		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0054494

Facility Name: Stonebridge Nursing Rehab

Address: 902 S Mcleansboro St (Number) Benton (City) 62812 (Zip Code)

County: Franklin

Telephone Number: (618) 439-4501 **Fax #** (618) 435-3141

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2017

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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/2020 to 12/31/2020 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 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	15	Skilled (SNF)	15	5,490	1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	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			4,226	4,226	8
9	SNF/PED					9
10	ICF	13,053	4,256		17,309	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,053	4,256	4,226	21,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.55%

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 [X] 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 [X]

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 [X] Date 3/1/17 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 3,935

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	159,028	7,912	5,063	172,003		172,003		172,003			1
2	Food Purchase		118,016		118,016		118,016		118,016			2
3	Housekeeping	135,477	10,814		146,291		146,291	573	146,864			3
4	Laundry	53,412	6,060		59,472		59,472		59,472			4
5	Heat and Other Utilities			60,864	60,864		60,864	613	61,477			5
6	Maintenance	35,089	14,194	32,178	81,461		81,461	(2,347)	79,114			6
7	Other (specify):* Waste Removal			12,072	12,072		12,072	66	12,138			7
8	TOTAL General Services	383,006	156,996	110,177	650,179		650,179	(1,095)	649,084			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,309,162	99,919	2,200	1,411,281		1,411,281	1,302	1,412,583			10
10a	Therapy			4,031	4,031		4,031		4,031			10a
11	Activities	17,530	1,296	2,548	21,374		21,374		21,374			11
12	Social Services	30,284		1,370	31,654		31,654		31,654			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* WLC Benefits Alloc							149	149			15
16	TOTAL Health Care and Programs	1,356,976	101,215	16,149	1,474,340		1,474,340	1,451	1,475,791			16
	C. General Administration											
17	Administrative	94,823		261,068	355,891		355,891	(238,661)	117,230			17
18	Directors Fees											18
19	Professional Services			28,775	28,775		28,775	340	29,115			19
20	Dues, Fees, Subscriptions & Promotions			15,996	15,996		15,996	(2,037)	13,959			20
21	Clerical & General Office Expenses	41,183	11,591	7,266	60,040		60,040	44,209	104,249			21
22	Employee Benefits & Payroll Taxes			259,250	259,250		259,250		259,250			22
23	Inservice Training & Education											23
24	Travel and Seminar			811	811		811	16	827			24
25	Other Admin. Staff Transportation			7,235	7,235		7,235	852	8,087			25
26	Insurance-Prop.Liab.Malpractice			91,773	91,773		91,773	799	92,572			26
27	Other (specify):* WLC Benefits Alloc							7,583	7,583			27
28	TOTAL General Administration	136,006	11,591	672,174	819,771		819,771	(186,899)	632,872			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,875,988	269,802	798,500	2,944,290		2,944,290	(186,543)	2,757,747			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 Rehab #0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			79,233	79,233		79,233	(65,846)	13,387			30
31	Amortization of Pre-Op. & Org.							277	277			31
32	Interest			1,318	1,318		1,318	(62)	1,256			32
33	Real Estate Taxes			7,168	7,168		7,168	447	7,615			33
34	Rent-Facility & Grounds			420,308	420,308		420,308		420,308			34
35	Rent-Equipment & Vehicles			14,781	14,781		14,781	58	14,839			35
36	Other (specify):*											36
37	**TOTAL Ownership**			522,808	522,808		522,808	(65,126)	457,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,590	1,590		1,590		1,590			38
39	Ancillary Service Centers		87,936	357,246	445,182		445,182		445,182			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,914	153,914		153,914		153,914			42
43	Other (specify):* **Disallowed Costs**			67,141	67,141		67,141	(67,141)				43
44	**TOTAL Special Cost Centers**		87,936	579,891	667,827		667,827	(67,141)	600,686			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,875,988	357,738	1,901,199	4,134,925		4,134,925	(318,810)	3,816,115			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

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(3,819)	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	(80,791)	30		9
10	Interest and Other Investment Income	(122)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(401)	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	(2,365)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(94)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,959)	43		24
25	Fund Raising, Advertising and Promotional	(20,612)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,211)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(4,545)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,919)		$	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)	(163,891)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (163,891)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (318,810)		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.		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	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Stonebridge Nursing Rehab

ID# 0054494

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (139)	43	1
2	Miscellaneous income offset	(631)	21	2
3	Capitalize Improvements over $2,500	(3,775)	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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18				18
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28				28
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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**	(4,545)		49

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	See Page 6 Supp		WLC Management Fir	Harrisburg	Management Co.

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	3	Housekeeping	$	WLC Management Firm, LLC	100.00%	$ 573	$ 573	1
2	V	5	Utilities		WLC Management Firm, LLC	100.00%	613	613	2
3	V	6	Maintenance		WLC Management Firm, LLC	100.00%	1,428	1,428	3
4	V	7	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	66	66	4
5	V	10	Nursing and Medical Records		WLC Management Firm, LLC	100.00%	1,302	1,302	5
6	V	15	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	149	149	6
7	V	17	Administrative	261,068	WLC Management Firm, LLC	100.00%	22,407	(238,661)	7
8	V	19	Professional Services		WLC Management Firm, LLC	100.00%	434	434	8
9	V	20	Dues, Fees, Subs & Prom		WLC Management Firm, LLC	100.00%	328	328	9
10	V	21	Clerical & General Office		WLC Management Firm, LLC	100.00%	44,840	44,840	10
11	V	24	Travel & Seminar		WLC Management Firm, LLC	100.00%	16	16	11
12	V	25	Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	852	852	12
13	V	26	Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	799	799	13
14	Total			$ 261,068			$ 73,807	$ * (187,261)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	27	Mgmt Allocation of Benefits	$	WLC Management Firm, LLC	100.00%	$ 7,583	$ 7,583	15
16	V	30	Depreciation		WLC Management Firm, LLC	100.00%	14,945	14,945	16
17	V	31	Amortization		WLC Management Firm, LLC	100.00%	277	277	17
18	V	32	Interest		WLC Management Firm, LLC	100.00%	60	60	18
19	V	33	Real Estate Taxes		WLC Management Firm, LLC	100.00%	447	447	19
20	V	35	Equipment Rental		WLC Management Firm, LLC	100.00%	58	58	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			$			$ 23,370	$ * 23,370	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			Alhambra Rehab and Healthcare	Alhambra	Acorn Estates	Mount Carmel	Supportive Living	1
2			Carrier Mills Nursing & Rehab Center	Carrier Mills				2
3			Duquoin Nursing & Rehablitation Center	Duquoin				3
4			Eldorado Rehab and Healthcare	Eldorado				4
5			Fairview Rehab and Healthcare	DuQuoin				5
6			Greenville Nursing and Rehab Center	Greenville				6
7			Heartland Nursing and Rehab	Casey				7
8			Oakview Nursing and Rehab	Mt Carmel				8
9			Pinckneyville Nursing & Rehab Center	Pinckneyville				9
10			Saline Care Nursing and Rehab Center	Harrisburg				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	3.55	8.86	Alloc. Salary	$ 22,407	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,407		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 Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: 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 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	Weightd Avg Census	240,729	12	$ 6,399	$ 6,399	21,535	$ 573	1
2	5	Utilities	Weightd Avg Census	240,729	12	6,853		21,535	613	2
3	6	Maintenance	Weightd Avg Census	240,729	12	15,959		21,535	1,428	3
4	7	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	734		21,535	66	4
5	10	Nursing and Medical Records	Weightd Avg Census	240,729	12	14,557	14,557	21,535	1,302	5
6	15	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	1,669		21,535	149	6
7	17	Administrative	Weightd Avg Census	240,729	12	250,490	250,490	21,535	22,407	7
8	19	Professional Services	Weightd Avg Census	240,729	12	4,836		21,535	434	8
9	20	Dues, Fees, Subscriptions & Prom	Weightd Avg Census	240,729	12	3,667		21,535	328	9
10	21	Clerical & General Office	Weightd Avg Census	240,729	12	501,243	488,721	21,535	44,840	10
11	24	Travel & Seminar	Weightd Avg Census	240,729	12	179		21,535	16	11
12	25	Other Admin Staff Transport	Weightd Avg Census	240,729	12	9,524		21,535	852	12
13	26	Insurance-Prop/Liab/Malprac	Weightd Avg Census	240,729	12	8,930		21,535	799	13
14	27	Mgmt Allocation of Benefits	Weightd Avg Census	240,729	12	84,770		21,535	7,583	14
15	30	Depreciation	Weightd Avg Census	240,729	12	167,061		21,535	14,945	15
16	31	Amortization	Weightd Avg Census	240,729	12	3,096		21,535	277	16
17	32	Interest	Weightd Avg Census	240,729	12	673		21,535	60	17
18	33	Real Estate Taxes	Weightd Avg Census	240,729	12	5,000		21,535	447	18
19	35	Equipment Rental	Weightd Avg Census	240,729	12	653		21,535	58	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,086,293	$ 760,167		$ 97,177	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Legence Bank		X	Line of Credit		11/27/19	169,258		6/30/21	4.7500	1,318	6
7												7
8												8
9	TOTAL Facility Related						$ 169,258	$			$ 1,318	9
	B. Non-Facility Related*											
10												10
11									Interest Income Offset		(122)	11
12									WLC Mgmt Allocation		60	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (62)	14
15	TOTALS (line 9+line14)						$ 169,258	$			$ 1,256	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.)

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 7,106	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.)	2019	$ 7,168	2
3. Under or (over) accrual (line 2 minus line 1).		$ 62	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 7,106	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.	**Allocation from Mgmt Co**	447	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$ 447	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,615	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016	7,048	9
2017	7,171	10
2018	7,120	11
2019	7,168	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Nursing Rehab 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-301-002	Long Term Care Property	$ 7,020.90	$ 7,020.90
2.	08-20-156-005	Long Term Care Property	$ 147.26	$ 147.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,168.16	$ 7,168.16

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

N/A

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

1. Total Amount Incurred: Allocated from Mgmt Co
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 277
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				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler - Flush System and Replace Dry Pipe Valve			2018	21,703		20	1,085	1,085	2,713	9
10	Demolish Two Storage Buildings			2019	6,800		20	340	340	510	10
11	Replace Roof on Storage Building			2019	10,895		20	545	545	817	11
12	Drywall/Electric Outlets/Paint - Admin/DON offices & Conf Room			2019	21,698		20	1,085	1,085	1,627	12
13	Asphalt Pavement Patch, Sealcoat and Stripe			2020	3,775		20	94	94	94	13
14											14
15											15
16											16
17											17
18											18
19											19
20	Financial Statement Depreciation					79,233			(79,233)		20
21											21
22											22
23	Allocated from WLC Management			2018	33,273		15-39	1,419	1,419	15,708	23
24	Allocated from WLC Management			2020	11,638		15	388	388	388	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

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 109,782	$ 79,233		$ 4,956	$ (74,277)	$ 21,857	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 Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 12,715	$	$ 1,272	$ 1,272	10 yrs	$ 3,630	71
72	Current Year Purchases	60,532		3,027	3,027	10 yrs	3,027	72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	400					400	74
75	TOTALS	$ 73,647	$	$ 4,299	$ 4,299		$ 7,057	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			20,442		4,132	4,132		20,442	78
79										79
80	TOTALS			$ 20,442	$	$ 4,132	$ 4,132		$ 20,442	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)	$ 203,871	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,233	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,387	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (65,846)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 49,356	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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:	1970	80	2/17/17	$ 420,308			3
4	Additions							4
5								5
6								6
7	TOTAL		80		$ 420,308 **			7

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

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning 2/1/19
Ending 1/31/34

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

	Fiscal Year Ending	Annual Rent
12.	1/31/2021	$ 421,092
13.	1/31/2022	$ 426,828
14.	1/31/2023	$ 440,700

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: $ 14,839 Description: Medical Equipment $12,745; Dietary Equipment $913; Office Equipment $1,123; HO Allocation $58
(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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	10A(3), 39(3)	hrs	$	6,545	$ 117,845	$	6,545	$ 117,845	1
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs		3,246	64,733		3,246	64,733	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		7,833	143,596		7,833	143,596	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 prescrpts				87,936		87,936	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			$	17,624	$ 326,174	$ 87,936	17,624	$ 414,110	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

STATE OF ILLINOIS

Facility Name & ID Number Stonebridge Nursing Rehab **#** 0054494 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2020 **(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	$ 1,085,940	$ 1,085,940	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,464)	1,906,192	1,906,192	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,691	8,691	6
7	Other Prepaid Expenses	67,458	67,458	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,268,281	$ 3,268,281	10
	B. Long-Term Assets			
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	76,877	109,782	15
16	Equipment, at Historical Cost	16,808	94,089	16
17	Accumulated Depreciation (book methods)	(92,712)	(49,356)	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	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 973	$ 154,515	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,269,254	$ 3,422,796	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (48,955)	$ (48,955)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,517	61,517	30
31	Accrued Taxes Payable (excluding real estate taxes)	(9,581)	(9,581)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,106	7,106	32
33	Accrued Interest Payable			33
34	Deferred Compensation	875,192	875,192	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	219	219	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 885,498	$ 885,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 885,498	$ 885,498	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,383,756	$ 2,537,298	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,269,254	$ 3,422,796	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,016,322	1
2	Restatements (describe):		2
3	Rounding	(5)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,016,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,391,911	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	(24,472)	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)**	$ 1,367,439	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)**	$ 2,383,756	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,036,403	1
2	Discounts and Allowances for all Levels	1,190,283	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,226,686	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,437	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,437	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	148,835	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	32,295	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,257	19
20	Radiology and X-Ray	749	20
21	Other Medical Services	(176)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 183,960	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	122	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 122	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	631	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 631	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,526,836	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	650,179	31
32	Health Care	1,474,340	32
33	General Administration	819,771	33
	B. Capital Expense		
34	Ownership	522,808	34
	C. Ancillary Expense		
35	Special Cost Centers	513,913	35
36	Provider Participation Fee	153,914	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,134,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,391,911	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,391,911	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,313,141	44
45	Private Pay - Net Inpatient Revenue	519,163	45
46	Medicare - Net Inpatient Revenue	2,334,996	46
47	Other-(specify) Insurance	59,386	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,226,686	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 Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,815	1,957	$ 60,811	$ 31.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,392	15,264	462,194	30.28	3
4	Licensed Practical Nurses	7,446	7,720	150,990	19.56	4
5	CNAs & Orderlies	42,243	43,710	635,167	14.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,630	1,729	17,530	10.14	9
10	Activity Assistants					10
11	Social Service Workers	1,947	2,059	30,284	14.71	11
12	Dietician					12
13	Food Service Supervisor	1,930	2,185	30,509	13.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,429	11,820	128,519	10.87	15
16	Dishwashers					16
17	Maintenance Workers	1,835	2,007	35,089	17.48	17
18	Housekeepers	11,808	12,314	135,477	11.00	18
19	Laundry	5,033	5,303	53,412	10.07	19
20	Administrator	2,467	2,593	94,823	36.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,202	2,261	41,183	18.21	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)	106,177	110,922	$ 1,875,988 *	$ 16.91	34

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	106	$ 5,063	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	2,200	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	14	803	L11, C3	44
45	Social Service Consultant	22	1,370	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	142	$ 15,436		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kelly Bishop	Administrator	0	77,289
Merle Taylor	Admin Reg Exec	0	16,634
Lon Linder	VP Operations	0	900
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,823

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 261,068
TOTAL (agree to Schedule V, line 17, col. 3)	$ 261,068
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Solutions, Inc.	Health Info Management	$ 1,450
American Healthtech	LTC Software	12,265
Information Controls	Payroll Service	4,734
Prime Care Technologies	Computer Services	4,024
Templin Healthcare Accounting	Accounting Services	4,468
Kemper CPA Group	Accounting Services	1,740
Jelliffe, Doerge & Phelps	Legal Services	94
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 28,775

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,550
Unemployment Compensation Insurance	11,904
FICA Taxes	139,676
Employee Health Insurance	48,009
Employee Meals	936
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals/Drug Tests	1,872
Life/Disability Insurance	5,917
Other Employee Benefits	1,386
TOTAL (agree to Schedule V, line 22, col.8)	$ 259,250

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	632
Health Care Worker Background Check	
(Indicate # of checks performed 25)	1,653
Patient Background Checks 100	1,800
License & Permits	610
Dues & Subcriptions	1,561
IHCA	5,760
Allocated From WLC Mgmt Firm	328
Less: Public Relations Expense	(2,365)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,959

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	811
Allocated From WLC Mgmt Firm	16
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 827

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing Rehab # 0054494 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. **5,760 IHCA**

(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?

(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. $ **4,732** 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. $ **153,914**
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 benefits on Schedule V. $ **936** 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 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.