

Facility Name & ID Number Stonebridge Senior Living Center

0033258 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,331	8,886		21,217	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,331	8,886		21,217	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.76%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold 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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
Date started 01/14/1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/14/1988 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Stonebridge Senior Living Center # 0033258 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	112,332	9,366	4,746	126,444		126,444		126,444		1
2	Food Purchase		114,548		114,548		114,548		114,548		2
3	Housekeeping	82,252	17,458		99,710		99,710	128	99,838		3
4	Laundry	62,503	7,126		69,629		69,629	92	69,721		4
5	Heat and Other Utilities			89,160	89,160		89,160	862	90,022		5
6	Maintenance	14,266	17,267	10,457	41,990		41,990	476	42,466		6
7	Other (specify):*										7
8	TOTAL General Services	271,353	165,765	104,363	541,481		541,481	1,558	543,039		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	546,438	40,832	1,375	588,645		588,645	1,045	589,690		10
10a	Therapy			2,588	2,588		2,588		2,588		10a
11	Activities	33,837	1,616	1,063	36,516		36,516	2,000	38,516		11
12	Social Services	12,002		3,555	15,557		15,557		15,557		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	592,277	42,448	8,581	643,306		643,306	3,045	646,351		16
	C. General Administration										
17	Administrative	68,795			68,795		68,795	91,691	160,486		17
18	Directors Fees			5,500	5,500		5,500		5,500		18
19	Professional Services			6,200	6,200		6,200	14,680	20,880		19
20	Dues, Fees, Subscriptions & Promotions			4,783	4,783		4,783	753	5,536		20
21	Clerical & General Office Expenses	106,897	10,085	23,371	140,353		140,353	25,043	165,396		21
22	Employee Benefits & Payroll Taxes			146,231	146,231		146,231		146,231		22
23	Inservice Training & Education			1,697	1,697		1,697		1,697		23
24	Travel and Seminar			408	408		408	832	1,240		24
25	Other Admin. Staff Transportation			1,072	1,072		1,072		1,072		25
26	Insurance-Prop.Liab.Malpractice			53,678	53,678		53,678	10,625	64,303		26
27	Other (specify):* Home Office Allocatio							3,147	3,147		27
28	TOTAL General Administration	175,692	10,085	242,940	428,717		428,717	146,771	575,488		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,039,322	218,298	355,884	1,613,504		1,613,504	151,374	1,764,878		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 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	
	D. Ownership											
30	Depreciation			30,825	30,825		30,825	19,890	50,715			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,826	24,826		24,826	(71)	24,755			32
33	Real Estate Taxes			5,825	5,825		5,825	640	6,465			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,323	8,323		8,323		8,323			35
36	Other (specify):*											36
37	TOTAL Ownership			69,799	69,799		69,799	20,459	90,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,254	53,254		53,254		53,254			42
43	Other (specify):* Non-allowable cost			8,501	8,501		8,501	(8,501)				43
44	TOTAL Special Cost Centers			61,755	61,755		61,755	(8,501)	53,254			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,039,322	218,298	487,438	1,745,058		1,745,058	163,332	1,908,390			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,443	30		9
10	Interest and Other Investment Income	(71)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(609)	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				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	(4,863)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(4,411)	Vari		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 7,489		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	155,843	Vari.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 155,843		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 163,332		37

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

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

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

BHF USE ONLY							
48		49		50		51	

Stonebridge Senior Living Center

ID# 0033258

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Funeral Expenses	\$ (320)	43	1
2	Political Donation	(200)	43	2
3	Patient Birthday Exp	(2,508)	43	3
4	IHCA Lobbying Dues Offset	(1,383)	20	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	(4,411)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stonebridge Senior Living Center# 0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	128	0	0	0	0	0	0	0	0	0	128	3
4	Laundry	0	92	0	0	0	0	0	0	0	0	0	92	4
5	Heat and Other Utilities	0	862	0	0	0	0	0	0	0	0	0	862	5
6	Maintenance	0	476	0	0	0	0	0	0	0	0	0	476	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,557	0	0	0	0	0	0	0	0	0	1,557	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	1,045	0	0	0	0	0	0	0	0	0	1,045	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,000	0	0	0	0	0	0	0	0	0	2,000	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	3,045	0	0	0	0	0	0	0	0	0	3,045	16
	C. General Administration													
17	Administrative	0	91,691	0	0	0	0	0	0	0	0	0	91,691	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,680	0	0	0	0	0	0	0	0	0	14,680	19
20	Fees, Subscriptions & Promotions	(1,383)	2,136	0	0	0	0	0	0	0	0	0	753	20
21	Clerical & General Office Expenses	0	25,043	0	0	0	0	0	0	0	0	0	25,043	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	832	0	0	0	0	0	0	0	0	0	832	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	10,625	0	0	0	0	0	0	0	0	0	10,625	26
27	Other (specify):*	0	3,147	0	0	0	0	0	0	0	0	0	3,147	27
28	TOTAL General Administration	(1,383)	148,154	0	0	0	0	0	0	0	0	0	146,771	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,383)	152,756	0	0	0	0	0	0	0	0	0	151,373	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stonebridge Senior Living Center# 0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	0	0	2,447	0	0	0	0	0	0	0	0	2,447	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	640	0	0	0	0	0	0	0	0	640	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	0	0	3,087	0	3,087	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):*	(8,500)	0	0	0	0	0	0	0	0	0	0	(8,500)	43
44	TOTAL Special Cost Centers	(8,500)	0	0	0	0	0	0	0	0	0	0	(8,500)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,883)	152,756	3,087	0	145,960	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Roger Herrin	100	Carrier Mills Nursing Home	Carrier Mill, IL	RDK Management	Harrisburg, IL	Management
		Saline Care Center	Harrisburg, IL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Housekeeping	\$	RDK Management, Inc.	100.00%	\$ 128	\$	128	1
2	V	4 Laundry		RDK Management, Inc.	100.00%	92		92	2
3	V	5 Heat and Other Utilities		RDK Management, Inc.	100.00%	862		862	3
4	V	6 Maintenance		RDK Management, Inc.	100.00%	476		476	4
5	V	10 Nursing and Medical Records		RDK Management, Inc.	100.00%	1,045		1,045	5
6	V	11 Activities		RDK Management, Inc.	100.00%	2,000		2,000	6
7	V	17 Administrative		RDK Management, Inc.	100.00%	91,691		91,691	7
8	V	19 Professional Services		RDK Management, Inc.	100.00%	14,680		14,680	8
9	V	20 Dues, Fees, Subscriptions & Promotions		RDK Management, Inc.	100.00%	2,136		2,136	9
10	V	21 Clerical & General Office Expenses		RDK Management, Inc.	100.00%	25,043		25,043	10
11	V	27 Employee Benefits & Payroll Taxes		RDK Management, Inc.	100.00%	3,147		3,147	11
12	V	24 Travel and Seminar		RDK Management, Inc.	100.00%	832		832	12
13	V	26 Insurance-Prop.Liab.Malpractice		RDK Management, Inc.	100.00%	10,625		10,625	13
14	Total		\$			\$ 152,756	\$ *	152,756	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	RDK Management, Inc.	100.00%	\$ 1,472	\$ 1,472	15
16	V	33 Real Estate Taxes		RDK Management, Inc.	100.00%	640	640	16
17	V	30 Depreciation		RDK Management, Inc.	100.00%	975	975	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 3,087	\$ * 3,087	39

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

Facility Name & ID Number Stonebridge Senior Living Center # 0033258 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dr. Roger Herrin	Owner	Manager	100.00	227,809	20	29.00	Salary	\$ 91,691	17(3)	1
2					See Sch 7A						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 91,691		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' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization RDK Management Inc.
 Street Address 607 S. Commercial
 City / State / Zip Code Harrisburg, IL 62946
 Phone Number (618) 926-3007
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Bed Day Available	123,708	3	\$ 446	\$ 35,502	\$ 128	1
2	4	Laundry	Bed Day Available	123,708	3	321	35,502	92	2
3	5	Heat and Other Utilities	Bed Day Available	123,708	3	3,003	35,502	862	3
4	6	Maintenance	Bed Day Available	123,708	3	1,657	35,502	476	4
5	10	Nursing and Medical Records	Bed Day Available	123,708	3	3,642	35,502	1,045	5
6	11	Activities	Bed Day Available	123,708	3	6,970	35,502	2,000	6
7	17	Administrative	Bed Day Available	123,708	3	319,500	319,500	91,691	7
8	19	Professional Services	Bed Day Available	123,708	3	51,153	35,502	14,680	8
9	20	Dues, Fees, Subscriptions & Prom	Bed Day Available	123,708	3	7,442	35,502	2,136	9
10	21	Clerical & General Office Expens	Bed Day Available	123,708	3	87,265	44,194	25,043	10
11	22	Employee Benefits & Payroll Tax	Bed Day Available	123,708	3	10,965	35,502	3,147	11
12	24	Travel and Seminar	Bed Day Available	123,708	3	2,900	35,502	832	12
13	26	Insurance-Prop.Liab.Malpractice	Bed Day Available	123,708	3	37,022	35,502	10,625	13
14	30	Depreciation	Bed Day Available	123,708	3	5,131	35,502	1,472	14
15	33	Real Estate Taxes	Bed Day Available	123,708	3	2,228	35,502	640	15
16	30	Depreciation	Direct Cost			975		975	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 540,620	\$ 363,694	\$ 155,844	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Farmers State Bank		X	Working Capital	Single Pay	7/17/08	500,000	332,420	07/17/09	0.0475	24,826	6						
7	Dr. Roger Herrin	X		Working Capital	Single Pay	10/29/04	529,746	529,746	Demand	None		7						
8												8						
9	TOTAL Facility Related						\$ 1,029,746	\$ 862,166			\$ 24,826	9						
B. Non-Facility Related*																		
10												10						
11										Interest Income Offset	(71)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (71)	14						
15	TOTALS (line 9+line14)						\$ 1,029,746	\$ 862,166			\$ 24,755	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' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Senior Living Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0033258

CONTACT PERSON REGARDING THIS REPORT William H. Moorman

TELEPHONE 618-993-2647 FAX #: 618-993-3981

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1-63-143-01</u>	<u>Land & Building</u>	\$ <u>5,599.32</u>	\$ <u>5,599.32</u>
2. <u>2-63-321-03</u>	<u>Land</u>	\$ <u>225.30</u>	\$ <u>225.30</u>
3. _____	<u>Home Office Building Allocation</u>	\$ <u>2,228.00</u>	\$ <u>640.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>8,052.62</u>	\$ <u>6,464.62</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,696 B. General Construction Type: Exterior CNCT W/BRICK Frame CNCT BLK/WD RF Number of Stories ONE

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).

N/A

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>958,320</u>	<u>1988</u>	<u>\$ 11,266</u>	<u>1</u>
2	<u>Nursing Home Admin (H.O.)</u>	<u>3,051</u>	<u>1993</u>	<u>5,453</u>	<u>2</u>
3	TOTALS	961,371		\$ 16,719	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96	1988	1975	\$ 754,463	\$	30	\$ 25,149	\$ 25,149	\$ 528,129	4
5	1	1992	1992	95,587		30	3,186	3,186	54,162	5
6										6
7										7
8										8
	Improvement Type**									
9	Asphalt		1988	5,650		15			5,650	9
10	Additions Per 1988 Audit		1988	933		10			933	10
11	Asphalt Parking Lot		1989	6,100		15			6,100	11
12	Sidewalk		1989	4,326		15			4,326	12
13	Curtains & Blinds		1989	2,646		12			2,646	13
14	Drapes		1989	2,100		12			2,100	14
15	Wallcoverings		1989	500		12			500	15
16	Mini Binds		1989	2,772		12			2,772	16
17	Renovation		1990	8,782		12			8,782	17
18	Chain Link Fence		1992	740		10			740	18
19	Interior Decorating - Blinds, Pictures, Etc.		1992	5,148		10			5,148	19
20	Roof		1993	2,976		10			2,976	20
21										21
22	Flooring		1994	7,485		10			7,485	22
23										23
24	Storage Barn		1996	1,858		10			1,858	24
25										25
26	Flooring		1997	2,712		10			2,712	26
27	Wallcoverings		1997	795		10			795	27
28	Handrails		1997	1,585		10			1,585	28
29	Mini Binds		1997	117		10			117	29
30										30
31										31
32	Renovation of Entire Facility - Construction Etc.		2005	151,742		30	5,058	5,058	20,232	32
33	Renovation of Entire Facility - Tile, Carpet, Drapes		2005	107,945		10	10,795	10,795	43,178	33
34	Improvements		2006	1,250		30	42	42	125	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' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$ 30,825			\$ (30,825)		37
38								38
39								39
40	1993	31,264		30	1,042	1,042	14,102	40
41	1994	1,351		30	45	45	575	41
42	1996	50		30	2	2	20	42
43	1998	227		30	8	8	75	43
44	2000	5,022		30	166	166	1,339	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		\$ 1,206,126	\$ 30,825		\$ 45,493	\$ 14,668	\$ 719,162	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Stonebridge Senior Living Center
 FYE: 12/31/08
 Provider # 0033258

TOTAL	STONE BRIDGE CARE HOME
100.00%	28.70%

LAND	TOTAL	STONE BRIDGE CARE HOME
USE: NURSING HOME ADMIN.		
SQUARE FEET: (10,629 * 100.00%)	10,629	3,051
YEAR ACQUIRED: 1993		
COST (ALLOCATED): (\$19,001 * 100.00%)	19,001	5,453

BUILDING IMPROVEMENTS	TOTAL	STONE BRIDGE CARE HOME
IMPROVEMENT TYPE: PURCHASE/REMODEL OF BLDG. USED FOR NURSING HOME		
YEAR CONSTRUCTED: 1993		
COST: (\$108,934 * 100.00%)	108,934	31,264
CURRENT BOOK DEPR: (\$2,825 * 100.0%)	2,825	811
LIFE IN YEARS: 30 YRS.	30 YRS.	30 YRS.
CURRENT STRAIGHT LINE DEPR:	3,631	1,042
ADJUSTMENTS:	806	231
ACCUM DEPR: (\$45505 + \$3,631)	49,136	14,102

YEAR CONSTRUCTED: 1994		
COST: (\$4,708 * 100.00%)	4,708	1,351
CURRENT BOOK DEPR: (\$164 * 100.00%)	164	47
LIFE IN YEARS: 30 YRS.	30 YRS.	30 YRS.
CURRENT STRAIGHT LINE DEPR:	157	45
ADJUSTMENTS:	-7	-2
ACCUM DEPR: (\$1846 + \$157)	2,003	575

YEAR CONSTRUCTED: 1996		
COST: (\$174 * 100.00%)	174	50
CURRENT BOOK DEPR: (\$10 * 100.00%)	10	3
LIFE IN YEARS: 30 YRS.	30 YRS.	30 YRS.
CURRENT STRAIGHT LINE DEPR:	6	2
ADJUSTMENTS:	-4	-1
ACCUM DEPR: (\$64 + \$6)	70	20

YEAR CONSTRUCTED: 1998		
COST: (\$792 * 100.00%)	792	227
CURRENT BOOK DEPR: (\$20 * 100.00%)	20	6
LIFE IN YEARS: 30 YRS.	30 YRS.	30 YRS.
CURRENT STRAIGHT LINE DEPR:	26	8
ADJUSTMENTS:	6	2
ACCUM DEPR: (\$234 + \$26)	260	75

YEAR CONSTRUCTED: 2000		
COST: (\$17,500 * 100.00%)	17,500	5,022
CURRENT BOOK DEPR: (\$776 * 100.00%)	776	223
LIFE IN YEARS: 30 YRS.	30 YRS.	30 YRS.
CURRENT STRAIGHT LINE DEPR:	883	166
ADJUSTMENTS:	-193	-57
ACCUM DEPR: (\$4081 + \$583)	4,664	1,339

TOTAL COST: (\$132,108 * 100.00%)	132,108	37,915
-----------------------------------	---------	--------

EQUIPMENT - PRIOR YEARS		
COST: 32971 (SCH. C, \$32,971 * 100.00%)		
8285 (RDK)		
41256	41,256	11,840
CURRENT BOOK DEPR: (\$1843 + 169 * 100.00%)	2,012	577
LIFE IN YEARS: 10 YRS	10 YRS	10 YRS
CURRENT STRAIGHT LINE DEPR:	4,126	1,184
ADJUSTMENTS:	2,114	607
ACCUM DEPR: (31626 + 4126)	35,752	10,261

EQUIPMENT - CURRENT YEAR		
COST: 0 (SCH. C, \$0 * 100.00%)		
0 (RDK)		
0	0	0
CURRENT BOOK DEPR: (\$0 * 100.00%)	0	0
LIFE IN YEARS: 10 YRS	10 YRS	10 YRS
CURRENT STRAIGHT LINE DEPR:	0	0
ADJUSTMENTS:	0	0
ACCUM DEPR:	0	0

VEHICLE		
MODEL: 1995 MERCEDES BENZ SL500		
YEAR ACQUIRED: 1995		
COST: (\$98,639 * 85% BUS USE * 100.0%)	83,843	24,063
CURRENT BOOK DEPR: (\$1,775 * 100.0%)	1,775	509
LIFE IN YEARS: 4 YRS.	4 YRS.	4 YRS.
CURRENT STRAIGHT LINE DEPR:	0	0
ADJUSTMENTS:	-1,775	-509
ACCUM DEPR: (\$83,843 + \$0)	83,843	24,063

Home Office Depre Reconciled:	
Per Page 6	1,472
Per Above	2,447
Adjustment Amount	<u>975</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 44,969	\$	\$ 3,560	\$ 3,560	10	\$ 32,066	71
72	Current Year Purchases	9,558		478	478	10	478	72
73	Fully Depreciated Assets	161,430					161,430	73
74	Home Office Allocations	11,840		1,184	1,184	10	10,261	74
75	TOTALS	\$ 227,797	\$	\$ 5,222	\$ 5,222		\$ 204,235	75

D. Vehicle Depreciation (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	Patient Transfer	1985 Ford Van	1988	\$ 8,500	\$	\$	\$		\$ 8,500	76
77	Facility Administration	1995 Mercedes Benz	1995	24,063					24,063	77
78										78
79										79
80	TOTALS			\$ 32,563	\$	\$	\$		\$ 32,563	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)	\$ 1,483,205	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 30,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,715	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,890	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 955,960	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			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: \$ 8,323 Description: Nursing 3,356 and Maint. 4,967

(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	<u>N/A</u>				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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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' COMPILATION REPORT**

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

	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	10A, L3	hrs		43	2,588		43	2,588	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$	43	\$ 2,588	\$	43	\$ 2,588	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' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,059	\$ 23,059	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	352,883	352,883	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,678	35,678	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Net Closing Cost</u>	2,446	2,446	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 414,066	\$ 414,066	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,500	16,719	13
14	Buildings, at Historical Cost	875,924	850,050	14
15	Leasehold Improvements, at Historical Cost	74,481	356,076	15
16	Equipment, at Historical Cost	506,590	260,360	16
17	Accumulated Depreciation (book methods)	(1,048,492)	(955,960)	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: <u>Goodwill</u>)	5,000	5,000	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 427,003	\$ 532,245	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 841,069	\$ 946,311	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 25,996	\$ 25,996	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	529,746	529,746	29
30	Accrued Salaries Payable	33,436	33,436	30
31	Accrued Taxes Payable (excluding real estate taxes)	122	122	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,726	5,726	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Booked Overdraft</u>	26,541	26,541	36
37	<u>Taxes Payable</u>	2,211	2,211	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 623,778	\$ 623,778	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	332,420	332,420	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)	\$ 332,420	\$ 332,420	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 956,198	\$ 956,198	46
47	TOTAL EQUITY (page 18, line 24)	\$ (115,129)	\$ (9,887)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 841,069	\$ 946,311	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (166,764)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (166,764)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,634	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 51,635	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)	\$ (115,129)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,818,863	1
2	Discounts and Allowances for all Levels	(22,242)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,796,621	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		13
14	Non-Patient Meals		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	71	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,796,692	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	541,481	31
32	Health Care	643,306	32
33	General Administration	428,717	33
	B. Capital Expense		
34	Ownership	69,799	34
	C. Ancillary Expense		
35	Special Cost Centers	8,501	35
36	Provider Participation Fee	53,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,745,058	40
41	Income before Income Taxes (line 30 minus line 40)**	51,634	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 51,634	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return filed on a cash basis.

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

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

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 38,272	\$ 18.40	1
2	Assistant Director of Nursing	1,257	1,257	21,015	16.72	2
3	Registered Nurses	2,144	2,161	61,009	28.23	3
4	Licensed Practical Nurses	11,185	11,185	126,595	11.32	4
5	CNAs & Orderlies	32,556	32,556	277,015	8.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,710	3,760	33,837	9.00	9
10	Activity Assistants			0		10
11	Social Service Workers	1,374	1,374	12,002	8.74	11
12	Dietician					12
13	Food Service Supervisor	1,097	1,100	13,452	12.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,884	12,884	98,880	7.67	15
16	Dishwashers					16
17	Maintenance Workers	1,532	1,532	14,266	9.31	17
18	Housekeepers	10,375	10,375	82,252	7.93	18
19	Laundry	7,146	7,146	62,503	8.75	19
20	Administrator	2,080	2,080	44,737	21.51	20
21	Assistant Administrator	1,360	1,360	24,058	17.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,964	12,217	106,897	8.75	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 MDS Coordinator	1,730	1,754	22,533	12.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,473	104,820	\$ 1,039,322 *	\$ 9.92	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	Monthly	\$ 4,746	1(3)	35
36	Medical Director	Monthly	5,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	750	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,063	11(3)	44
45	Social Service Consultant	Monthly	1,063	12(2)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,122		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Stonebridge Senior Living Center
Provider # 0033258
12/31/2008

Schedule 21A

Schedule XIX (C) - Professional Fees.

TOTAL (agree to Schedule V, line 19, column 3)	6,200
Allocation from RDK Management	14,680
TOTAL (agree to Schedule V, line 19, column 8)	<u>20,880</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/08

Ending:

12/31/08

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. IHCA - \$3,855
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,072 Line L10, C2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,254
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? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients?
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT