

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0004259 Facility Name: Stephenson Nursing Center Address: 2946 South Walnut Rd Freeport 61032 Number City Zip Code County: Stephenson Telephone Number: 815-235-6173 Fax # 815-235-1309 HFS ID Number: Date of Initial License for Current Owners: 1/1/1971 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other x GOVERNMENTAL State x County Other In the event there are further questions about this report, please contact: Name: Rob Schlicht Telephone Number: 414-431-9335 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 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) (Type or Print Name) (Title) Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) Rob Schlicht Director Wipfli LLP 10000 Innovation Drive, Suite 250 Milwaukee WI 53226 414-431-9335 Fax # 414-431-9303 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
---	---

Facility Name & ID Number Stephenson Nursing Center

0004259 Report Period Beginning: 01/01/2020 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>148</u>	Skilled (SNF)	<u>148</u>	<u>54,168</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3	<u>2</u>	Intermediate (ICF)	<u>2</u>	<u>732</u>	<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	<u>7</u>

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>19,449</u>	<u>6,923</u>	<u>2,815</u>	<u>29,187</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>19,449</u>	<u>6,923</u>	<u>2,815</u>	<u>29,187</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.16%

D. How many bed reserve days during this year were paid by the Department? _____ (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) n/a

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

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

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

I. On what date did you start providing long term care at this location? Date started 01/01/1961

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☐ If YES, enter number of beds certified _____ and days of care provided 1,277

Medicare Intermediary WPS Medicare

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 01/01/2020 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		460	657,303	657,763		657,763	(2,383)	655,380			1
2	Food Purchase											2
3	Housekeeping	40,041		2,890	42,931		42,931		42,931			3
4	Laundry	236,934	43,617		280,551		280,551		280,551			4
5	Heat and Other Utilities			86,923	86,923		86,923		86,923			5
6	Maintenance	77,160	119,228	26,750	223,138		223,138		223,138			6
7	Other (specify):* Rec secretary	1,000			1,000		1,000		1,000			7
8	TOTAL General Services	355,135	163,305	773,866	1,292,306		1,292,306	(2,383)	1,289,923			8
	B. Health Care and Programs											
9	Medical Director			8,800	8,800		8,800		8,800			9
10	Nursing and Medical Records	2,117,636	143,628	11,499	2,272,763		2,272,763		2,272,763			10
10a	Therapy											10a
11	Activities	158,681	1,375		160,056		160,056		160,056			11
12	Social Services	71,059			71,059		71,059		71,059			12
13	CNA Training											13
14	Program Transportation		4,515		4,515		4,515		4,515			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,347,376	149,518	20,299	2,517,193		2,517,193		2,517,193			16
	C. General Administration											
17	Administrative	107,194			107,194		107,194		107,194			17
18	Directors Fees											18
19	Professional Services			25,208	25,208		25,208		25,208			19
20	Dues, Fees, Subscriptions & Promotions			60,317	60,317		60,317	(2,195)	58,122			20
21	Clerical & General Office Expenses	165,686	68,766	42,195	276,647		276,647	(27,363)	249,284			21
22	Employee Benefits & Payroll Taxes			1,713,036	1,713,036		1,713,036		1,713,036			22
23	Inservice Training & Education											23
24	Travel and Seminar			129	129		129		129			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			261,258	261,258		261,258		261,258			26
27	Other (specify):* gain/loss			2,117	2,117		2,117		2,117			27
28	TOTAL General Administration	272,880	68,766	2,104,260	2,445,906		2,445,906	(29,558)	2,416,348			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,975,391	381,589	2,898,425	6,255,405		6,255,405	(31,941)	6,223,464			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			113,084	113,084		113,084	75,314	188,398			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			113,084	113,084		113,084	75,314	188,398			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		344,877		344,877		344,877		344,877			39
40	Barber and Beauty Shops		124		124		124		124			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,132	210,132		210,132		210,132			42
43	Other (specify):* marketing	29,396			29,396		29,396		29,396			43
44	TOTAL Special Cost Centers	29,396	345,001	210,132	584,529		584,529		584,529			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,004,787	726,590	3,221,641	6,953,018		6,953,018	43,373	6,996,391			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(2,383)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	75,314	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,195)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(27,363)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 43,373		\$	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	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 43,373		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	offset miscellaneous revenue	\$ (27,363)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(27,363)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stephenson Nursing Center# 0004259

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(2,383)	0	0	0	0	0	0	0	0	0	0	(2,383)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,383)	0	0	0	0	0	0	0	0	0	0	(2,383)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,195)	0	0	0	0	0	0	0	0	0	0	(2,195)	20
21	Clerical & General Office Expenses	(27,363)	0	0	0	0	0	0	0	0	0	0	(27,363)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(29,558)	0	0	0	0	0	0	0	0	0	0	(29,558)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,941)	0	0	0	0	0	0	0	0	0	0	(31,941)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	75,314	0	0	0	0	0	0	0	0	0	0	75,314	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	75,314	0	0	0	0	0	0	0	0	0	0	75,314	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	43,373	0	0	0	0	0	0	0	0	0	0	43,373	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 01/01/2020 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	Rebecca Quiggle	Chairman		0.00	0	0	0	0	\$	0		1
2	Anthony Kuhlemeier	Member		0.00	0	0	0	0		0		2
3	Scott Helms	Member		0.00	0	0	0	0		0		3
4	Ronnie Bush	Member		0.00	0	0	0	0		0		4
5	Christopher Clukey	Member		0.00	0	0	0	0		0		5
6	Andy Schroeder	Member		0.00	0	0	0	0		0		6
7	Charles Hilton	Member		0.00	0	0	0	0		0		7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			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.

Ending: 2/31/2020

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

IL478-2471

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													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

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

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

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

FACILITY NAME Stephenson Nursing Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0004259

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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.

A. Square Feet:

54,954

B. General Construction Type:

Exterior

brick and cement

Frame

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.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

01/01/2020

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	84		1971		\$ 613,691	\$	40	\$	\$	613,691	4
5	66		1988		1,687,286	42,182	40	42,182		1,370,918	5
6	Alzheimers Unit		1993		189,427	4,736	40	4,736		129,051	6
7	Garage Building		1972		2,912		20			2,912	7
8	Building		1984		149,592	3,740	40	3,740		131,774	8
	Improvement Type**										
9	Improvement		1980		15,878		10			15,878	9
10	boiler reparis		1981		1,000		15			1,000	10
11	roof repairs		1981		10,634		20			10,634	11
12	sidewalks		1982		1,276		20			1,276	12
13	Improvement		1983		2,555		25			2,555	13
14	Improvement		1987		3,816		15			3,816	14
15	Improvement		1989		27,483	687	40	687		21,642	15
16	Improvement		1992		8,038		10			8,038	16
17	Improvement		1981		1,110		10			1,110	17
18	Improvement		1994		8,557	214	40	214		5,581	18
19	Improvement		1994		8,991		40			8,991	19
20	Improvement		1995		8,258	206	40	206		5,270	20
21	parking lot expansion		1995		10,659		20			10,659	21
22	water heater		1996		2,475		20			2,475	22
23	water heater		1996		3,449		10			3,449	23
24	fire dampers		1996		744	30	25	30		727	24
25	parking lot expansion		1996		26,914		20			26,914	25
26	roof top air/heat units		1997		14,936		25			14,936	26
27	smoke detectors		1997		2,248		10			2,248	27
28	carpeting & vinyl		1997		3,828		10			3,828	28
29	roof top air/heat units		1998		14,997		10			14,997	29
30	water heater/sprinkling system		1998		17,742		10			17,742	30
31	carpeting & vinyl		1998		3,449		10			3,449	31
32	blacktopping		1971		6,755		10			6,755	32
33	roof		1979		11,804		10			11,804	33
34	roof		1978		9,092		10			9,092	34
35	roof		1978		4,546		10			4,546	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

01/01/2020 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	2	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	Tuckpointing	1975	\$ 2,700	\$	35	\$	\$	\$ 2,700	37
38	fire doors	1975	4,443		35			4,443	38
39	plaster	1976	917		35			917	39
40	alarm system	1976	350		35			350	40
41	fire alarm	1983	1,360		10			1,360	41
42	alarm system	1990	11,316		10			11,316	42
43	water softner	1990	9,178		10			9,178	43
44	dehumidifier	1990	9,500		10			9,500	44
45	ansul fire door	1999	1,374		10			1,374	45
46	roof a/c unit	1999	11,080		10			11,080	46
47	paving	2000	7,942	318	25	318		6,516	47
48	smoke wall	2000	13,973	699	20	699		12,929	48
49	boiler	2001	4,752		10			4,752	49
50	steel door	2001	568	14	40	14		275	50
51	block heater	2002	655		10			655	51
52	temperature control	2002	1,000		10			1,000	52
53	manhole for sewer	2002	4,800		10			4,800	53
54	fence	2003	4,220		10			4,220	54
55	boiler and installation	2004	4,961		10			4,961	55
56	doors and frames	2008	10,520		10			10,520	56
57	Vinyl kitchen wall	2009	2,056	51	40	51		612	57
58	Kitchen doors and hardware	2009	3,617	90	40	90		1,080	58
59	Kitchen floor	2009	14,517	363	40	363		4,356	59
60	Ceiling grid	2009	3,431	86	40	86		1,032	60
61	Roof project	2009	1,053	26	40	26		312	61
62	Lighting System	2011	28,884	722	40	722		7,220	62
63	Heater element and blower	2012	9,097	227	40	227		2,043	63
64	Install canopy	2012	6,300	158	40	158		1,422	64
65	Replace flooring in front lobby	2012	12,048	301	40	301		2,709	65
66	Parking Lot	2013	135,839	3,342	40	3,342		26,736	66
67	Canopy	2014	109,049	2,726	40	2,726		16,356	67
68	Bi-parting entry door	2015	10,500	1,050	10	1,050		6,300	68
69	Canopy (finish)	2015	16,559	414	40	414		2,484	69
70	TOTAL (lines 4 thru 69)		\$ 3,332,701	\$ 62,382		\$ 62,382	\$	\$ 2,643,266	70

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

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

01/01/2020 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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,332,701	\$ 62,382		\$ 62,382	\$	\$ 2,643,266	1
2	Shingle Roof	2015	224,000	11,200	20	11,200		67,200	2
3	Dining room flooring	2015	7,840	784	10	784		4,704	3
4	Water Heater	2013	3,656	366	10	366		2,562	4
5	Water Heater	2013	3,735	374	10	374		2,618	5
6	Water Softner	2013	11,750	1,175	10	1,175		8,225	6
7	Roofing	2016	105,660	5,283	20	5,283		26,415	7
8	Dielectric unions/expansion tank	2017	4,680	468	10	468		1,872	8
9	heat exchanger	2017	3,140	314	10	314		1,256	9
10	Doors, painting, flooring in rooms 101-104, 114, 116, 213-216	2017	7,425	743	10	743		2,972	10
11	repair generator	2017	11,606	1,161	10	1,161		4,644	11
12	Replace Flooring in main hallway and dining rooms	2017	18,939	1,894	10	1,894		7,576	12
13	Replace exterior windows	2019	170,795	17,080	10	17,080		25,620	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,905,927	\$ 103,224		\$ 103,224	\$	\$ 2,798,930	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 711,822	\$ 85,174	\$ 85,174	\$		\$ 603,602	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	598,054					598,054	73
74								74
75	TOTALS	\$ 1,309,876	\$ 85,174	\$ 85,174	\$		\$ 1,201,656	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	resident use only	auto/bronco	1989	\$ 12,672	\$	\$	\$		\$ 12,672	76
77	resident use only	dodge van	1999	35,748					35,748	77
78	resident use only	2014 dodge journey	2014	20,038					20,038	78
79	resident use only	2014 ford starcraft	2014	58,809					58,809	79
80	TOTALS			\$ 127,267	\$	\$	\$		\$ 127,267	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,343,070	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,398	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,127,853	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(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	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2021 \$ _____

13. _____/2022 \$ _____

14. _____/2023 \$ _____

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			234,277			234,277	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				88,165		88,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 234,277	\$ 88,165		\$ 322,442	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,802,865	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 194,000)	769,714		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>prop tax receivable</u>	500,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,072,579	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,701,026		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	603,826		16
17	Accumulated Depreciation (book methods)	(3,119,325)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	14,492		21
22	Other Long-Term Assets (specify: <u>def outflow imrf</u>)	553,985		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,754,004	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,826,583	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 438,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,284		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	500,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>net pension liab/def inflows</u>	2,038,028		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,149,515	\$	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)	\$ 3,149,515	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,677,068	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,826,583	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,756,821	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,756,821	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(148,160)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (148,160)	17
	B. Transfers (Itemize):		
18	equity adjustment	(931,593)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (931,593)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,677,068	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning: 01/01/2020

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.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,280,626	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,280,626	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	50	13
14	Non-Patient Meals	2,383	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,433	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,012	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,012	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	real estate tax	490,424	28
28a	miscellaneous revenue	27,363	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 517,787	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,804,858	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,292,306	31
32	Health Care	2,517,193	32
33	General Administration	2,445,906	33
	B. Capital Expense		
34	Ownership	113,084	34
	C. Ancillary Expense		
35	Special Cost Centers	374,397	35
36	Provider Participation Fee	210,132	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,953,018	40
41	Income before Income Taxes (line 30 minus line 40)**	(148,160)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (148,160)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,392	2,080	\$ 61,056	\$ 29.35	1
2	Assistant Director of Nursing	456	520	31,128	59.86	2
3	Registered Nurses	18,257	23,970	781,737	32.61	3
4	Licensed Practical Nurses	6,386	7,987	188,686	23.62	4
5	CNAs & Orderlies	52,542	64,466	1,020,621	15.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,664	1,808	26,465	14.64	9
10	Activity Assistants	9,313	10,179	132,216	12.99	10
11	Social Service Workers	2,944	4,160	71,059	17.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,608	5,163	78,160	15.14	17
18	Housekeepers	1,816	2,080	40,041	19.25	18
19	Laundry	19,713	21,764	236,934	10.89	19
20	Administrator	1,124	1,220	107,194	87.86	20
21	Assistant Administrator					21
22	Other Administrative	11,452	12,698	165,686	13.05	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,800	2,080	34,408	16.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>marketing</u>	1,544	1,912	29,396	15.37	33
34	TOTAL (lines 1 - 33)	135,011	162,087	\$ 3,004,787 *	\$ 18.54	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		8,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,342	10-3	39
40	Physical Therapy Consultant		234,277	39-2	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,157	10-3	45
46	Other(specify) <u>psychiatric</u>		16,038	39-2	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 270,614		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number

Stephenson Nursing Center

STATE OF ILLINOIS

0004259

Report Period Beginning:

01/01/2020

Page 21

Ending: 12/31/2020

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	
Norm Gross		Administrator	0	\$ 107,194		Workers' Compensation Insurance		\$ 16,799		IDPH License Fee		\$	
						Unemployment Compensation Insurance				Advertising: Employee Recruitment		23,165	
						FICA Taxes		186,685		Health Care Worker Background Check			
						Employee Health Insurance		767,760		(Indicate # of checks performed)			
						Employee Meals				Patient Background Checks		620	
						Illinois Municipal Retirement Fund (IMRF)*		233,406		licenses		32,937	
						employee incentives		1,535		marketing		2,195	
						retirement payout		3,173		dues and subscriptions		1,400	
						change in imrf liability		116,219					
						change in opeb liability		387,459					
										Less: Public Relations Expense		(2,195)	
										Non-allowable advertising		()	
										Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 107,194		TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,713,036		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 58,122	
(List each licensed administrator separately.)													
B. Administrative - Other						E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Amount		Description		Line #	Amount	Description		Amount	
				\$					\$	Out-of-State Travel		\$	
										In-State Travel		129	
										Seminar Expense			
										Entertainment Expense		()	
										(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3)				\$		TOTAL			\$	TOTAL		\$ 129	
(Attach a copy of any management service agreement)													
C. Professional Services													
Vendor/Payee		Type		Amount									
Wipfli		accounting		\$ 25,208									
TOTAL (agree to Schedule V, line 19, column 3)				\$ 25,208									
(For legal fee disclosure, see page 39 of instructions)													

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? no 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. \$ 210,132
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (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. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sikich
- (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. n/a
Attach invoices and a summary of services for all architect and appraisal fees.