

		FOR BHF USE					

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0054494</u></p> <p><b>Facility Name:</b> <u>Stonebridge Nursing and Rehab Center</u></p> <p><b>Address:</b> <u>902 S Mcleansboro St</u> <u>Benton</u> <u>62812</u>          Number City Zip Code</p> <p><b>County:</b> <u>Franklin</u></p> <p><b>Telephone Number:</b> <u>(618) 439-4501</u> <b>Fax #</b> <u>(618) 435-3141</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>3/1/2017</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>(630) 361-2868</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name &amp; Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( ) _____</td> </tr> </table> <p align="right"><b>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</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Print Name and Title) <u>Larry Templin Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>(630) 361-2868</u> Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing and Rehab Center

# 0054494 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	15	Skilled (SNF)	15	5,475	1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,790	2,790	8
9	SNF/PED					9
10	ICF	10,165	4,770		14,935	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,165	4,770	2,790	17,725	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.70%

D. How many bed reserve days during this year were paid by the Department? 0 (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  Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?  
Date started 3/1/17

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/1/17 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 15 and days of care provided 2,457

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing and Rehab Center # 0054494 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	128,768	11,084	5,934	145,786		145,786		145,786		1
2	Food Purchase		105,286		105,286		105,286		105,286		2
3	Housekeeping	116,713	10,244		126,957		126,957	667	127,624		3
4	Laundry	47,915	6,581		54,496		54,496		54,496		4
5	Heat and Other Utilities			74,053	74,053		74,053	228	74,281		5
6	Maintenance	32,057	11,707	51,634	95,398		95,398	(1,258)	94,140		6
7	Other (specify):* <b>Waste Removal</b>			6,563	6,563		6,563	59	6,622		7
8	<b>TOTAL General Services</b>	325,453	144,902	138,184	608,539		608,539	(304)	608,235		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	938,980	41,510	2,400	982,890		982,890		982,890		10
10a	Therapy			3,229	3,229		3,229		3,229		10a
11	Activities	15,139	1,020	3,449	19,608		19,608		19,608		11
12	Social Services	22,524	14	1,041	23,579		23,579		23,579		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	976,643	42,544	16,119	1,035,306		1,035,306		1,035,306		16
	<b>C. General Administration</b>										
17	Administrative	73,376		174,443	247,819		247,819	(155,960)	91,859		17
18	Directors Fees										18
19	Professional Services			40,057	40,057		40,057	959	41,016		19
20	Dues, Fees, Subscriptions & Promotions			14,962	14,962		14,962	(1,683)	13,279		20
21	Clerical & General Office Expenses	30,039	12,270	9,730	52,039		52,039	53,469	105,508		21
22	Employee Benefits & Payroll Taxes			171,184	171,184		171,184		171,184		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,604	1,604		1,604	11	1,615		24
25	Other Admin. Staff Transportation			6,036	6,036		6,036	641	6,677		25
26	Insurance-Prop.Liab.Malpractice			39,481	39,481		39,481	174	39,655		26
27	Other (specify):* <b>WLC Benefits Alloc</b>							6,265	6,265		27
28	<b>TOTAL General Administration</b>	103,415	12,270	457,497	573,182		573,182	(96,124)	477,058		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,405,511	199,716	611,800	2,217,027		2,217,027	(96,428)	2,120,599		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Stonebridge Nursing and Rehab Center

#0054494

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,095	9,095		9,095	(4,049)	5,046			30
31	Amortization of Pre-Op. & Org.							299	299			31
32	Interest			19,190	19,190		19,190	447	19,637			32
33	Real Estate Taxes			8,626	8,626		8,626	433	9,059			33
34	Rent-Facility & Grounds			402,602	402,602		402,602	809	403,411			34
35	Rent-Equipment & Vehicles			3,319	3,319		3,319		3,319			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			442,832	442,832		442,832	(2,061)	440,771			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,851	392,627	471,478		471,478		471,478			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,034	132,034		132,034		132,034			42
43	Other (specify):* <b>Disallowed Costs</b>			108,788	108,788		108,788	(108,788)				43
44	<b>TOTAL Special Cost Centers</b>		78,851	633,449	712,300		712,300	(108,788)	603,512			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,405,511	278,567	1,688,081	3,372,159		3,372,159	(207,277)	3,164,882			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(3,597)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,691)	30		9
10	Interest and Other Investment Income	(49)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	43		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	(1,683)	20		17
18	Fines and Penalties	(14)	33		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(85,014)	43		24
25	Fund Raising, Advertising and Promotional	(19,227)	43		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 See Page 5A	(2,315)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (120,087)		\$	30

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

		1	2	
		Amount	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)	(87,190)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (87,190)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (207,277)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Stonebridge Nursing and Rehab Center

ID# 0054494

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Gifts	\$ (453)	43	1
2	Miscellaneous income offset	(159)	21	2
3	Reclassify Installment for Sprinkler System	(1,703)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(2,315)		49

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
Scott Stout	100	Carrier Mills Nursing & Rehab Center	Carrier Mills	WLC Management Fir	Harrisburg	Management Co.
		DuQuoin Nursing and Rehab Center	DuQuoin			
		Eldorado Rehab and Healthcare	Eldorado			
		Greenville Nursing and Rehab Center	Greenville			
		Pinckneyville Nursing & Rehab Center	Pinckneyville			
		Saline Care Nursing and Rehab Center	Harrisburg			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Housekeeping	\$	WLC Management Firm, LLC	100.00%	\$ 667	\$	667	1
2	V	5 Utilities		WLC Management Firm, LLC	100.00%	228		228	2
3	V	6 Maintenance		WLC Management Firm, LLC	100.00%	445		445	3
4	V	7 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	59		59	4
5	V	17 Administrative	174,443	WLC Management Firm, LLC	100.00%	18,483		(155,960)	5
6	V	19 Professional Services		WLC Management Firm, LLC	100.00%	959		959	6
7	V	21 Clerical & General Office		WLC Management Firm, LLC	100.00%	53,628		53,628	7
8	V	24 Travel & Seminar		WLC Management Firm, LLC	100.00%	11		11	8
9	V	25 Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	641		641	9
10	V	26 Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	174		174	10
11	V	27 Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	6,265		6,265	11
12	V	30 Depreciation		WLC Management Firm, LLC	100.00%	3,642		3,642	12
13	V	31 Amortization-Pre Org Costs		WLC Management Firm, LLC	100.00%	299		299	13
14	Total		\$ 174,443			\$ 85,501	\$ *	(88,942)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	32 Interest	\$	WLC Management Firm, LLC	100.00%	\$ 496	\$	496	15
16	V	33 Real Estate Taxes		WLC Management Firm, LLC	100.00%	447		447	16
17	V	34 Rent-Facility & Grounds		WLC Management Firm, LLC	100.00%	809		809	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		\$			\$ 1,752	\$ *	1,752	39

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

SEE ACCOUNTANTS' PREPARATION REPORT



Facility Name & ID Number Stonebridge Nursing and Rehab Center # 0054494 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	4	10.00	Alloc. Salary	\$ 18,483	L17, C7	1	
2											2	
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											9
10	anticipated to be considered allowable by the IL. Dept. of HFS.											10
11											11	
12											12	
13								TOTAL	\$ 18,483		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing and Rehab Center

# 0054494

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

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 WLC Management Firm, LLC  
 Street Address 215 East Locust Street  
 City / State / Zip Code Harrisburg, IL 62946  
 Phone Number ( 618 ) 294-8696  
 Fax Number ( 618 ) 294-8699

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	3	Housekeeping	Census	177,417	7	\$ 6,679	\$ 6,679	17,725	\$ 667	1
2	5	Utilities	Census	177,417	7	2,280		17,725	228	2
3	6	Maintenance	Census	177,417	7	4,451		17,725	445	3
4	7	Mgmt Allocation of Benefits	Census	177,417	7	593		17,725	59	4
5	17	Administrative	Census	177,417	7	185,000	185,000	17,725	18,483	5
6	19	Professional Services	Census	177,417	7	9,603		17,725	959	6
7	21	Clerical & General Office	Census	177,417	7	536,784	522,122	17,725	53,628	7
8	24	Travel & Seminar	Census	177,417	7	115		17,725	11	8
9	25	Other Admin Staff Transport	Census	177,417	7	6,420		17,725	641	9
10	26	Insurance-Prop/Liab/Malprac	Census	177,417	7	1,744		17,725	174	10
11	27	Mgmt Allocation of Benefits	Census	177,417	7	62,710		17,725	6,265	11
12	30	Depreciation	Census	177,417	7	36,453		17,725	3,642	12
13	31	Amortization-Pre Org Costs	Census	177,417	7	2,991		17,725	299	13
14	32	Interest	Census	177,417	7	4,967		17,725	496	14
15	33	Real Estate Taxes	Census	177,417	7	4,478		17,725	447	15
16	34	Rent-Facility & Grounds	Census	177,417	7	8,098		17,725	809	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 873,366	\$ 713,801		\$ 87,253	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Stonebridge Nursing and Rehab Center

# 0054494

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Legence Bank		X	Line of Credit		11/16/18	439,258	439,258	11/30/19	0.0525	19,190	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 439,258	\$ 439,258			\$ 19,190	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11										Interest Income Offset	(49)	11						
12										Allocated From WLC	496	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 447	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 439,258	\$ 439,258			\$ 19,637	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A                      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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.		\$	<b>6,513</b>	<b>1</b>
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.)	2017	\$	<b>7,171</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>658</b>	<b>3</b>
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>7,751</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>650</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>9,059</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013		<b>8</b>	
	2014		<b>9</b>	
	2015		<b>10</b>	
	2016	<b>7,048</b>	<b>11</b>	
	2017	<b>7,171</b>	<b>12</b>	
<b>FOR BHF USE ONLY</b>				
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2017	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>Note: Beginning balance adjusted to actual (corrected due from prior owner)</b>				

**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.**

SEE ACCOUNTANTS' PREPARATION REPORT

## 2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Nursing and Rehab Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0054494

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

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

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>08-20-301-002</u>	<u>Long Term Care Property</u>	\$ <u>6,881.92</u>	\$ <u>6,881.92</u>
2.	<u>08-20-156-004</u>	<u>Long Term Care Property</u>	\$ <u>144.34</u>	\$ <u>144.34</u>
3.	<u>08-20-156-005</u>	<u>Long Term Care Property</u>	\$ <u>144.34</u>	\$ <u>144.34</u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>			\$ <u><u>7,170.60</u></u>	\$ <u><u>7,170.60</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,696 B. General Construction Type: Exterior Concrete & Brick Frame Concrete Block WD RI Number of Stories 1

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

1. Total Amount Incurred: 4,485 2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 299 4. Dates Incurred: 2017

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

XI. OWNERSHIP COSTS:

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: 1, 2, 3, 4, 1. Row 2: 2, 3, 4, 2. Row 3: 3 TOTALS, 4, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Sprinkler - Flush System and Replace Dry Pipe Valve		2018		21,703		20	543	543	543
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19	Financial Statement Depreciation					9,095			(9,095)	
20										20
21										21
22										22
23	Allocated from WLC Management		2018		45,065		25	902	902	902
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 66,768	\$ 9,095		\$ 1,445	\$ (7,650)	\$ 1,445	70

SEE ACCOUNTANTS' PREPARATION REPORT

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



Facility Name & ID Number Stonebridge Nursing and Rehab Center

# 0054494

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	\$ 4,500	\$	\$ 450	\$ 450	10 yrs	\$ 675	71
72	Current Year Purchases	\$ 8,215		411	411	10 yrs	411	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	557		56	56		92	74
75	TOTALS	\$ 13,272	\$	\$ 917	\$ 917		\$ 1,178	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78	Allocated from WLC Mgmt			17,928		2,684	2,684		4,514	78
79										79
80	TOTALS			\$ 17,928	\$	\$ 2,684	\$ 2,684		\$ 4,514	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)	\$ 97,968	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,095	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 5,046	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,049)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,137	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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: CTR Partnership, LP

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:	<u>1970</u>	<u>80</u>	<u>2/17/17</u>	\$ <u>402,602</u>			3
4	Additions							4
5		<u>Allocated from WLC</u>			<u>809</u>			5
6								6
7	<b>TOTAL</b>		<b>80</b>		\$ <b>403,411</b>			7

10. Effective dates of current rental agreement:

Beginning 3/1/2017

Ending 2/29/2032

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

Fiscal Year Ending                      Annual Rent

12.	<u>2/28/2019</u>	\$ <u>403,968</u>
13.	<u>2/29/2020</u>	\$ <u>417,097</u>
14.	<u>2/28/2021</u>	\$ <u>430,653</u>

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 \_\_\_\_\_.

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 3,319 Description: Medical Equipment \$2,983; Dietary Equipment \$336

(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			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	39(3)	hrs	\$	8,471	\$ 144,862				8,471	\$ 144,862					1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,401	68,720				3,401	68,720					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		8,696	151,265				8,696	151,265					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescripts							78,851					78,851	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$	20,568	\$ 364,847	\$	78,851		20,568	\$ 443,698					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.

SEE ACCOUNTANTS' PREPARATION REPORT

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2018**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 162,183	\$ 162,183	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,240 )	761,468	761,468	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,477	6,477	6
7	Other Prepaid Expenses	3,969	3,969	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 934,097	\$ 934,097	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,083	66,768	15
16	Equipment, at Historical Cost	12,715	31,200	16
17	Accumulated Depreciation (book methods)	(12,932)	(7,137)	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,866	\$ 90,831	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 935,963	\$ 1,024,928	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 93,216	\$ 93,216	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	439,258	439,258	29
30	Accrued Salaries Payable	56,220	56,220	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,755	1,755	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,751	7,751	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 598,200	\$ 598,200	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 598,200	\$ 598,200	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 337,763	\$ 426,728	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 935,963	\$ 1,024,928	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>200,263</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment-Depreciation</b>	<b>(3,837)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>196,426</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>141,337</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>141,337</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>337,763</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name &amp; ID Number Stonebridge Nursing and Rehab Center

# 0054494

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,321,719	1
2	Discounts and Allowances for all Levels	12,234	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,333,953	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	178,006	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 178,006	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	735	19
20	Radiology and X-Ray	416	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,329	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	49	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 49	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	159	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 159	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,513,496	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	608,539	31
32	Health Care	1,035,306	32
33	General Administration	573,182	33
<b>B. Capital Expense</b>			
34	Ownership	442,832	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	580,266	35
36	Provider Participation Fee	132,034	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,372,159	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	141,337	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 141,337	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,400,136	44
45	Private Pay - Net Inpatient Revenue	595,806	45
46	Medicare - Net Inpatient Revenue	1,182,861	46
47	Other-(specify) <u>Insurance</u>	155,150	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,333,953	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing and Rehab Center

# 0054494

Report Period Beginning: 1/1/2018

Ending:

12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,067	2,147	\$ 61,185	\$ 28.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,548	13,954	357,758	25.64	3
4	Licensed Practical Nurses	3,766	3,913	80,195	20.49	4
5	CNAs & Orderlies	35,517	36,727	439,842	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,319	1,436	15,139	10.54	9
10	Activity Assistants					10
11	Social Service Workers	1,690	1,730	22,524	13.02	11
12	Dietician					12
13	Food Service Supervisor	1,977	2,161	28,292	13.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,739	10,985	100,476	9.15	15
16	Dishwashers					16
17	Maintenance Workers	1,903	1,941	32,057	16.52	17
18	Housekeepers	11,543	12,144	116,713	9.61	18
19	Laundry	4,941	5,211	47,915	9.19	19
20	Administrator	2,153	2,185	73,376	33.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,037	2,053	30,039	14.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	93,200	96,587	\$ 1,405,511 *	\$ 14.55	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	121	\$ 5,934	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,237	L11, C3	44
45	Social Service Consultant	16	1,041	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	156	\$ 16,612		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT



**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Derek Johnson	Administrator	0	\$ 73,376	Workers' Compensation Insurance	\$ 29,541	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	13,443	Advertising: Employee Recruitment	1,839	
				FICA Taxes	105,228	Health Care Worker Background Check		
				Employee Health Insurance	10,596	(Indicate # of checks performed 15 )	717	
				Employee Meals	948	Patient Background Checks	1,286	
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Physicals/Drug Tests	2,472	Dues & Subscriptions	1,860	
				Life/Disability Insurance	5,727	IHCA	5,280	
				Other Employee Benefits	3,229			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,376					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 174,443					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 174,443					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sandberg Phoenix & Von Gontard	Legal		\$ 4,300	N/A			Out-of-State Travel	\$
E-Solutions, Inc.	Health Info Management		1,731					
American Healthtech	LTC Software		20,764				In-State Travel	772
Information Controls	Payroll Service		2,714					
WH Administrators, Inc	ACA Compliance Consultant		4,610				Seminar Expense	832
Templin Healthcare Accounting	Accounting Services		4,438				Allocated From WLC Mgmt Firm	11
Kemper CPA Group	Accounting Services		1,500				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 40,057	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,615

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

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. 5,280 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,417 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. \_\_\_\_\_
- (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. \$ 132,034  
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 948 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (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% Line 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? N/A
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_
- (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