIRECT ALLOCATION						17	16
17	35	AUTO RENTAL	DIRECT ALLOCATION						812	17
18	35	EQUIPMENT RENTAL	DIRECT ALLOCATION						35	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 10,047	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	ADMIN. CMP. - V. DAVIS (NON-	DIRECT ALLOCATION			$	$		$ 873	1
2	17	ADMIN. CMP. - VAR. (NON-OWI	DIRECT ALLOCATION						1,902	2
3	17	ADMIN. CMP. - CFO (NON-OWN	DIRECT ALLOCATION						1,566	3
4	27	EMP. BEN.-V. DAVIS (NON-OWI	DIRECT ALLOCATION						234	4
5	27	EMP. BEN.- NON-OWNER	DIRECT ALLOCATION						517	5
6	27	EMP. BEN.- CFO (NON-OWNER	DIRECT ALLOCATION						181	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					$	$		$ 5,274	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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			$	$		$ 138,733	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					$	$		$ 138,733	25

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 Payable			$	$ 5,725,911			$ 301,206	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit				440,000			25,542	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,165,911			$ 326,748	9
	B. Non-Facility Related*											
10	Interest Income										(792)	10
11	Allocated From Damen Healthcare										433	11
12	Allocated from Dynamic HC										116	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (243)	14
15	TOTALS (line 9+line14)						$	$ 6,165,911			$ 326,505	15

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

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

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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.**	$	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.)		$ 28,308	2
3. Under or (over) accrual (line 2 minus line 1).		$ 28,308	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 28,308	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	27,856	8
	2014	28,393	9
	2015	29,963	10
	2016	29,885	11
	2017	28,098	12

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

Allocated from Dynamic HC $210

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 OF STERLING THE COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0054882

CONTACT PERSON REGARDING THIS REPORT

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

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-402-001	Long Term Care Property	$ 28,097.84	$ 28,097.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,097.84	$ 28,097.84

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CITADEL OF STERLING THE COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0054882

CONTACT PERSON REGARDING THIS REPORT

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

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) 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 OF STERLING THE # 0054882 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,000 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories 1

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			$ 48,888	1
2	Sterling Building			100,000	2
3	TOTALS			$ 148,888	3

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	121			1974	$ 6,052,408	$ 168,030	35	$ 172,926	$ 4,896	$ 3,979,621	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	18,723		20			18,721	9
10	Various			1994	6,356		20			6,356	10
11	Various			1995	13,538		20			13,536	11
12	Various			1996	33,635		20			33,627	12
13	Various			1997	33,822		20			33,178	13
14	Various			1998	35,361		20	(487)	(487)	34,741	14
15	Various			1999	47,068		20	2,319	2,319	46,695	15
16	Various			2000	11,922		20	596	596	10,956	16
17	Various			2001	21,256		20	1,063	1,063	18,670	17
18	Various			2002	95,605		20			95,605	18
19	Various			2003	29,333		20			29,333	19
20	Various			2004	53,564		20			53,564	20
21	Various			2005	27,344		20	241	241	25,930	21
22	Various			2006	19,001		20			19,001	22
23	Various			2007	20,058		20	412	412	16,605	23
24	Various			2008	27,237		20	833	833	27,237	24
25	Various			2009	29,407		20	754	754	6,834	25
26	Various			2010	5,936		20	152	152	1,319	26
27	Various			2011	18,507		20	791	791	5,684	27
28	Various			2012	339,689		20	16,984	16,984	103,322	28
29	Various			2013	223,201		20	11,613	11,613	82,016	29
30	Various			2014	73,826		20	4,497	4,497	20,657	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 OF STERLING THE # 0054882 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)		21,893	892		892		3,179	68
69	Financial Statement Depreciation			20,683			(20,683)		69
70	TOTAL (lines 4 thru 69)		$ 7,258,690	$ 189,605		$ 213,586	$ 23,980	$ 4,686,387	70

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 7,258,690	$ 189,605		$ 213,586	$ 23,980	$ 4,686,387	1
2	Kitchen Remodel Work	2015			20				2
3	Kitchen Remodel Work	2015			20				3
4	Plumbing And Mechanical	2015			20				4
5	Plumbing Work / Remodeling	2015	5,222		20	261	261	1,023	5
6	Plumbing And Mechanical	2015			20				6
7	Plumbing And Mechanical	2015			20				7
8	Plumbing And Mechanical	2015			20				8
9	Plumbing And Mechanical	2015			20				9
10	Security	2015			20				10
11	Kitchen Remodel Work	2015			20				11
12	Remodeling - Tile & Brickwork In Kitchen	2015	5,987		20	299	299	1,148	12
13	Cameras	2015	4,255		20	213	213	816	13
14	Cameras	2015			20				14
15	Glass Work In Therapyroom	2015			20				15
16	Bathroom Remodel-Pipe Cover, Shower Rom Toilet Flange	2015	3,721		20	186	186	713	16
17	Security	2015			20				17
18	Wall Covering	2015			20				18
19	Bathroom - Install Sink/Faucet, Floor, Lighting Work	2015	7,253		20	363	363	1,299	19
20	Heat Pump	2015			20				20
21	Flooring	2015			20				21
22	Security System	2015			20				22
23	Security System	2016			20				23
24	Insulation In Thermos	2016			20				24
25	Roofing Work	2016			20				25
26	Roofing Work	2016			20				26
27	Roofing Work	2016			20				27
28	Door	2016			20				28
29	Boiler - Installed Pump 115V Inline Br 2-1/2" Kit	2016	2,878		20	82	82	212	29
30	Security System	2016			20				30
31	Security System	2016			20				31
32	Video Monitor System	2016	3,227		20	645	645	1,775	32
33	Install New Wall Flashing	2016	3,002		20	150	150	413	33
34	TOTAL (lines 1 thru 33)		$ 7,294,235	$ 189,605		$ 215,785	$ 26,180	$ 4,693,785	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 7,294,235	$ 189,605		$ 215,785	$ 26,180	$ 4,693,785	1
2	Install New Door Holders For Security System	2016	2,990		20	150	150	374	2
3	6" Sewer Pipe - Install Cipp Liner To Fix Hole	2017	4,490		20	225	225	281	3
4	Harder Signs-Supply And Install Replacement Sign	2018	2,580		20	430	430	430	4
5	Facility Courtyard - Concrete Replacement	2018	18,400		20	1,227	1,227	1,227	5
6	Courtyard/Front Door/ Flag Pole Improvements	2018	20,034		20	1,336	1,336	1,336	6
7	Remove & Replace Facility A/C	2018	7,720		20	450	450	450	7
8	Geostar Mechanical- Install New Water Heater	2018	20,770		20	1,038	1,038	1,038	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)		$ 7,371,219	$ 189,605		$ 220,640	$ 31,035	$ 4,698,921	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 7,371,219	$ 189,605		$ 220,640	$ 31,035	$ 4,698,921	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)		$ 7,371,219	$ 189,605		$ 220,640	$ 31,035	$ 4,698,921	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 7,371,219	$ 189,605		$ 220,640	$ 31,035	$ 4,698,921	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)		$ 7,371,219	$ 189,605		$ 220,640	$ 31,035	$ 4,698,921	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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 OF STERLING THE # 0054882 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	21,893	892	20	892		3,179	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)		$ 21,893	$ 892		$ 892	$	$ 3,179	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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		$ 21,893	$ 892		$ 892	$	$ 3,179	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)		$ 21,893	$ 892		$ 892	$	$ 3,179	34

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

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$ 318,043	$ 873	$ 27,902	$ 27,028	10	$ 272,971	71
72	Current Year Purchases	3,089		309	309	10	309	72
73	Fully Depreciated Assets	902,325				10	902,325	73
74								74
75	TOTALS	$ 1,223,457	$ 873	$ 28,211	$ 27,337		$ 1,175,605	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		BUS	2000	$ 45,441	$	$	$	5	$ 45,441	76
77		BRUN WHEEL CHAIR LIFT INS	2008	4,985				5	4,985	77
78										78
79										79
80	TOTALS			$ 50,426	$	$	$		$ 50,426	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)	$ 8,793,990	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,479	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 248,851	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 58,372	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,924,951	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 OF STERLING THE # 0054882 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				10,320			5
6								6
7	TOTAL				$ 10,320 **			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: $ 19,711 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		$ 1,147.33	$ 13,768	17
18	Facility			1,319	18
19	Allocated from Damen Healthcare			4,130	19
20	Allocated from Dynamic HC			812	20
21	TOTAL		$ 1,147.33	$ 20,029	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 OF STERLING THE # 0054882 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	$		$ 279,834	$		$ 279,834	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			19,309			19,309	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			359,243			359,243	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				170,801		170,801	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					28,796	1,036		29,832	13
14	TOTAL			$		$ 687,182	$ 171,837		$ 859,019	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.

STATE OF ILLINOIS

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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	$ 122,178	$ 221,221	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	739,283	739,283	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,612	24,612	6
7	Other Prepaid Expenses	1,800	1,800	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	8,666	24,802	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 896,539	$ 1,011,718	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		104,235	13
14	Buildings, at Historical Cost		5,991,902	14
15	Leasehold Improvements, at Historical Cost	66,924	66,924	15
16	Equipment, at Historical Cost	11,413	374,413	16
17	Accumulated Depreciation (book methods)	(6,183)	(4,253,027)	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	29,384	1,948,947	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 101,538	$ 4,233,394	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 998,077	$ 5,245,112	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 575,854	$ 1,025,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	440,000	440,000	29
30	Accrued Salaries Payable	148,188	148,188	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,161	6,161	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,378	2,378	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	143	143	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,172,724	$ 1,622,724	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,725,911	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,725,911	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,172,724	$ 7,348,635	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (174,647)	$ (2,103,523)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 998,077	$ 5,245,112	48

*(See instructions.)

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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**	$ 35,256	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 35,256	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(209,903)	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)**	$ (209,903)	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)**	$ (174,647)	24 *

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

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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	$ 6,113,152	1
2	Discounts and Allowances for all Levels	(2,106,717)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,006,435	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,026,254	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,026,254	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	180,441	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,082	19
20	Radiology and X-Ray	2,236	20
21	Other Medical Services	2,262	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 199,021	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	792	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 792	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	6,999	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,999	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,239,501	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,048,942	31
32	Health Care	2,088,506	32
33	General Administration	1,514,014	33
	B. Capital Expense		
34	Ownership	646,652	34
	C. Ancillary Expense		
35	Special Cost Centers	969,658	35
36	Provider Participation Fee	181,632	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,449,404	40
41	**Income before Income Taxes (line 30 minus line 40)****	(209,903)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (209,903)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,186,352	44
45	Private Pay - Net Inpatient Revenue	917,661	45
46	Medicare - Net Inpatient Revenue	282,675	46
47	Other-(specify) Managed Care	567,011	47
48	Other-(specify) Hospice / Insurance	52,736	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,006,435	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.**

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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	2,006	2,229	$ 73,588	$ 33.01	1
2	Assistant Director of Nursing	1,924	2,137	59,965	28.06	2
3	Registered Nurses	7,253	8,059	213,313	26.47	3
4	Licensed Practical Nurses	19,359	21,510	496,891	23.10	4
5	CNAs & Orderlies	48,333	53,703	786,209	14.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	509	597	10,061	16.85	8
9	Activity Director	1,919	2,133	32,290	15.14	9
10	Activity Assistants	6,549	7,278	79,181	10.88	10
11	Social Service Workers	4,937	5,486	85,849	15.65	11
12	Dietician					12
13	Food Service Supervisor	1,955	2,171	35,438	16.32	13
14	Head Cook	4,630	5,144	60,858	11.83	14
15	Cook Helpers/Assistants	12,013	13,348	150,695	11.29	15
16	Dishwashers					16
17	Maintenance Workers	5,530	6,145	88,740	14.44	17
18	Housekeepers	10,570	11,744	132,243	11.26	18
19	Laundry	6,032	6,702	76,402	11.40	19
20	Administrator	2,011	2,235	86,325	38.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,937	3,263	69,016	21.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,149	1,277	17,311	13.56	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	1,448	1,609	45,049	28.00	33
34	TOTAL (lines 1 - 33)	141,064	156,770	$ 2,599,424 *	$ 16.58	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	$ 12,167	01-03	35
36	Medical Director	Monthly	26,300	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,071	10-03	38
39	Pharmacist Consultant	Monthly	9,182	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	Monthly	704	11-03	44
45	Social Service Consultant	Monthly	2,814	12-03	45
46	Other(specify) Psychiatric	Monthly	4,052	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 58,290		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Logan	Administrator	0	$ 86,325
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,325

B. Administrative - Other

Description	Amount
Management Fees - JK Management	$ 282,597
TOTAL (agree to Schedule V, line 17, col. 3)	$ 282,597
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fees	$ 3,249
See Schedule	Legal Fees	37,170
ProPay HR	Payroll Service Fees	20,048
Rhonda Reed	Other Professional Fees	1,000
Personnel Planners, Inc.	Unemployment Consulting	852
MTS Consulting	Tax Consulting Services	928
Achieve Accreditation, LLC.	Accreditation Services	936
Telemedicine Solutions LLC	Data Processing	5,236
Prime Care Technologies	Data Processing	1,295
IIT/Source Tech	Data Processing	2,266
Point Click Care Tech, Inc	Data Processing	48,723
See Supplemental Schedule		49,842
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 171,545

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,521
Unemployment Compensation Insurance	50,937
FICA Taxes	190,338
Employee Health Insurance	123,797
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	1,943
Holiday Expense	818
401K Expense	1,723
Vision/Dental Insurance	2,774
Supplemental Insurance-Life	3,975
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,826

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,086
Health Care Worker Background Check	
(Indicate # of checks performed 15)	1,489
Patient Background Checks 17	1,696
Dues & Subscriptions	7,567
License and Fees	4,680
Allocated from Damen Healthcare	153
Allocated from Dynamic HC	242
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,903

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,297
Allocated from Damen Healthcare	33
Allocated from Dynamic HC	23
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,353

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CITADEL OF STERLING THE # 0054882 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. **HCCI $11513**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **343** 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. $ **181,632**
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? **No** Indicate the amount. $ **N/A**

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

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

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

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