

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	278	223	2,447	2,948	8
9	SNF/PED					9
10	ICF	11,163	7,124		18,287	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,441	7,347	2,447	21,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.72%

D. How many bed-hold days during this year were paid by the Department?

None (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)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 15 and days of care provided 2,447

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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	121,541	5,859	4,997	132,397		132,397		132,397		1
2	Food Purchase		116,205		116,205		116,205		116,205		2
3	Housekeeping	107,676	12,364		120,040		120,040		120,040		3
4	Laundry	78,975	6,833		85,808		85,808	61	85,869		4
5	Heat and Other Utilities			77,285	77,285		77,285	1,490	78,775		5
6	Maintenance	24,284	19,328	50,053	93,665		93,665	(14,380)	79,285		6
7	Other (specify):* Waste Removal			7,278	7,278		7,278		7,278		7
8	TOTAL General Services	332,476	160,589	139,613	632,678		632,678	(12,829)	619,849		8
	B. Health Care and Programs										
9	Medical Director			6,125	6,125		6,125		6,125		9
10	Nursing and Medical Records	755,324	51,094	1,200	807,618		807,618		807,618		10
10a	Therapy			198,108	198,108		198,108		198,108		10a
11	Activities	24,476			24,476		24,476		24,476		11
12	Social Services		1,852	1,990	3,842		3,842		3,842		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	779,800	52,946	207,423	1,040,169		1,040,169		1,040,169		16
	C. General Administration										
17	Administrative	182,751		202,052	384,803		384,803	(101,721)	283,082		17
18	Directors Fees										18
19	Professional Services			46,658	46,658		46,658	1,400	48,058		19
20	Dues, Fees, Subscriptions & Promotions			14,509	14,509		14,509	(427)	14,082		20
21	Clerical & General Office Expenses	53,276	21,846	10,521	85,643		85,643	40,427	126,070		21
22	Employee Benefits & Payroll Taxes			168,387	168,387		168,387		168,387		22
23	Inservice Training & Education										23
24	Travel and Seminar			868	868		868	333	1,201		24
25	Other Admin. Staff Transportation			8,475	8,475		8,475	17,905	26,380		25
26	Insurance-Prop.Liab.Malpractice			40,949	40,949		40,949	1,598	42,547		26
27	Other (specify):* RDK/SI Employee Ben							10,478	10,478		27
28	TOTAL General Administration	236,027	21,846	492,419	750,292		750,292	(30,007)	720,285		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,348,303	235,381	839,455	2,423,139		2,423,139	(42,836)	2,380,303		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			63,303	63,303		63,303	2,802	66,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			6,839	6,839		6,839	175	7,014			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,960	5,960		5,960		5,960			35
36	Other (specify):*											36
37	TOTAL Ownership			76,102	76,102		76,102	2,977	79,079			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,908		75,908		75,908		75,908			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,393	164,393		164,393		164,393			42
43	Other (specify):* Non-allowable Costs			39,043	39,043		39,043	(39,043)				43
44	TOTAL Special Cost Centers		75,908	203,436	279,344		279,344	(39,043)	240,301			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,348,303	311,289	1,118,993	2,778,585		2,778,585	(78,902)	2,699,683			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,516)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	390	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(308)	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	(803)	20		17
18	Fines and Penalties	(6,250)	43		18
19	Entertainment	(5,426)	43		19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(815)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,089)	43		24
25	Fund Raising, Advertising and Promotional	(5,101)	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	(18,833)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,151)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,751)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (23,751)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (78,902)		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

Stonebridge Senior Lvg Ctr

ID# 0051888

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Birthday Expense	\$ (2,263)	43	1
2	Gifts	(226)	43	2
3	Investment Expenses/Foreign Tax paid	(1,464)	43	3
4	Offset Property Insurance proceeds	(14,880)	6	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		(18,833)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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	61	0	0	0	0	0	0	0	0	0	61	4
5	Heat and Other Utilities	0	1,490	0	0	0	0	0	0	0	0	0	1,490	5
6	Maintenance	(14,880)	500	0	0	0	0	0	0	0	0	0	(14,380)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,880)	2,051	0	0	0	0	0	0	0	0	0	(12,829)	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	(49,286)	(52,435)	0	0	0	0	0	0	0	0	(101,721)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(815)	999	1,216	0	0	0	0	0	0	0	0	1,400	19
20	Fees, Subscriptions & Promotions	(803)	331	45	0	0	0	0	0	0	0	0	(427)	20
21	Clerical & General Office Expenses	0	12,400	28,027	0	0	0	0	0	0	0	0	40,427	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	333	0	0	0	0	0	0	0	0	333	24
25	Other Admin. Staff Transportation	0	17,395	510	0	0	0	0	0	0	0	0	17,905	25
26	Insurance-Prop.Liab.Malpractice	0	1,528	70	0	0	0	0	0	0	0	0	1,598	26
27	Other (specify):*	0	4,677	5,801	0	0	0	0	0	0	0	0	10,478	27
28	TOTAL General Administration	(1,618)	(11,956)	(16,433)	0	(30,007)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,498)	(9,905)	(16,433)	0	(42,836)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stonebridge Senior Lvg Ctr# 0051888

Report Period Beginning:

1/1/2014 Ending:

12/31/2014

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	390	2,412	0	0	0	0	0	0	0	0	0	2,802	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	175	0	0	0	0	0	0	0	0	0	175	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	390	2,587	0	2,977	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):*	(39,043)	0	0	0	0	0	0	0	0	0	0	(39,043)	43
44	TOTAL Special Cost Centers	(39,043)	0	0	0	0	0	0	0	0	0	0	(39,043)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(55,151)	(7,318)	(16,433)	0	0	0	0	0	0	0	0	(78,902)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Steven B. Herrin</u>	<u>95</u>	<u>Carrier Mills Nursing & Rehab</u>	<u>Carrier Mills</u>	<u>RDK Management, Inc.</u>	<u>Harrisburg</u>	<u>Management Co.</u>
<u>Dr. Roger Herrin</u>	<u>5</u>	<u>Saline Care Center</u>	<u>Harrisburg</u>	<u>SI Management Svc, LLC</u>	<u>Harrisburg</u>	<u>Management Co.</u>
		<u>Pinckneyville Nursing & Rehab</u>	<u>Pinckneyville</u>			
		<u>DuQuoin Nursing & Rehab</u>	<u>DuQuoin</u>			

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	<u>4 Laundry</u>	\$	<u>RDK Management, Inc.</u>	<u>100.00%</u>	\$ <u>61</u>	\$	<u>61</u>	<u>1</u>
2	V	<u>5 Utilities</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>1,490</u>		<u>1,490</u>	<u>2</u>
3	V	<u>6 Repairs and Maint.</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>500</u>		<u>500</u>	<u>3</u>
4	V	<u>17 Administrative</u>	<u>119,252</u>	<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>69,966</u>		<u>(49,286)</u>	<u>4</u>
5	V	<u>19 Professional Fees</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>999</u>		<u>999</u>	<u>5</u>
6	V	<u>20 Fees, Subscriptions</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>331</u>		<u>331</u>	<u>6</u>
7	V	<u>21 Clerical And General</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>12,400</u>		<u>12,400</u>	<u>7</u>
8	V	<u>25 Admin. Staff Trans.</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>17,395</u>		<u>17,395</u>	<u>8</u>
9	V	<u>26 Insurance-Prop./Liab./Malprac.</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>1,528</u>		<u>1,528</u>	<u>9</u>
10	V	<u>27 Gen. Admin. Emp. Ben.</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>4,677</u>		<u>4,677</u>	<u>10</u>
11	V	<u>30 Depreciation</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>2,412</u>		<u>2,412</u>	<u>11</u>
12	V	<u>33 Real Estate Tax</u>		<u>RDK Management, Inc.</u>	<u>100.00%</u>	<u>175</u>		<u>175</u>	<u>12</u>
13	V								<u>13</u>
14	Total		\$ <u>119,252</u>			\$ <u>111,934</u>	\$ *	<u>(7,318)</u>	<u>14</u>

* 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	17 Administrative	\$ 82,800	SI Management Services, LLC	100.00%	\$ 30,365	\$ (52,435)
16	V	19 Professional Fees		SI Management Services, LLC	100.00%	1,216	1,216
17	V	20 Fees, Subscriptions		SI Management Services, LLC	100.00%	45	45
18	V	21 Clerical And General		SI Management Services, LLC	100.00%	28,027	28,027
19	V	24 Travel and Seminar		SI Management Services, LLC	100.00%	333	333
20	V	25 Admin. Staff Trans.		SI Management Services, LLC	100.00%	510	510
21	V	26 Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	70	70
22	V	27 Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	5,801	5,801
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 82,800			\$ 66,367	\$ * (16,433)

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

Facility Name & ID Number Stonebridge Senior Lvg Ctr # 0051888 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	Administrative	5%	See Att Sch 7A	4.50	11.25	Alloc. Salary	\$ 61,861	L17, C7	1
2	Steven Herrin	Owner	Administrative	95%	None	40	100.00	Salary	105,531	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 167,392		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

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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 South Commercial
 City / State / Zip Code Harrisburg, Illinois
 Phone Number (618) 252-7707
 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	Census	118,000	5	339	21,235	\$ 61	1
2	5	Utilities	Census	118,000	5	8,278	21,235	1,490	2
3	6	Repairs and Maint.	Census	118,000	5	2,777	21,235	500	3
4	17	Administrative	Census	118,000	5	388,792	388,792	69,966	4
5	19	Professional Fees	Census	118,000	5	5,552	21,235	999	5
6	20	Fees, Subscriptions	Census	118,000	5	1,842	21,235	331	6
7	21	Clerical And General	Census	118,000	5	68,903	44,301	12,400	7
8	25	Admin. Staff Trans.	Census	118,000	5	96,661	21,235	17,395	8
9	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	8,492	21,235	1,528	9
10	27	Gen. Admin. Emp. Ben.	Census	118,000	5	25,990	21,235	4,677	10
11	30	Depreciation	Census	118,000	5	13,405	21,235	2,412	11
12	33	Real Estate Tax	Census	118,000	5	970	21,235	175	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	TOTALS				\$ 622,001	\$ 433,093		\$ 111,934	25

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning:

1/1/2014

Ending: 2/31/2014

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 SI Management Services, LLC
 Street Address 607 South Commercial
 City / State / Zip Code Harrisburg, Illinois
 Phone Number (618) 252-7707
 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	17	Administrative	Census	118,000	5	168,736	168,736	21,235	\$ 30,365	1
2	19	Professional Fees	Census	118,000	5	6,755	21,235	21,235	1,216	2
3	20	Fees, Subscriptions	Census	118,000	5	250	21,235	21,235	45	3
4	21	Clerical And General	Census	118,000	5	155,745	154,984	21,235	28,027	4
5	24	Travel and Seminar	Census	118,000	5	1,851	21,235	21,235	333	5
6	25	Admin. Staff Trans.	Census	118,000	5	2,835	21,235	21,235	510	6
7	26	Insurance-Prop./Liab./Malprac.	Census	118,000	5	388	21,235	21,235	70	7
8	27	Gen. Admin. Emp. Ben.	Census	118,000	5	32,236	21,235	21,235	5,801	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	TOTALS					\$ 368,796	\$ 323,720		\$ 66,367	25

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 report.				\$	6,659	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013			\$	6,653	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(6)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	6,845	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			Allocated from RDK		175	
TOTAL REFUND	\$	For	Tax Year.		175	6
		(Attach a copy of the real estate tax appeal board's decision.)		\$		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7,014	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	<u>6,017</u>	8	FOR BHF USE ONLY		
	2010	<u>6,187</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013	13
	2011	<u>6,267</u>	10	14	PLUS APPEAL COST FROM LINE 5	14
	2012	<u>6,465</u>	11	15	LESS REFUND FROM LINE 6	15
	2013	<u>6,653</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION	16
2014 Tax Accrual = \$6,653 x 1.03 = \$6,845						

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Senior Lvg Ctr COUNTY Franklin
 FACILITY IDPH LICENSE NUMBER 0051888
 CONTACT PERSON REGARDING THIS REPORT Larry Templin
 TELEPHONE (630) 361-2868 FAX #: _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-20-156-003</u>	<u>Long Term Care Property</u>	\$ <u>267.80</u>	\$ <u>267.80</u>
2. <u>08-20-301-002</u>	<u>Long Term Care Property</u>	\$ <u>6,384.90</u>	\$ <u>6,384.90</u>
3. <u>06-2-275-02</u>	<u>Home Office Allocation</u>	\$ <u>969.58</u>	\$ <u>175.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>7,622.28</u></u>	\$ <u><u>6,827.70</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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: _____
 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>	1
2	<u>Home Office Allocation</u>			<u>4,735</u>	2
3	TOTALS	958,320		\$ 16,001	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	96	1988	1970	\$ 754,463	\$	30	\$ 25,149	\$ 25,149	\$ 679,023	4
5	1	1992	1992	95,587		30	3,186	3,186	73,278	5
6										6
7										7
8										8
Improvement Type**										
9	Various	1988		6,583		20			6,583	9
10	Various	1989		18,444		20			18,444	10
11	Various	1990		8,782		20			8,782	11
12	Various	1992		5,888		20			5,888	12
13	Various	1993		2,976		20			2,976	13
14	Various	1994		7,485		20			7,485	14
15	Various	1996		1,858		20			1,858	15
16	Various	1997		5,209		20			5,209	16
17	Various	2005		227,161		20	15,853	15,853	158,528	17
18	Light Fixtures	2010		3,937		20	197	197	985	18
19	New Sprinkler Heads	2010		3,390		20	170	170	849	19
20	Install Generator, Wiring	2010		28,506		20	1,425	1,425	7,126	20
21	Roof Shingles	2011		4,385		20	439	439	1,755	21
22	Roof Work	2011		4,837		20	242	242	1,693	22
23	Renovation Of Medicare Patient Rooms And Therapy Rooms - Bli	2012				20				23
24	- Blinds, Flooring, Cabinetry, Painting, Signage, And Fixtures	2012		48,531		20	2,427	2,427	7,280	24
25	Renovation Of Medicare Patient Rooms And Therapy Rooms -	2012				20				25
26	- Blinds, Wall Sconces, Electrical Work And Fixtures	2012		3,792		20	190	190	569	26
27	Roof	2013		14,500		20	725	725	1,450	27
28	Asphalt Drive	2014		4,543		20	114	114	114	28
29	Replace Leaking Sprinkler Heads	2014		1,695		20	42	42	42	29
30	Fiberglass 9 Lite Door	2014		770		20	19	19	19	30
31	Carpeting-one room	2014		181		20	5	5	5	31
32	Landscaping and Drainage work	2014		6,397		20	160	160	160	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41	Leasehold Information								41
42								42	
43	1993	27,146		20	425	425	19,922	43	
44	1994	1,173		20			1,173	44	
45	1996	43		20	2	2	41	45	
46	1998	197		20	10	10	168	46	
47	2000	4,361		20	218	218	3,271	47	
48								48	
49								49	
50								50	
51								51	
52	Financial Statement Depreciation								52
53			63,303			(63,303)		53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)								70
		\$ 1,292,820	\$ 63,303		\$ 50,998	\$ (12,305)	\$ 1,014,676		

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 112,776	\$	\$ 11,278	\$ 11,278	10	\$ 63,509	71
72	Current Year Purchases	11,838		592	592	10	592	72
73	Fully Depreciated Assets	185,733					185,733	73
74	Allocated from Mgmt Co.	12,000		2,584	2,584	5-10	11,154	74
75	TOTALS	\$ 322,347	\$	\$ 14,454	\$ 14,454		\$ 260,988	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		See Attached		\$ 39,088	\$	\$ 653	\$ 653		\$ 33,216	76
77										77
78										78
79	Allocated from Mgmt Co.			20,894				5	20,894	79
80	TOTALS			\$ 59,982	\$	\$ 653	\$ 653		\$ 54,110	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)	\$ 1,691,150	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,105	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,802	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,329,774	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.

Stonebridge Senior Lvg Ctr

Period Beginning
Period End

1/1/2014
12/31/2014

Schedule XI D. Ownership Costs - Vehicles

Use	Make, Model and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Facility	1985 Ford Van	1988	8,500			-	5	8,500
Facility	1995 Mercedes Benz	1995	24,063			-	5	24,063
Administrative	2015 Kia Sorrento	2014	5,685		569	569	5	569
Administrative	2001 Ford Mustang	2014	840		84	84	5	84
Total			\$ 39,088	\$ -	\$ 653	\$ 653		\$ 33,216

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

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								5
6								6
7	TOTAL				\$			7

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 5,960 Description: Medical Equipment \$5,493; Office Equipment \$467

(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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Stonebridge Senior Lvg Ctr # 0051888 Report Period Beginning: 1/1/2014 Ending: 12/31/2014
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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$	87,552	\$		\$	87,552	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs				25,380				25,380	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs				85,176				85,176	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					75,908			75,908	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			\$		\$	198,108	\$	75,908	\$	274,016	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.

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(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	\$ 602,186	\$ 602,186	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	738,400	738,400	3
4	Supply Inventory (priced at)	4,000	4,000	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	42,830	42,830	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,387,416	\$ 1,387,416	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	250,855	250,855	12
13	Land	13,500	16,001	13
14	Buildings, at Historical Cost	875,924	850,050	14
15	Leasehold Improvements, at Historical Cost	248,958	442,770	15
16	Equipment, at Historical Cost	678,952	382,329	16
17	Accumulated Depreciation (book methods)	(1,344,685)	(1,329,774)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	5,000	5,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 728,504	\$ 617,231	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,115,920	\$ 2,004,647	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 72,240	\$ 72,240	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	29,155	29,155	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,654	3,654	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,845	6,845	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)	\$ 111,894	\$ 111,894	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)	\$ 111,894	\$ 111,894	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,004,026	\$ 1,892,753	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,115,920	\$ 2,004,647	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,599,293	1
2	Restatements (describe):		2
3	Rounding	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,599,298	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	820,284	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	(415,556)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 404,728	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,004,026	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,537,544	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,537,544	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	32,505	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 32,505	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***	4,121	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,121	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Prior year disallowed legal reimbursements/Other	9,819	28
28a	Property Insurance claim proceeds	14,880	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,699	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,598,869	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	632,678	31
32	Health Care	1,040,169	32
33	General Administration	750,292	33
B. Capital Expense			
34	Ownership	76,102	34
C. Ancillary Expense			
35	Special Cost Centers	114,951	35
36	Provider Participation Fee	164,393	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,778,585	40
41	Income before Income Taxes (line 30 minus line 40)**	820,284	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 820,284	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,519,939	44
45	Private Pay - Net Inpatient Revenue	1,024,020	45
46	Medicare - Net Inpatient Revenue	910,308	46
47	Other-(specify) <u>Insurance</u>	83,277	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,537,544	49

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

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

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

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

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

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1/1/2014

Ending:

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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	2,240	2,376	\$ 49,480	\$ 20.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,332	6,621	112,049	16.92	3
4	Licensed Practical Nurses	12,034	12,846	196,730	15.31	4
5	CNAs & Orderlies	37,555	39,120	397,065	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,846	2,960	24,476	8.27	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,695	14,521	121,541	8.37	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,025	24,284	11.99	17
18	Housekeepers	11,617	12,179	107,676	8.84	18
19	Laundry	9,136	9,548	78,975	8.27	19
20	Administrator	1,992	2,080	59,432	28.57	20
21	Assistant Administrator					21
22	Other Administrative	2,345	2,425	123,319	50.85	22
23	Office Manager					23
24	Clerical	5,216	5,557	53,276	9.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,018	112,258	\$ 1,348,303 *	\$ 12.01	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	105	\$ 4,997	L1, C3	35
36	Medical Director	Monthly	6,125	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	34	1,990	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	139	\$ 14,312		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

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Stonebridge Senior Lvg Ctr

0051888

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

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. 4,416 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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. \$ 6,238 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. 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. \$ 164,393
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? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.