

Facility Name & ID Number Stonebridge Senior Living Center

0033258 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	35,405	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,404	9,476		21,880	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,404	9,476		21,880	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.80%

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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Stonebridge Senior Living Center # 0033258 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	115,018	8,414	4,872	128,304		128,304		128,304		1
2	Food Purchase		108,317		108,317		108,317		108,317		2
3	Housekeeping	108,430	16,973		125,403		125,403		125,403		3
4	Laundry	51,467	6,050		57,517		57,517	365	57,882		4
5	Heat and Other Utilities			96,820	96,820		96,820	2,366	99,186		5
6	Maintenance	41,674	28,455	15,744	85,873		85,873	6,051	91,924		6
7	Other (specify):*										7
8	TOTAL General Services	316,589	168,209	117,436	602,234		602,234	8,782	611,016		8
	B. Health Care and Programs										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	560,930	32,926	1,600	595,456		595,456		595,456		10
10a	Therapy										10a
11	Activities	41,181	1,590		42,771		42,771		42,771		11
12	Social Services	19,315		2,728	22,043		22,043		22,043		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	621,426	34,516	11,828	667,770		667,770		667,770		16
	C. General Administration										
17	Administrative	59,123			59,123		59,123	117,519	176,642		17
18	Directors Fees			446	446		446		446		18
19	Professional Services			7,622	7,622		7,622	19,551	27,173		19
20	Dues, Fees, Subscriptions & Promotions			6,602	6,602		6,602	447	7,049		20
21	Clerical & General Office Expenses	60,316	13,795	29,683	103,794		103,794	20,503	124,297		21
22	Employee Benefits & Payroll Taxes			150,865	150,865		150,865		150,865		22
23	Inservice Training & Education			1,897	1,897		1,897		1,897		23
24	Travel and Seminar			838	838		838	52	890		24
25	Other Admin. Staff Transportation			1,325	1,325		1,325		1,325		25
26	Insurance-Prop.Liab.Malpractice			61,945	61,945		61,945	15,977	77,922		26
27	Other (specify):* Home office benefits							190	190		27
28	TOTAL General Administration	119,439	13,795	261,223	394,457		394,457	174,239	568,696		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,057,454	216,520	390,487	1,664,461		1,664,461	183,021	1,847,482		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	20,168	50,993			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,604	6,604		6,604	(135)	6,469			32
33	Real Estate Taxes			5,500	5,500		5,500	663	6,163			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,970	16,970		16,970		16,970			35
36	Other (specify):*											36
37	TOTAL Ownership			59,899	59,899		59,899	20,696	80,595			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,750		2,750		2,750		2,750			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):* Non-allowable cost			10,748	10,748		10,748	(10,748)				43
44	TOTAL Special Cost Centers		2,750	63,856	66,606		66,606	(10,748)	55,858			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,057,454	219,270	514,242	1,790,966		1,790,966	192,969	1,983,935			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	17,721	30		9
10	Interest and Other Investment Income	(135)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(449)	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	(7,831)	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 PG5A	(3,677)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 5,629		\$	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)	187,340	Vari.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 187,340		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 192,969		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Stonebridge Senior Living Center

ID# 0033258

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Funeral Expenses	\$ (193)	43	1
2	Political Donation	(333)	43	2
3	Patient Birthday Exp	(1,942)	43	3
4	IHCA Lobbying Dues Offset	(928)	20	4
5	Misc Income	(281)	21	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	(3,677)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stonebridge Senior Living Center# 0033258

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	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	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	365	0	0	0	0	0	0	0	0	0	365	4
5	Heat and Other Utilities	0	2,366	0	0	0	0	0	0	0	0	0	2,366	5
6	Maintenance	0	6,051	0	0	0	0	0	0	0	0	0	6,051	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	8,782	0	8,782	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	117,519	0	0	0	0	0	0	0	0	0	117,519	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,551	0	0	0	0	0	0	0	0	0	19,551	19
20	Fees, Subscriptions & Promotions	(928)	1,375	0	0	0	0	0	0	0	0	0	447	20
21	Clerical & General Office Expenses	(281)	20,784	0	0	0	0	0	0	0	0	0	20,503	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	52	0	0	0	0	0	0	0	0	0	52	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	15,977	0	0	0	0	0	0	0	0	0	15,977	26
27	Other (specify):*	0	190	0	0	0	0	0	0	0	0	0	190	27
28	TOTAL General Administration	(1,209)	175,448	0	174,239	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,209)	184,230	0	183,021	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stonebridge Senior Living Center# 0033258

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	17,721	2,447	0	0	0	0	0	0	0	0	0	20,168	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(135)	0	0	0	0	0	0	0	0	0	0	(135)	32
33	Real Estate Taxes	0	663	0	0	0	0	0	0	0	0	0	663	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	17,586	3,110	0	20,696	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):*	(10,748)	0	0	0	0	0	0	0	0	0	0	(10,748)	43
44	TOTAL Special Cost Centers	(10,748)	0	0	0	0	0	0	0	0	0	0	(10,748)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	5,629	187,340	0	0	0	0	0	0	0	0	0	192,969	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	4 Laundry	\$	RDK Management, Inc.	100.00%	\$ 365	\$	365 1
2	V	5 Heat and Other Utilities		RDK Management, Inc.	100.00%	2,366		2,366 2
3	V	6 Maintenance		RDK Management, Inc.	100.00%	6,051		6,051 3
4	V	17 Administrative		RDK Management, Inc.	100.00%	117,519		117,519 4
5	V	19 Professional Services		RDK Management, Inc.	100.00%	19,551		19,551 5
6	V	20 Dues, Fees, Subscriptions & Promotions		RDK Management, Inc.	100.00%	1,375		1,375 6
7	V	21 Clerical & General Office Expenses		RDK Management, Inc.	100.00%	20,784		20,784 7
8	V	27 Employee Benefits & Payroll Taxes		RDK Management, Inc.	100.00%	190		190 8
9	V	24 Travel and Seminar		RDK Management, Inc.	100.00%	52		52 9
10	V	26 Insurance-Prop.Liab.Malpractice		RDK Management, Inc.	100.00%	15,977		15,977 10
11	V	30 Depreciation		RDK Management, Inc.	100.00%	2,447		2,447 11
12	V	33 Real Estate Taxes		RDK Management, Inc.	100.00%	663		663 12
13	V							
14	Total		\$			\$ 187,340	\$ *	187,340 14

* 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: 01/01/09 Ending: 12/31/09

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	291,980	20	29.00	Salary	\$ 117,519	17(7)	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	\$ 117,519		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

Stonebridge Senior Living Center

ID # 0033258

Compensation Received From Other Related Nursing Home

FYE: 12/31/2009

Schedule 7A

Other Related Nursing Homes:	Roger Herrin
Carrier Mills Nursing Home (ID # 0025130)	119,942
Saline Care Center (ID # 0029462)	172,038
Total	<u>291,980</u>

Above Salaries received through RDK Management, Inc.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	4	Laundry	Bed Days Available	123,370	3	\$ 1,272	\$ 35,405	\$ 365	1
2	5	Heat and Other Utilities	Bed Days Available	123,370	3	8,244	35,405	2,366	2
3	6	Maintenance	Bed Days Available	123,370	3	21,085	35,405	6,051	3
4	17	Administrative	Bed Days Available	123,370	3	409,500	409,500	117,519	4
5	19	Professional Services	Bed Days Available	123,370	3	68,126	35,405	19,551	5
6	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	123,370	3	4,791	35,405	1,375	6
7	21	Clerical & General Office Expens	Bed Days Available	123,370	3	72,424	44,050	20,784	7
8	27	Employee Benefits & Payroll Tax	Bed Days Available	123,370	3	661	35,405	190	8
9	24	Travel and Seminar	Bed Days Available	123,370	3	180	35,405	52	9
10	26	Insurance-Prop.Liab.Malpractice	Bed Days Available	123,370	3	55,671	35,405	15,977	10
11	30	Depreciation	Bed Days Available	123,370	3	4,978	35,405	1,429	11
12	33	Real Estate Taxes	Bed Days Available	123,370	3	2,311	35,405	663	12
13	30	Depreciation	Direct Cost			1,018		1,018	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 650,261	\$ 453,550	\$ 187,340	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

01/01/09

Ending:

12/31/09

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	\$ 553,278	4
5	1		1992	1992	95,587		30	3,186	3,186	57,348	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	25,290	32
33	Renovation of Entire Facility - Tile, Carpet, Drapes		2005		107,945		10	10,795	10,795	53,973	33
34	Improvements		2006		1,250		30	42	42	167	34
35	In Pro - Remodel Hallways new wall covering and Cove Base		2009		6,187		20	155	155	155	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	15,144	40
41	1994	1,351		30	45	45	620	41
42	1996	50		30	2	2	22	42
43	1998	227		30	8	8	82	43
44	2000	5,022		30	166	166	1,506	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		\$ 1,212,313	\$ 30,825		\$ 45,648	\$ 14,823	\$ 764,810	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 54,527	\$	\$ 4,038	\$ 4,038	10	\$ 36,582	71
72	Current Year Purchases	2,460		123	123	10	123	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	\$ 230,257	\$	\$ 5,345	\$ 5,345		\$ 208,396	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)	\$ 1,491,852	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)	\$ 50,993	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,168	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,005,769	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

HOME OFFICE ASSETS

12/31/2009

	TOTAL	CARRIER MILLS NURSING HOME	SALINE CARE CENTER	STONE BRIDGE CARE HOME		
	100.00%	29.29%	42.01%	28.70%		
LAND						
USE: NURSING HOME ADMIN.						
SQUARE FEET: (10,629 * 100.00%)	10,629	3,113	4,465	3,051	To Pg 11	
YEAR ACQUIRED: 1993						
COST (ALLOCATED): (\$19,001 * 100.00%)	19,001	5,564	7,982	5,453	To Pg 11	3250-000
BUILDING IMPROVEMENTS						
IMPROVEMENT TYPE: PURCHASE/REMODEL						
OF BLDG. USED FOR NURSING HOME						
YEAR CONSTRUCTED: 1993						
COST: (\$108,934 * 100.00%)	108,934	31,907	45,764	31,264	To Pg 12A	
CURRENT BOOK DEPR: (\$2,825 * 100.00%)	2,825	827	1,187	811		
LIFE IN YEARS:	30 YRS.	30 YRS.	30 YRS.	30 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	3,631	1,064	1,525	1,042	To Pg 12A	
ADJUSTMENTS:	806	237	338	231		
ACCUM DEPR: (\$49136 + \$3,631)	52,767	15,455	22,167	15,144	To Pg 12A	
YEAR CONSTRUCTED: 1994						
COST: (\$4,708 * 100.00%)	4,708	1,379	1,978	1,351	To Pg 12A	
CURRENT BOOK DEPR: (\$164 * 100.00%)	164	48	69	47		
LIFE IN YEARS:	30 YRS.	30 YRS.	30 YRS.	30 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	157	46	66	45	To Pg 12A	
ADJUSTMENTS:	-7	-2	-3	-2		
ACCUM DEPR: (\$2003 + \$157)	2,160	633	907	620	To Pg 12A	
YEAR CONSTRUCTED: 1996						
COST: (\$174 * 100.00%)	174	51	73	50	To Pg 12A	
CURRENT BOOK DEPR: (\$10 * 100.00%)	10	3	5	3		
LIFE IN YEARS:	30 YRS.	30 YRS.	30 YRS.	30 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	6	2	2	2	To Pg 12A	
ADJUSTMENTS:	-4	-1	-3	-1		
ACCUM DEPR: (\$70 + \$6)	76	22	32	22	To Pg 12A	
YEAR CONSTRUCTED: 1998						
COST: (\$792 * 100.00%)	792	232	333	227	To Pg 12A	
CURRENT BOOK DEPR: (\$20 * 100.00%)	20	6	8	6		
LIFE IN YEARS:	30 YRS.	30 YRS.	30 YRS.	30 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	26	8	11	8	To Pg 12A	
ADJUSTMENTS:	6	2	3	2		
ACCUM DEPR: (\$260 + \$26)	286	85	120	82	To Pg 12A	
YEAR CONSTRUCTED: 2000						
COST: (\$17,500 * 100.00%)	17,500	5,126	7,352	5,022	To Pg 12A	
CURRENT BOOK DEPR: (\$776 * 100.00%)	776	227	326	223		
LIFE IN YEARS:	30 YRS.	30 YRS.	30 YRS.	30 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	583	171	246	166	To Pg 12A	
ADJUSTMENTS	-193	-56	-80	-57		
ACCUM DEPR: (\$4664 + \$583)	5,247	1,537	2,204	1,506	To Pg 12A	
TOTAL COST: (\$132,108 * 100.00%)	132,108	38,694	55,499	37,915		
EQUIPMENT - PRIOR YEARS						
COST: 32971 (SCH. C, \$32,971 * 100.00%)						
8285 (RDK)						
41256	41,256	12,084	17,332	11,840	To Pg 13	3210-000
CURRENT BOOK DEPR: (\$1843 + 169 * 100.00%)	2,012	589	844	577		
LIFE IN YEARS:	10 YRS	10 YRS	10 YRS	10 YRS	To Pg 13	
CURRENT STRAIGHT LINE DEPR:	4,126	1,208	1,733	1,184	To Pg 13	
ADJUSTMENTS:	2,114	619	889	607		
ACCUM DEPR: (31626 + 4126)	35,752	10,472	15,019	10,261	To Pg 13	3310-000
EQUIPMENT - CURRENT YEAR						
COST: 0 (SCH. C, \$0 * 100.00%)						
0 (RDK)						
0	0	0	0	0		
CURRENT BOOK DEPR: (\$0 * 100.00%)	0	0	0	0		
LIFE IN YEARS:	10 YRS	10 YRS	10 YRS	10 YRS		
CURRENT STRAIGHT LINE DEPR:	0	0	0	0		
ADJUSTMENTS:	0	0	0	0		
ACCUM DEPR:	0	0	0	0		
VEHICLE						
MODEL: 1995 MERCEDES BENZ SL500						
YEAR ACQUIRED: 1995						
COST: (\$98,639 * 85% BUS USE * 100.0%)	83,843	24,558	35,222	24,063	To Pg 12A	3205-000
CURRENT BOOK DEPR: (\$1,775 * 100.0%)	1,775	520	746	509		
LIFE IN YEARS:	4 YRS.	4 YRS.	4 YRS.	4 YRS.	To Pg 12A	
CURRENT STRAIGHT LINE DEPR:	0	0	0	0	To Pg 12A	
ADJUSTMENTS:	-1,775	-520	-746	-509		
ACCUM DEPR: (\$83,843 + \$0)	83,843	24,558	35,222	24,063	To Pg 12A	3320-000

7,938

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:				\$			3
4	Additions							4
5		<u>N/A</u>						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: \$ 16,970 Description: Nursing 13,351 and Maint. 3,619

(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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				2,750		2,750	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			\$		\$	2,750		\$ 2,750	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# 0033258Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 77,662	\$ 77,662	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	147,233	147,233	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,339	46,339	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Net Closing Cost</u>	1,971	1,971	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 273,205	\$ 273,205	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	362,263	15
16	Equipment, at Historical Cost	519,496	262,820	16
17	Accumulated Depreciation (book methods)	(1,078,842)	(1,005,769)	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 (spe <u>Goodwill</u>)	5,000	5,000	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 409,559	\$ 491,083	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 682,764	\$ 764,288	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,478	\$ 13,478	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	679,746	679,746	29
30	Accrued Salaries Payable	1,237	1,237	30
31	Accrued Taxes Payable (excluding real estate taxes)	155	155	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,210	5,210	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 699,826	\$ 699,826	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)	\$ 699,826	\$ 699,826	46
47	TOTAL EQUITY(page 18, line 24)	\$ (17,062)	\$ 64,462	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 682,764	\$ 764,288	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (115,129)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (115,129)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	198,074	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	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(7)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 98,067	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)	\$ (17,062)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Living Center

0033258

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 2,011,912	1
2	Discounts and Allowances for all Levels	(23,288)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,988,624	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***	135	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 135	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Misc Income</u>	281	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 281	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,989,040	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	602,234	31
32	Health Care	667,770	32
33	General Administration	394,457	33
B. Capital Expense			
34	Ownership	59,899	34
C. Ancillary Expense			
35	Special Cost Centers	13,498	35
36	Provider Participation Fee	53,108	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,790,966	40
41	Income before Income Taxes (line 30 minus line 40)**	198,074	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 198,074	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 prepared on 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:

01/01/09

Ending:

12/31/09

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	2,160	39,111	\$ 18.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,492	2,846	45,937	16.14	3
4	Licensed Practical Nurses	10,430	11,362	142,119	12.51	4
5	CNAs & Orderlies	33,239	35,128	285,515	8.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,923	1,986	17,228	8.67	8
9	Activity Director	2,929	3,047	41,181	13.51	9
10	Activity Assistants					10
11	Social Service Workers	1,975	2,071	19,315	9.33	11
12	Dietician					12
13	Food Service Supervisor	2,125	2,153	20,216	9.39	13
14	Head Cook	5,094	5,393	47,542	8.82	14
15	Cook Helpers/Assistants	5,705	5,987	47,260	7.89	15
16	Dishwashers					16
17	Maintenance Workers	4,221	4,384	41,674	9.51	17
18	Housekeepers	10,575	11,177	108,430	9.70	18
19	Laundry	6,412	6,766	51,467	7.61	19
20	Administrator	2,144	2,160	59,123	27.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,313	6,367	60,316	9.47	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: <u>MDS Coordinator</u>	2,181	2,238	31,019	13.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,835	105,223	\$ 1,057,454 *	\$ 10.05	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	\$ 4,872	1(3) 35
36	Medical Director	Monthly	7,500	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	1,350	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			44
45	Social Service Consultant	Monthly	2,728	12(2) 45
46	Other(specify) <u>Psych.</u>	Monthly	250	10(3) 46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 16,700	49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Stonebridge Senior Living Center
Provider # 0033258
12/31/2009

Schedule 21A

Schedule XIX (C) - Professional Fees.

TOTAL (agree to Schedule V, line 19, column 3)	7,622
Allocation from RDK Management	19,551
TOTAL (agree to Schedule V, line 19, column 8)	<u>27,173</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
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:

01/01/09

Ending:

12/31/09

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 - \$3,092
- (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. \$ 9,816 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 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. \$ 53,108
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? 0
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? N/A
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
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT