FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0051888

Facility Name: Stonebridge Senior Lving Ctr

Address: 902 S Mcleansboro St (Number) Benton (City) 62812 (Zip Code)

County: Franklin

Telephone Number: (618) 439-4501 **Fax #** (618) 435-3141

HFS ID Number:

Date of Initial License for Current Owners: 39626

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,501	2,501	8
9	SNF/PED					9
10	ICF	11,416	6,495		17,911	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,416	6,495	2,501	20,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.90%

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 [X] 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 [X]

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 [X] Date 01/14/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,422

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	128,613	7,204	5,285	141,102		141,102		141,102			1
2	Food Purchase		115,501		115,501		115,501		115,501			2
3	Housekeeping	106,994	11,813		118,807		118,807	412	119,219			3
4	Laundry	87,166	8,660		95,826		95,826		95,826			4
5	Heat and Other Utilities			84,576	84,576		84,576	281	84,857			5
6	Maintenance	30,075	33,638	44,924	108,637		108,637	(18,262)	90,375			6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			6,752	6,752		6,752	19	6,771			7
8	TOTAL General Services	352,848	176,816	141,537	671,201		671,201	(17,550)	653,651			8
	B. Health Care and Programs											
9	Medical Director			6,750	6,750		6,750		6,750			9
10	Nursing and Medical Records	835,226	49,910	1,200	886,336		886,336	20,756	907,092			10
10a	Therapy			183,479	183,479		183,479		183,479			10a
11	Activities	25,645			25,645		25,645		25,645			11
12	Social Services	19,757	1,404	2,288	23,449		23,449		23,449			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							2,482	2,482			15
16	TOTAL Health Care and Programs	880,628	51,314	193,717	1,125,659		1,125,659	23,238	1,148,897			16
	C. General Administration											
17	Administrative	169,149		216,553	385,702		385,702	(81,065)	304,637			17
18	Directors Fees											18
19	Professional Services			30,337	30,337		30,337	890	31,227			19
20	Dues, Fees, Subscriptions & Promotions			12,831	12,831		12,831	(412)	12,419			20
21	Clerical & General Office Expenses	30,044	19,727	15,015	64,786		64,786	31,554	96,340			21
22	Employee Benefits & Payroll Taxes			209,528	209,528		209,528		209,528			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,497	2,497		2,497	109	2,606			24
25	Other Admin. Staff Transportation			5,834	5,834		5,834	2,116	7,950			25
26	Insurance-Prop.Liab.Malpractice			52,914	52,914		52,914	343	53,257			26
27	Other (specify):* RDK/SI Benefits Alloc							12,056	12,056			27
28	TOTAL General Administration	199,193	19,727	545,509	764,429		764,429	(34,409)	730,020			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,432,669	247,857	880,763	2,561,289		2,561,289	(28,721)	2,532,568			29

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

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

Facility Name & ID Number Stonebridge Senior Lving Ctr #0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,756	68,756		68,756	8,529	77,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			6,717	6,717		6,717	154	6,871			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,563	6,563		6,563		6,563			35
36	Other (specify):*											36
37	**TOTAL Ownership**			82,036	82,036		82,036	8,683	90,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,004		100,004		100,004		100,004			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,840	159,840		159,840		159,840			42
43	Other (specify):* Non-allowable Costs			32,206	32,206		32,206	(32,206)				43
44	**TOTAL Special Cost Centers**		100,004	192,046	292,050		292,050	(32,206)	259,844			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,432,669	347,861	1,154,845	2,935,375		2,935,375	(52,244)	2,883,131			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(2,667)	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	7,622	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	(507)	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	(574)	20		17
18	Fines and Penalties				18
19	Entertainment	(5,680)	43		19
20	Contributions	(1,252)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(132)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,895)	43		24
25	Fund Raising, Advertising and Promotional	(3,440)	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	(26,507)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,032)		$	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 Amount	2 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)	(8,212)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,212)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,244)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Stonebridge Senior Lving Ctr

ID# 0051888

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Funeral Expense	$ (77)	43	1
2	Birthday Expense	(1,795)	43	2
3	Gifts	(91)	43	3
4	Investment Expenses/Foreign Tax paid	(5,802)	43	4
5	Miscellaneous income offset	(235)	21	5
6	Out of State Travel	(159)	24	6
7	Capitalized Repairs and Maintenance	(18,348)	6	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**	(26,507)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	412	0	0	0	0	0	0	0	0	412	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	281	0	0	0	0	0	0	0	0	281	5
6	Maintenance	(18,348)	0	86	0	0	0	0	0	0	0	0	(18,262)	6
7	Other (specify):*	0	0	19	0	0	0	0	0	0	0	0	19	7
8	**TOTAL General Services**	(18,348)	0	798	0	0	0	0	0	0	0	0	(17,550)	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	20,756	0	0	0	0	0	0	0	0	0	20,756	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	2,482	0	0	0	0	0	0	0	0	0	2,482	15
16	**TOTAL Health Care and Programs**	0	23,238	0	0	0	0	0	0	0	0	0	23,238	16
	C. General Administration													
17	Administrative	0	(73,011)	(8,054)	0	0	0	0	0	0	0	0	(81,065)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(132)	379	643	0	0	0	0	0	0	0	0	890	19
20	Fees, Subscriptions & Promotions	(574)	75	87	0	0	0	0	0	0	0	0	(412)	20
21	Clerical & General Office Expenses	(235)	28,987	2,802	0	0	0	0	0	0	0	0	31,554	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	(159)	10	258	0	0	0	0	0	0	0	0	109	24
25	Other Admin. Staff Transportation	0	945	1,171	0	0	0	0	0	0	0	0	2,116	25
26	Insurance-Prop.Liab.Malpractice	0	343	0	0	0	0	0	0	0	0	0	343	26
27	Other (specify):*	0	8,343	3,713	0	0	0	0	0	0	0	0	12,056	27
28	**TOTAL General Administration**	(1,100)	(33,929)	620	0	0	0	0	0	0	0	0	(34,409)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,448)	(10,691)	1,418	0	0	0	0	0	0	0	0	(28,721)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	7,622	0	907	0	0	0	0	0	0	0	0	8,529	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	154	0	0	0	0	0	0	0	0	154	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**	7,622	0	1,061	0	0	0	0	0	0	0	0	8,683	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):*	(32,206)	0	0	0	0	0	0	0	0	0	0	(32,206)	43
44	**TOTAL Special Cost Centers**	(32,206)	0	0	0	0	0	0	0	0	0	0	(32,206)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,032)	(10,691)	2,479	0	0	0	0	0	0	0	0	(52,244)	45

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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
Steven B. Herrin	95	Carrier Mills Nursing & Rehab	Carrier Mills	RDK Management, In	Harrisburg	Management Co.
Dr. Roger Herrin	5	Saline Care Center	Harrisburg	SI Management Svc, L	Harrisburg	Management Co.
		Pinckneyville Nursing & Rehab	Pinckneyville			
		DuQuoin Nursing & Rehab	DuQuoin			

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing Wages	$	SI Management Services, LLC	100.00%	$ 20,756	$ 20,756	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	2,482	2,482	2
3	V	17	Administrative	114,255	SI Management Services, LLC	100.00%	41,244	(73,011)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	379	379	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	75	75	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	28,987	28,987	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	10	10	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	945	945	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	343	343	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	8,343	8,343	10
11	V								11
12	V								12
13	V								13
14	Total			$ 114,255			$ 103,564	$ * (10,691)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	$	RDK Management, Inc.	100.00%	$ 412	$ 412	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	281	281	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	86	86	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	19	19	18
19	V	17	Administrative	102,298	RDK Management, Inc.	100.00%	94,244	(8,054)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	643	643	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	87	87	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	2,802	2,802	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	258	258	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	1,171	1,171	24
25	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	3,713	3,713	25
26	V	30	Depreciation		RDK Management, Inc.	100.00%	907	907	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	154	154	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,298			$ 104,777	$ * 2,479	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dr. Roger Herrin	Owner	Administrative	0.05	See Att Sch 7A	3.22	8.05	Alloc. Salary	$ 85,291	L17, C7	1
2	Steven Herrin	Owner	Administrative	0.95	None	40	100.00	Salary	120,000	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	$ 205,291		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 [X] NO [ ]

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

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: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Wages	Census	126,706	5	128,842	128,842	20,412	$ 20,756	1
2	15	Health Care and Prog Emp. Ben.	Census	126,706	5	15,408		20,412	2,482	2
3	17	Administrative	Census	126,706	5	256,018	256,018	20,412	41,244	3
4	19	Professional Fees	Census	126,706	5	2,350		20,412	379	4
5	20	Fees, Subscriptions	Census	126,706	5	465		20,412	75	5
6	21	Clerical And General	Census	126,706	5	179,937	177,087	20,412	28,987	6
7	24	Travel and Seminar	Census	126,706	5	61		20,412	10	7
8	25	Admin. Staff Trans.	Census	126,706	5	5,866		20,412	945	8
9	26	Insurance-Prop./Liab./Malprac.	Census	126,706	5	2,129		20,412	343	9
10	27	Gen. Admin. Emp. Ben.	Census	126,706	5	51,789		20,412	8,343	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					$ 642,865	$ 561,947		$ 103,564	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 [X] NO [ ]

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

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: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	126,706	5	2,554	2,554	20,412	$ 412	1
2	5	Utilities	Census	126,706	5	1,746		20,412	281	2
3	6	Maintenance	Census	126,706	5	535	379	20,412	86	3
4	7	General Svcs. Emp. Ben.	Census	126,706	5	117		20,412	19	4
5	17	Administrative	Census	126,706	5	585,011	585,011	20,412	94,244	5
6	19	Professional Services	Census	126,706	5	3,992		20,412	643	6
7	20	Dues, Fees, Subs & Promotions	Census	126,706	5	540		20,412	87	7
8	21	Clerical and General Office	Census	126,706	5	17,394		20,412	2,802	8
9	24	Travel and Seminar	Census	126,706	5	1,600		20,412	258	9
10	25	Other Admin. Staff Transport.	Census	126,706	5	7,267		20,412	1,171	10
11	27	Mgmt. Allocation of Benefits	Census	126,706	5	23,048		20,412	3,713	11
12	30	Depreciation	Census	126,706	5	5,630		20,412	907	12
13	33	Real Estate Taxes	Census	126,706	5	957		20,412	154	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 650,391	$ 587,944		$ 104,777	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 6,845	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.)	2014	$ 6,747	2
3. Under or (over) accrual (line 2 minus line 1).		$ (98)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 6,815	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	154	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ 154	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 6,871	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	6,187	8
2011	6,267	9
2012	6,465	10
2013	6,653	11
2014	6,747	12

2015 Tax Accrual = $6,747 x 1.01 = $6,815

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Senior Lving 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20-156-003	Long Term Care Property	$ 271.64	$ 271.64
2.	08-20-301-002	Long Term Care Property	$ 6,475.62	$ 6,475.62
3.	06-2-275-02	Home Office Allocation	$ 958.10	$ 958.10
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,705.36	$ 7,705.36

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	958,320	1988	$ 11,266	1
2	Home Office Allocation			4,735	2
3	TOTALS	958,320		$ 16,001	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		1988	1970	$ 754,463	$	30	$ 25,149	$ 25,149	$ 704,172	4
5	1		1992	1992	95,587		30	3,186	3,186	76,464	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	11,358	11,358	169,886	17
18	Light Fixtures			2010	3,937		20	197	197	1,182	18
19	New Sprinkler Heads			2010	3,390		20	170	170	1,019	19
20	Install Generator, Wiring			2010	28,506		20	1,425	1,425	8,551	20
21	Roof Shingles			2011	4,385		20	219	219	1,974	21
22	Roof Work			2011	4,837		20	242	242	1,935	22
23	Renovation Of Medicare Patient Rooms And Therapy Rooms - Blinds, Flo			2012			20				23
24	- Blinds, Flooring, Cabinetry, Painting, Signage, And Fixtures			2012	48,531		20	2,427	2,427	9,707	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	759	26
27	Roof			2013	14,500		20	725	725	2,175	27
28	Asphalt Drive			2014	4,543		20	227	227	341	28
29	Replace Leaking Sprinkler Heads			2014	1,695		20	85	85	127	29
30	Fiberglass 9 Lite Door			2014	770		20	39	39	58	30
31	Carpeting-one room			2014	181		20	9	9	14	31
32	Landscaping and Drainage work			2014	6,397		20	320	320	480	32
33	Facility Remodel - Replace & repair drywall, rewire electric,										33
34	Replace doors, Painting & staining, Replace Sprinkler heads			2015	91,638		20	2,291	2,291	2,291	34
35	Corner / Wall Guards			2015	7,055		20	229	229	229	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring & Cove Base-North wing rooms and hallways	2015	4,955		20	124	$ 124	$ 124	37
38	Window Coverings-North wing rooms and hallways	2015	5,473		20	137	137	137	38
39	Wall Light Fixtures - North wing rooms and hallways	2015	3,653		20	91	91	91	39
40	Wallcoverings - North wing rooms and hallways	2015	6,109		20	153	153	153	40
41	Bathroom Remodel - Replace toilets, faucets, mirrors, grab bars,								41
42	flooring, rewire electric and paint	2015	31,777		20	794	794	794	42
43	Interior Design Development Fee	2015	2,295		20	57	57	57	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	Leasehold Information								56
57									57
58	Allocated From RDK Management	1993	27,146		20	425	425	20,347	58
59	Allocated From RDK Management	1994	1,173		20			1,173	59
60	Allocated From RDK Management	1996	43		20	2	2	43	60
61	Allocated From RDK Management	1998	197		20	10	10	178	61
62	Allocated From RDK Management	2000	4,361		20	218	218	3,489	62
63									63
64									64
65									65
66									66
67	Financial Statement Depreciation			68,756			(68,756)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,445,775	$ 68,756		$ 50,499	$ (18,257)	$ 1,065,175	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 124,614	$	$ 18,571	$ 18,571	3-10	$ 82,672	71
72	Current Year Purchases	52,406		3,956	3,956	5-7	3,956	72
73	Fully Depreciated Assets	185,733				10	185,733	73
74	Allocated from Mgmt Co.	12,000		1,079	1,079	5-10	11,326	74
75	TOTALS	$ 374,753	$	$ 23,606	$ 23,606		$ 283,687	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 Sch 13A	Various	$ 74,785	$	$ 3,180	$ 3,180	5	$ 36,396	76
77										77
78										78
79		Allocated from Mgmt Co		20,894				5	20,894	79
80	TOTALS			$ 95,679	$	$ 3,180	$ 3,180		$ 57,290	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)	$ 1,932,208	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,756	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,285	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,529	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,406,152	85	

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Stonebridge Senior Lving Ctr

Period Beginning **1/1/15**
Period End **12/31/15**

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		1,137	1,137	5	1,706
Administrative	2001 Ford Mustang	2014	840		168	168	5	252
Facility	2015 Dodge Caravan	2015	35,697		1,875	1,875	5	1,875
	Total		**$ 74,785**	**$ -**	**$ 3,180**	**$ 3,180**		**$ 36,396**

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 6,563 Description: Medical Equipment $5,921; Office Equipment $642
    (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	N/A		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$		$ 75,381	$		$ 75,381	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			26,533			26,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs			81,565			81,565	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				100,004		100,004	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			$		$ 183,479	$ 100,004		$ 283,483	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 155,793	$ 155,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	703,350	703,350	3
4	Supply Inventory (priced at)	4,000	4,000	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	38,411	38,411	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 901,554	$ 901,554	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	600,363	600,363	12
13	Land	13,500	16,001	13
14	Buildings, at Historical Cost	875,924	850,050	14
15	Leasehold Improvements, at Historical Cost	395,833	595,725	15
16	Equipment, at Historical Cost	756,894	470,432	16
17	Accumulated Depreciation (book methods)	(1,413,441)	(1,406,152)	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)**	$ 1,234,073	$ 1,131,419	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,135,627	$ 2,032,973	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 74,081	$ 74,081	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,748	33,748	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,049	3,049	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,815	6,815	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)**	$ 117,693	$ 117,693	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)**	$ 117,693	$ 117,693	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,017,934	$ 1,915,280	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,135,627	$ 2,032,973	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,004,026	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	8,353	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,012,379	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,525	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	(431,970)	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)**	$ 5,555	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)**	$ 2,017,934	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,356,251	1
2	Discounts and Allowances for all Levels	(24,359)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,331,892	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,632	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 43,632	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***	157	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 157	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	235	28
28a	SI Mgmt Inc (loss)	(3,016)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,781)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,372,900	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	671,201	31
32	Health Care	1,125,659	32
33	General Administration	764,429	33
	B. Capital Expense		
34	Ownership	82,036	34
	C. Ancillary Expense		
35	Special Cost Centers	132,210	35
36	Provider Participation Fee	159,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,935,375	40
41	**Income before Income Taxes (line 30 minus line 40)****	437,525	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 437,525	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,548,409	44
45	Private Pay - Net Inpatient Revenue	794,256	45
46	Medicare - Net Inpatient Revenue	815,165	46
47	Other-(specify) Insurance	164,954	47
48	Other-(specify)	9,108	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,331,892	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,080	$ 49,968	$ 24.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,215	6,336	143,216	22.60	3
4	Licensed Practical Nurses	11,714	12,260	212,512	17.33	4
5	CNAs & Orderlies	41,638	42,871	429,530	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,774	1,781	17,012	9.55	9
10	Activity Assistants	958	1,011	8,633	8.54	10
11	Social Service Workers	1,815	1,891	19,757	10.45	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,179	22,701	10.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,411	12,002	105,912	8.82	15
16	Dishwashers					16
17	Maintenance Workers	1,975	1,988	30,075	15.13	17
18	Housekeepers	11,132	11,691	106,994	9.15	18
19	Laundry	9,329	9,696	87,166	8.99	19
20	Administrator	1,958	2,006	49,149	24.50	20
21	Assistant Administrator					21
22	Other Administrative	2,000	2,080	120,000	57.69	22
23	Office Manager					23
24	Clerical	2,205	2,333	30,044	12.88	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)	108,020	112,205	$ 1,432,669 *	$ 12.77	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 5,285	L1, C3	35
36	Medical Director	Monthly	6,750	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	35	2,288	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	144	$ 15,523		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steven Johnson	Administrator	0	$ 43,279
Steven Hopkins	Administrator	0	5,870
Steven B Herrin	Owner	95	120,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,149

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 216,553
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216,553
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Office	Legal	$ 282
Adam Lawler Law Firm llc	Legal	132
Kerns Frost & Pearlman	Legal	2,153
Templin Healthcare Accounting	Accounting	4,083
James Henson PC	Accounting	3,694
Payroll Services by Extra Help	Payroll Service	1,856
Galaxy Hosted Software	Web Hosting Service	1,200
Lintech	LTC Software	10,030
Ability Network	Health Info Management	689
IT Next Gen	Web Hosting Service	190
See Attached Sch 21C		6,028
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 30,337

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,520
Unemployment Compensation Insurance	17,457
FICA Taxes	99,766
Employee Health Insurance	21,424
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expenses	3,684
Personal/Funeral Day Expense	916
Life Ins / Disability	2,156
Other Employee Benefits	1,605
TOTAL (agree to Schedule V, line 22, col.8)	$ 209,528

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	715
Health Care Worker Background Check	
(Indicate # of checks performed 47)	1,350
Patient Background Checks 52	1,207
License & Permits	101
Dues & Subcriptions	472
IHCA	4,432
Allocated From RDK/SI Management	162
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,419

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,348
Seminar Expense	990
Allocated From SI Management	268
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,606

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name: **Stonebridge Senior Lving Ctr**
IDPH License ID Number: **0051888**
Fiscal Year End: **12/31/15**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
American Health Tech	LTC Software	4,225
Esolutions	Health Info Management	1,180
Passport Software	Accounting Software	623
	Total	**6,028**

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stonebridge Senior Lving Ctr # 0051888 Report Period Beginning: 1/1/15 Ending: 12/31/15

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. **4,432 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? **5-7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,487** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **159,840**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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.

Stonebridge Senior Lving Ctr

Period Beginning	**1/1/15**
Period End	**12/31/15**

ATTACHED SCHEDULE I

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	**923**
Fuel and miscellaneous supplies	**4,911**
Allocated from Mgmt Co	**2,116**
	7,950