

		FOR BHF USE					

LL1

**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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

<p><b>I. IDPH License ID Number:</b> <u>0051268</u></p> <p><b>Facility Name:</b> <u>STOCKTON HEALTHCARE &amp; REHAB</u></p> <p><b>Address:</b> <u>501 FRONT STREET</u> <u>STOCKTON</u> <u>61085</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>JO DAVIESS</u></p> <p><b>Telephone Number:</b> <u>815-947-2215</u> <b>Fax #</b> <u>815-947-2651</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>JANUARY 1ST, 2011</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>JESSICA KOPP</u> <b>Telephone Number:</b> <u>815-232-1324</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____ <u>4/30/15</u> (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>GINA MILLER</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td style="border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____ <u>4/30/15</u> (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>JESSICA KOPP</u> <u>CPA</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) <u>THOMPSON &amp; KOPP INC</u> <u>206 S GALENA AVE, SUITE 110, FREEPORT IL 61032</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>815-232-1324</u> <b>Fax #</b> <u>815-235-1050</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>4/30/15</u> (Date)		(Type or Print Name) <u>GINA MILLER</u>		(Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____ <u>4/30/15</u> (Date)		(Print Name and Title) <u>JESSICA KOPP</u> <u>CPA</u>		(Firm Name & Address) <u>THOMPSON &amp; KOPP INC</u> <u>206 S GALENA AVE, SUITE 110, FREEPORT IL 61032</u>		(Telephone) <u>815-232-1324</u> <b>Fax #</b> <u>815-235-1050</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																						
	<input type="checkbox"/> Limited Liability Co.																																						
	<input type="checkbox"/> Trust																																						
	<input type="checkbox"/> Other _____																																						
<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>4/30/15</u> (Date)																																						
	(Type or Print Name) <u>GINA MILLER</u>																																						
	(Title) <u>ADMINISTRATOR</u>																																						
<b>Paid Preparer</b>	(Signed) _____ <u>4/30/15</u> (Date)																																						
	(Print Name and Title) <u>JESSICA KOPP</u> <u>CPA</u>																																						
	(Firm Name & Address) <u>THOMPSON &amp; KOPP INC</u> <u>206 S GALENA AVE, SUITE 110, FREEPORT IL 61032</u>																																						
	(Telephone) <u>815-232-1324</u> <b>Fax #</b> <u>815-235-1050</u>																																						

Facility Name & ID Number STOCKTON HEALTHCARE & REHAB

# 0051268 Report Period Beginning: 1/1/14 Ending: 12/31/14

**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	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,234	5,732	1,632	11,598	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,234	5,732	1,632	11,598	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.85%**

**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

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

**I. On what date did you start providing long term care at this location?**  
Date started 01/01/2011

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 01/01/2011 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 49 and days of care provided 1,632

Medicare Intermediary NATIONAL GOVERNAMNET SERVICES

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number **STOCKTON HEALTHCARE & REHAB** # **0051268** Report Period Beginning: **1/1/14** Ending: **12/31/14**

**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
	<b>A. General Services</b>										
1	Dietary	117,589	6,667	1,680	125,936		125,936		125,936		1
2	Food Purchase		95,620		95,620	(10,691)	84,929		84,929		2
3	Housekeeping	9,140			9,140		9,140		9,140		3
4	Laundry	16,984	390		17,374		17,374		17,374		4
5	Heat and Other Utilities			61,431	61,431		61,431		61,431		5
6	Maintenance	28,685		37,690	66,375		66,375		66,375		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	172,398	102,677	100,801	375,876	(10,691)	365,185		365,185		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	591,787	80,335	2,041	674,163		674,163		674,163		10
10a	Therapy	19,574		2,246	21,820		21,820		21,820		10a
11	Activities	8,746		550	9,296		9,296		9,296		11
12	Social Services	24,609		276	24,885		24,885		24,885		12
13	CNA Training										13
14	Program Transportation			1,647	1,647		1,647		1,647		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	644,716	80,335	6,760	731,811		731,811		731,811		16
	<b>C. General Administration</b>										
17	Administrative	41,242			41,242		41,242		41,242		17
18	Directors Fees										18
19	Professional Services			44,641	44,641		44,641		44,641		19
20	Dues, Fees, Subscriptions & Promotions			17,732	17,732		17,732	(7,643)	10,089		20
21	Clerical & General Office Expenses	14,949	9,619	7,290	31,858		31,858		31,858		21
22	Employee Benefits & Payroll Taxes			105,304	105,304	10,691	115,995		115,995		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,500	2,500		2,500		2,500		24
25	Other Admin. Staff Transportation			3,833	3,833		3,833		3,833		25
26	Insurance-Prop.Liab.Malpractice			29,754	29,754		29,754		29,754		26
27	Other (specify):* <b>BANK FEES</b>			3,368	3,368		3,368	(3,368)			27
28	<b>TOTAL General Administration</b>	56,191	9,619	214,422	280,232	10,691	290,923	(11,011)	279,912		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	873,305	192,631	321,983	1,387,919		1,387,919	(11,011)	1,376,908		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			15,896	15,896		15,896	39,231	55,127		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			22,871	22,871		22,871	33,700	56,571		32
33	Real Estate Taxes			18,998	18,998		18,998		18,998		33
34	Rent-Facility & Grounds			61,200	61,200		61,200	(60,000)	1,200		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			118,965	118,965		118,965	12,931	131,896		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			257,502	257,502		257,502		257,502		39
40	Barber and Beauty Shops			4,420	4,420		4,420		4,420		40
41	Coffee and Gift Shops			765	765		765		765		41
42	Provider Participation Fee			87,086	87,086		87,086		87,086		42
43	Other (specify):* Penalties			1,152	1,152		1,152		1,152		43
44	<b>TOTAL Special Cost Centers</b>			350,925	350,925		350,925		350,925		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	873,305	192,631	791,873	1,857,809		1,857,809	1,920	1,859,729		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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

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

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

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

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

ID# 0051268

Report Period Beginning: 1/1/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STOCKTON HEALTHCARE & REHAB

# 0051268

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number STOCKTON HEALTHCARE & REHAB # 0051268 Report Period Beginning: 1/1/14 Ending: 12/31/14

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	39,231	0	0	0	0	0	0	0	0	0	39,231	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	33,700	0	0	0	0	0	0	0	0	0	33,700	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(60,000)	0	0	0	0	0	0	0	0	0	(60,000)	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	<b>TOTAL Ownership</b>	0	12,931	0	0	0	0	0	0	0	0	0	12,931	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	0	12,931	0	0	0	0	0	0	0	0	0	12,931	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
JOSEPH BRANDMAN custodian for Children	100%	BELLWOOD NURSING CENTER LLC	BELLWOOD, IL	STOCKTON, LLC	STOCKTON, IL	BLDG RENTAL

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	34 RENT	\$ 60,000	STOCKTON REALTY LLC	100.00%	\$		(60,000) 1
2	V	32 INTEREST		STOCKTON REALTY LLC		33,700		33,700 2
3	V	30 DEPRECIATION		STOCKTON REALTY LLC		39,231		39,231 3
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 60,000			\$ 72,931	\$ *	12,931 14

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

Facility Name & ID Number

STOCKTON HEALTHCARE & REHAB

# 0051268

Report Period Beginning:

1/1/14

Ending:

12/31/14

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number STOCKTON HEALTHCARE & REHAB # 0051268 Report Period Beginning: 1/1/14 Ending: 12/31/14

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 STOCKTON HEALTHCARE & REHAB # 0051268 Report Period Beginning: 1/1/14 Ending: 12/31/14

**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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10			
										Related**		Purpose of Loan
Name of Lender	YES	NO	Original	Balance								
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	1st EQUITY BANK		X	MORTGAGE	\$4,022.67	3/30/14	\$ 650,000	\$ 596,305	3/30/15	5.5000	\$ 33,700	1
2	Due to Shareholder	X		OPERATING EXPENSE	N/A	1/1/2011	126,772	307,772		1.9100	5,162	2
3	Due to Shareholder	X		OPERATING EXPENSE	N/A	11/12/14	125,000	100,000		1.9100	955	3
4												4
5												5
<b>Working Capital</b>												
6	1st EQUITY BANK		X	WORKING CAPITAL	INTEREST	3/30/14	300,000	299,450	3/30/15	5.5000	16,698	6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$4,022.67		\$ 1,201,772	\$ 1,303,527			\$ 56,515	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,201,772	\$ 1,303,527			\$ 56,515	15

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2013 report.			\$ <b>15,823</b>	<b>1</b>																				
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.)			\$ <b>17,132</b>	<b>2</b>																				
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>1,309</b>	<b>3</b>																				
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>17,689</b>	<b>4</b>																				
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>5</b>																				
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>6</b>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>18,998</b>	<b>7</b>																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	<b>2009</b>	_____	<b>8</b>	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2013</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2013	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>FOR BHF USE ONLY</b>																								
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2013	\$	<b>13</b>																					
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																					
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																					
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																					
	<b>2010</b>	_____	<b>9</b>																					
	<b>2011</b>	<b>13,918</b>	<b>10</b>																					
	<b>2012</b>	<b>15,712</b>	<b>11</b>																					
	<b>2013</b>	<b>17,132</b>	<b>12</b>																					

**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 STOCKTON HEALTHCARE & REHAB COUNTY JO DAVIESS

FACILITY IDPH LICENSE NUMBER 0051268

CONTACT PERSON REGARDING THIS REPORT JESSICA KOPP

TELEPHONE 8152321324 FAX #: 8152351050

**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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-002-158-03</u>	<u>S12 T27N R4E</u>	\$ <u>17,132.00</u>	\$ <u>17,132.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>17,132.00</u></u>	\$ <u><u>17,132.00</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?        YES   X   NO

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

**C. Tax Bills**

Attach 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: 13,242 B. General Construction Type: Exterior MASONRY Frame WOOD 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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$, 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	49	2011		\$ 360,000	\$ 9,231	39	\$ 9,231		\$ 36,923	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	REMODELING - 2011		2011	177,277	11,818	15	11,818		42,349	9
10	REMODELING - 2012:		2012							10
11	HEATERS			9,079	330	27.5	330		853	11
12	NURSES STATION - ELECTRICAL			25,997	945	27.5	945		2,363	12
13	FIRE ALARM SYSTEM			28,456	1,027	27.5	1,027		2,140	13
14	HVAC		2013	8,500	425	20	425		779	14
15	ROOF		2013	9,825	418	39	418		502	15
16	ROOF PATCHING		2014	15,500	397	39	397		397	16
17	EXTERIOR DOOR		2014	3,722	90	27.5	90		90	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number STOCKTON HEALTHCARE & REHAB

# 0051268

Report Period Beginning:

1/1/14

Ending:

12/31/14

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								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 638,356	\$ 24,681		\$ 24,681	\$	\$ 86,397	70

\*\*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	\$ 304,104	\$ 30,444	\$ 30,444	\$	10	\$ 120,961	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 304,104	\$ 30,444	\$ 30,444	\$		\$ 120,961	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 942,460	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,125	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,125	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 207,357	85

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

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

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1	1715 hrs	19,574				1,715	19,574	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts	59,880					59,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>THERAPY</u>	39-3		197,486					197,486	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 276,940		\$	\$	1,715	\$ 276,940	14

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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 56,837	\$ 61,870	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	839,740	839,740	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,159	5,159	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Florence</u>	12,127	12,127	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 913,863	\$ 918,896	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		360,000	14
15	Leasehold Improvements, at Historical Cost	278,146	278,146	15
16	Equipment, at Historical Cost	6,104	306,104	16
17	Accumulated Depreciation (book methods)	(50,435)	(207,076)	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): <u>Due from Other</u>	200,025	200,025	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 433,840	\$ 937,199	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,347,703	\$ 1,856,095	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 66,742	\$ 66,742	26
27	Officer's Accounts Payable		27,909	27
28	Accounts Payable-Patient Deposits	778	778	28
29	Short-Term Notes Payable	59,735	59,735	29
30	Accrued Salaries Payable	32,341	32,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,598)	(2,598)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,689	17,689	32
33	Accrued Interest Payable	14,970	14,970	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Vacation Accrual</u>	16,801	16,801	36
37	<u>Due to BNC</u>	29,500	39,500	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 235,958	\$ 273,867	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	299,450	299,450	39
40	Mortgage Payable		596,305	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Other</u>	407,008	407,008	43
44	<u>Intercompany</u>	58,883		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 765,341	\$ 1,302,763	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,001,299	\$ 1,576,630	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 346,404	\$ 279,465	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,347,703	\$ 1,856,095	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>190,689</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment - Depreciation</b>	<b>39,128</b>	<b>3</b>
<b>4</b>	<b>Leasehold Improvements</b>		<b>4</b>
<b>5</b>	<b>2013 PPA - 2014 PPA = \$11861</b>		<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>229,817</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>116,587</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>116,587</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>346,404</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,969,695	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,969,695	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	3,891	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,891	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	810	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 810	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,974,396	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	375,876	31
32	Health Care	731,811	32
33	General Administration	280,232	33
<b>B. Capital Expense</b>			
34	Ownership	118,965	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	263,839	35
36	Provider Participation Fee	87,086	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,857,809	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	116,587	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 116,587	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 670,756	44
45	Private Pay - Net Inpatient Revenue	724,013	45
46	Medicare - Net Inpatient Revenue	574,926	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,969,695	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No cash basis 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 **STOCKTON HEALTHCARE & REHAB**

# **0051268**

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	2,196	2,252	\$ 51,276	\$ 22.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,245	8,365	172,173	20.58	3
4	Licensed Practical Nurses	3,099	3,184	64,398	20.23	4
5	CNAs & Orderlies	29,535	30,328	303,940	10.02	5
6	CNA Trainees					6
7	Licensed Therapist	1,715	1,899	19,574	10.31	7
8	Rehab/Therapy Aides					8
9	Activity Director	754	834	8,746	10.49	9
10	Activity Assistants					10
11	Social Service Workers	2,043	2,083	24,609	11.81	11
12	Dietician					12
13	Food Service Supervisor	2,068	2,235	29,088	13.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,454	9,838	88,501	9.00	15
16	Dishwashers					16
17	Maintenance Workers	2,047	2,111	28,685	13.59	17
18	Housekeepers	1,053	1,053	9,140	8.68	18
19	Laundry	1,774	1,814	16,984	9.36	19
20	Administrator	1,484	1,521	41,242	27.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,168	1,168	14,949	12.80	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)	66,635	68,685	\$ 873,305 *	\$ 12.71	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	\$ 1,680	1-3	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	1,035	10-3	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	2,246	10a-3	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	550	11-3	44
45	Social Service Consultant	276	12-3	45
46	Other(specify) <u>MEDICARE CONSULTANT</u>	12,000	19-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,787		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LISA CAREY	ADMINISTRATOR		\$ 4,640	Workers' Compensation Insurance	\$ 25,379	IDPH License Fee	\$ 4,055	
MICHAEL NUDELL	ADMINISTRATOR			Unemployment Compensation Insurance	13,217	Advertising: Employee Recruitment	4,813	
DELORES DOWNS	ADMINISTRATOR		31,987	FICA Taxes	66,708	Health Care Worker Background Check	211	
GINA MILLER	ADMINISTRATOR		4,615	Employee Health Insurance		(Indicate # of checks performed )		
				Employee Meals	10,691	Patient Background Checks	35 560	
				Illinois Municipal Retirement Fund (IMRF)*		LLC RENEWAL	250	
						FOOD LICENSE	200	
						ADVERTISING	7,643	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,242			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	(7,643)	
Description			Amount			Yellow page advertising	( )	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,089	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 115,995			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
INTUIT	PAYROLL PROCESSING		\$ 1,719			\$	Out-of-State Travel	\$
THOMPSON & KOPP	ACCOUNTANT		21,895					
WESCOM SOLUTIONS	COMPUTER CONSULT		4,954				In-State Travel	
MEYER MAGENCE	LEGAL		3,250				TRAVEL EXPENSE	4,351
STEPHEN SHER	LEGAL		660					
PERSONNEL PLANNERS	PAYROLL CONSULT		162				Seminar Expense	
							SEMINARS	1,738
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 32,640	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,089

\* Attach copy of IMRF notifications

\*\*See instructions.

**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	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name &amp; ID Number STOCKTON HEALTHCARE &amp; REHAB

# 0051268

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,536 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 87,126  
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. \$ 10,691 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees