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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0054494

Facility Name: Stonebridge Nursing & Rehab

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 1/1/16 to 12/31/16 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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	5,490	1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	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			2,747	2,747	8
9	SNF/PED					9
10	ICF	9,751	6,218		15,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,751	6,218	2,747	18,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.92%

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 2,312

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: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	135,111	9,674	5,350	150,135		150,135		150,135			1
2	Food Purchase		104,023		104,023		104,023		104,023			2
3	Housekeeping	116,930	11,220		128,150		128,150	2,753	130,903			3
4	Laundry	82,201	7,969		90,170		90,170		90,170			4
5	Heat and Other Utilities			87,252	87,252		87,252	249	87,501			5
6	Maintenance	32,497	15,089	39,020	86,606		86,606	2,015	88,621			6
7	Other (specify):* Waste Rem/RDK/SI Benefits A			7,248	7,248		7,248	1,160	8,408			7
8	TOTAL General Services	366,739	147,975	138,870	653,584		653,584	6,177	659,761			8
	B. Health Care and Programs											
9	Medical Director			6,050	6,050		6,050		6,050			9
10	Nursing and Medical Records	899,924	34,177	1,200	935,301		935,301	22,699	958,000			10
10a	Therapy											10a
11	Activities	25,260			25,260		25,260		25,260			11
12	Social Services	22,207	2,236	1,876	26,319		26,319		26,319			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RDK/SI Benefits Alloc							3,027	3,027			15
16	TOTAL Health Care and Programs	947,391	36,413	9,126	992,930		992,930	25,726	1,018,656			16
	C. General Administration											
17	Administrative	164,494		218,792	383,286		383,286	(127,858)	255,428			17
18	Directors Fees											18
19	Professional Services			35,942	35,942		35,942	241	36,183			19
20	Dues, Fees, Subscriptions & Promotions			9,704	9,704		9,704	77	9,781			20
21	Clerical & General Office Expenses	26,532	16,581	15,348	58,461		58,461	18,230	76,691			21
22	Employee Benefits & Payroll Taxes			201,931	201,931		201,931		201,931			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,327	3,327		3,327	56	3,383			24
25	Other Admin. Staff Transportation			9,493	9,493		9,493	4,129	13,622			25
26	Insurance-Prop.Liab.Malpractice			50,837	50,837		50,837	956	51,793			26
27	Other (specify):* RDK/SI Benefits Alloc							9,681	9,681			27
28	TOTAL General Administration	191,026	16,581	545,374	752,981		752,981	(94,488)	658,493			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,505,156	200,969	693,370	2,399,495		2,399,495	(62,585)	2,336,910			29

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

SEE ACCOUNTANTS' PREPARATION 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 Nursing & Rehab #0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			92,504	92,504		92,504	(3,740)	88,764			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9	9		9	(9)				32
33	Real Estate Taxes			6,746	6,746		6,746	134	6,880			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,915	5,915		5,915		5,915			35
36	Other (specify):*											36
37	**TOTAL Ownership**			105,174	105,174		105,174	(3,615)	101,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,044	200,101	309,145		309,145		309,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,022	136,022		136,022		136,022			42
43	Other (specify):* Disallowed Costs			65,389	65,389		65,389	(65,389)				43
44	**TOTAL Special Cost Centers**		109,044	401,512	510,556		510,556	(65,389)	445,167			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,505,156	310,013	1,200,056	3,015,225		3,015,225	(131,589)	2,883,636			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(3,108)	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	(4,247)	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	(231)	43		13
14	Non-Care Related Interest	(9)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(434)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,826)	43		19
20	Contributions	(300)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,120)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,081)	43		24
25	Fund Raising, Advertising and Promotional	(8,037)	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	(22,552)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,945)		$	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)	(58,644)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,644)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (131,589)		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' PREPARATION REPORT

Stonebridge Nursing & Rehab

ID# 0054494

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Funeral Expense	$ (137)	43	1
2	Birthday Expense	(1,306)	43	2
3	Gifts	(55)	43	3
4	Miscellaneous income offset	(1,746)	21	4
5	Disallow Loss on Investments	(19,308)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,552)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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	2,753	0	0	0	0	0	0	0	0	2,753	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	249	0	0	0	0	0	0	0	0	249	5
6	Maintenance	0	0	2,015	0	0	0	0	0	0	0	0	2,015	6
7	Other (specify):*	0	0	1,160	0	0	0	0	0	0	0	0	1,160	7
8	**TOTAL General Services**	0	0	6,177	0	0	0	0	0	0	0	0	6,177	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	22,699	0	0	0	0	0	0	0	0	0	22,699	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	3,027	0	0	0	0	0	0	0	0	0	3,027	15
16	**TOTAL Health Care and Programs**	0	25,726	0	0	0	0	0	0	0	0	0	25,726	16
	C. General Administration													
17	Administrative	0	(80,523)	(47,335)	0	0	0	0	0	0	0	0	(127,858)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,120)	802	559	0	0	0	0	0	0	0	0	241	19
20	Fees, Subscriptions & Promotions	(434)	445	66	0	0	0	0	0	0	0	0	77	20
21	Clerical & General Office Expenses	(1,746)	17,939	2,037	0	0	0	0	0	0	0	0	18,230	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	27	29	0	0	0	0	0	0	0	0	56	24
25	Other Admin. Staff Transportation	0	2,051	2,078	0	0	0	0	0	0	0	0	4,129	25
26	Insurance-Prop.Liab.Malpractice	0	398	558	0	0	0	0	0	0	0	0	956	26
27	Other (specify):*	0	7,474	2,207	0	0	0	0	0	0	0	0	9,681	27
28	**TOTAL General Administration**	(3,300)	(51,387)	(39,801)	0	0	0	0	0	0	0	0	(94,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,300)	(25,661)	(33,624)	0	0	0	0	0	0	0	0	(62,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,247)	507	0	0	0	0	0	0	0	0	0	(3,740)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9)	0	0	0	0	0	0	0	0	0	0	(9)	32
33	Real Estate Taxes	0	0	134	0	0	0	0	0	0	0	0	134	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**	(4,256)	507	134	0	0	0	0	0	0	0	0	(3,615)	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):*	(65,389)	0	0	0	0	0	0	0	0	0	0	(65,389)	43
44	**TOTAL Special Cost Centers**	(65,389)	0	0	0	0	0	0	0	0	0	0	(65,389)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(72,945)	(25,154)	(33,490)	0	0	0	0	0	0	0	0	(131,589)	45

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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, Inc	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%	$ 22,699	$ 22,699	1
2	V	15	Health Care and Prog Emp. Ben.		SI Management Services, LLC	100.00%	3,027	3,027	2
3	V	17	Administrative	118,980	SI Management Services, LLC	100.00%	38,457	(80,523)	3
4	V	19	Professional Fees		SI Management Services, LLC	100.00%	802	802	4
5	V	20	Fees, Subscriptions		SI Management Services, LLC	100.00%	445	445	5
6	V	21	Clerical And General		SI Management Services, LLC	100.00%	17,939	17,939	6
7	V	24	Travel and Seminar		SI Management Services, LLC	100.00%	27	27	7
8	V	25	Admin. Staff Trans.		SI Management Services, LLC	100.00%	2,051	2,051	8
9	V	26	Insurance-Prop./Liab./Malprac.		SI Management Services, LLC	100.00%	398	398	9
10	V	27	Gen. Admin. Emp. Ben.		SI Management Services, LLC	100.00%	7,474	7,474	10
11	V	30	Depreciation		SI Management Services, LLC	100.00%	507	507	11
12	V								12
13	V								13
14	Total			$ 118,980			$ 93,826	$ * (25,154)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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%	$ 2,753	$ 2,753	15
16	V	5	Utilities		RDK Management, Inc.	100.00%	249	249	16
17	V	6	Maintenance		RDK Management, Inc.	100.00%	2,015	2,015	17
18	V	7	General Svcs. Emp. Ben.		RDK Management, Inc.	100.00%	1,160	1,160	18
19	V	17	Administrative	99,812	RDK Management, Inc.	100.00%	52,477	(47,335)	19
20	V	19	Professional Services		RDK Management, Inc.	100.00%	559	559	20
21	V	20	Dues, Fees, Subs & Promotions		RDK Management, Inc.	100.00%	66	66	21
22	V	21	Clerical and General Office		RDK Management, Inc.	100.00%	2,037	2,037	22
23	V	24	Travel and Seminar		RDK Management, Inc.	100.00%	29	29	23
24	V	25	Other Admin. Staff Transport.		RDK Management, Inc.	100.00%	2,078	2,078	24
25	V	26	Insurance-Prop./Liab./Malprac.		RDK Management, Inc.	100.00%	558	558	25
26	V	27	Mgmt. Allocation of Benefits		RDK Management, Inc.	100.00%	2,207	2,207	26
27	V	33	Real Estate Taxes		RDK Management, Inc.	100.00%	134	134	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			$ 99,812			$ 66,322	$ * (33,490)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	8.37	12.31	Alloc. Fee	$ 44,170	L17, C7	1
2	Steven Herrin	Owner	Administrative	0.95	27,500			Salary	120,000	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8	Steven Herrin received $27,500 of guaranteed payments from Duquoin Nursing and Rehab										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 164,170		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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	134,154	5	162,702	162,702	18,716	$ 22,699	1
2	15	Health Care and Prog Emp. Ben.	Census	134,154	5	21,694		18,716	3,027	2
3	17	Administrative	Census	134,154	5	275,658	275,657	18,716	38,457	3
4	19	Professional Fees	Census	134,154	5	5,751		18,716	802	4
5	20	Fees, Subscriptions	Census	134,154	5	3,189		18,716	445	5
6	21	Clerical And General	Census	134,154	5	128,583	126,166	18,716	17,939	6
7	24	Travel and Seminar	Census	134,154	5	191		18,716	27	7
8	25	Admin. Staff Trans.	Census	134,154	5	14,698		18,716	2,051	8
9	26	Insurance-Prop./Liab./Malprac.	Census	134,154	5	2,853		18,716	398	9
10	27	Gen. Admin. Emp. Ben.	Census	134,154	5	53,576		18,716	7,474	10
11	30	Depreciation	Census	134,154	5	3,634		18,716	507	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					$ 672,529	$ 564,525		$ 93,826	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	134,154	5	19,736	19,736	18,716	$ 2,753	1
2	5	Utilities	Census	134,154	5	1,783		18,716	249	2
3	6	Maintenance	Census	134,154	5	14,444	11,560	18,716	2,015	3
4	7	General Svcs. Emp. Ben.	Census	134,154	5	8,314		18,716	1,160	4
5	17	Administrative	Census	134,154	5	376,148	59,539	18,716	52,477	5
6	19	Professional Services	Census	134,154	5	4,010		18,716	559	6
7	20	Dues, Fees, Subs & Promotions	Census	134,154	5	471		18,716	66	7
8	21	Clerical and General Office	Census	134,154	5	14,604		18,716	2,037	8
9	24	Travel and Seminar	Census	134,154	5	207		18,716	29	9
10	25	Other Admin. Staff Transport.	Census	134,154	5	14,897		18,716	2,078	10
11	26	Ins.-Prop.Liab.Malpractice	Census	134,154	5	3,999		18,716	558	11
12	27	Mgmt. Allocation of Benefits	Census	134,154	5	15,817		18,716	2,207	12
13	33	Real Estate Taxes	Census	134,154	5	962		18,716	134	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					$ 475,392	$ 90,835		$ 66,322	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	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 # _____

*** 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' PREPARATION 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 Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 6,815	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.)	2015	$ 6,769	2
3. Under or (over) accrual (line 2 minus line 1).		$ (46)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 6,792	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	134	
TOTAL REFUND $ **For** **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ 134	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 6,880	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	6,267	8
2012	6,465	9
2013	6,653	10
2014	6,747	11
2015	6,769	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stonebridge Nursing & Rehab COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0054494

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 252-7707 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 272.66	$ 272.66
2.	08-20-301-002	Long Term Care Property	$ 6,496.50	$ 6,496.50
3.	06-2-275-02	Home Office Allocation	$ 963.32	$ 134.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,732.48	$ 6,903.16

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,696 B. General Construction Type: Exterior Concrete & Brick Frame Concrete Block WD Rl 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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 729,321	4
5	1		1992	1992	95,587		30	3,186	3,186	79,650	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	181,244	17
18	Light Fixtures			2010	3,937		20	197	197	1,379	18
19	New Sprinkler Heads			2010	3,390		20	170	170	1,189	19
20	Install Generator, Wiring			2010	28,506		20	1,425	1,425	9,976	20
21	Roof Shingles			2011	4,385		20	219	219	2,193	21
22	Roof Work			2011	4,837		20	242	242	2,177	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	12,134	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	949	26
27	Roof			2013	14,500		20	725	725	2,900	27
28	Asphalt Drive			2014	4,543		20	227	227	568	28
29	New Drainage System & Replacement of Damaged Door - Back office			2014	2,720		20	136	136	340	29
30	Painting			2014	2,517		20	126	126	315	30
31	Material & Labor to Flush Out the Existing Cross Mains and Feeds			2014	7,895		20	395	395	988	31
32	Carpeting-one room			2014	181		20	9	9	23	32
33	Landscaping work			2014	4,447		20	222	222	555	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Facility Remodel - Replace & repair drywall, rewire electric,						$	$	37
38	Replace doors, Painting & staining, Replace Sprinkler heads	2015	91,638		20	2,291	2,291	4,582	38
39	Corner / Wall Guards	2015	7,055		20	229	229	458	39
40	Flooring & Cove Base	2015	4,955		20	124	124	248	40
41	Window Coverings	2015	5,473		20	137	137	274	41
42	Wall Light Fixtures	2015	3,653		20	91	91	182	42
43	Wallcoverings	2015	6,109		20	153	153	306	43
44	Bathroom Remodel - Replace toilets, faucets, mirrors, grab bars,								44
45	flooring, rewire electric and paint	2015	31,777		20	794	794	1,588	45
46	Interior Design Development Fee	2015	2,295		20	57	57	114	46
47	Complete Bathroom Remodel-Paint Shower Wall and Install								47
48	Medicine Cabinets	2015	1,575		20	79	79	79	48
49	Remodel Front Entrance - New walls, electrical wiring, paint,								49
50	trim, light fixture, window treatments, flooring, AC unit	2016	18,249		20	456	456	456	50
51	New Security System	2016	13,755		20	344	344	344	51
52	Sealcoat, Crackfill and Stripe Asphalt Parking Lot	2016	2,832		20	71	71	71	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)		$ 1,457,983	$		$ 51,229	$ 51,229	$ 1,091,828	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	
1	Totals from Page 12A, Carried Forward		$ 1,457,983	$		$ 51,229	$ 51,229	$ 1,091,828	1
2									2
3									3
4									4
5	Leasehold Information								5
6									6
7	Allocated From RDK Management	1993	27,146		20	425	425	20,772	7
8	Allocated From RDK Management	1994	1,173		20			1,173	8
9	Allocated From RDK Management	1996	43		20			43	9
10	Allocated From RDK Management	1998	197		20	10	10	188	10
11	Allocated From RDK Management	2000	4,361		20	218	218	3,707	11
12									12
13									13
14									14
15									15
16	Financial Statement Depreciation			90,629			(90,629)		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	TOTAL (lines 1 thru 33)		$ 1,490,903	$ 90,629		$ 51,882	$ (38,747)	$ 1,117,711	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 177,020	$	$ 25,112	$ 25,112	5-10 yrs	$ 111,740	71
72	Current Year Purchases	19,928		2,647	2,647	5-7 yrs	2,647	72
73	Fully Depreciated Assets	185,733					185,733	73
74	Allocated from Mgmt Co.	12,000		679	679		11,498	74
75	TOTALS	$ 394,681	$	$ 28,438	$ 28,438		$ 311,618	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			50,722	$	$ 8,444	$ 8,444		$ 18,902	76
77										77
78										78
79	Allocated from Mgmt Co			20,894				5	20,894	79
80	TOTALS			$ 71,616	$	$ 8,444	$ 8,444		$ 39,796	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)	$ 1,973,201	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 90,629	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,764	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,865)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,469,125	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	2012 Mercedes	$ 88,715	$ 1,875	$ 20,772	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 88,715	$ 1,875	$ 20,772	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Stonebridge Nursing & Rehab

Period Beginning **1/1/16**
Period End **12/31/16**

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
Administrative	2015 Kia Sorrento	2014	5,685		1,137	1,137	5	2,843
Administrative	2001 Ford Mustang	2014	840		168	168	5	420
Facility	2015 Dodge Caravan	2015	35,697		7,139	7,139	5	7,139
		Total	**$ 50,722**	**$ -**	**$ 8,444**	**$ 8,444**		**$ 18,902**

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,915 Description: Medical Equipment $5,208 ; Office Equipment $707
(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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	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	39(3)	hrs	$		$ 80,664	$		$ 80,664	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			24,935			24,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			94,502			94,502	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				109,044		109,044	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			$		$ 200,101	$ 109,044		$ 309,145	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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab **#** 0054494 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16 **(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	$ 238,024	$ 238,024	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	739,701	739,701	3
4	Supply Inventory (priced at)	4,000	4,000	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	39,849	39,849	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,021,574	$ 1,021,574	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,585	6,585	12
13	Land	13,500	16,001	13
14	Buildings, at Historical Cost	875,924	850,050	14
15	Leasehold Improvements, at Historical Cost	444,363	640,853	15
16	Equipment, at Historical Cost	760,812	466,297	16
17	Accumulated Depreciation (book methods)	(1,505,945)	(1,469,125)	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)**	$ 600,239	$ 515,661	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,621,813	$ 1,537,235	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,741	$ 57,741	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,461	41,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,876	1,876	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,792	6,792	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)**	$ 107,870	$ 107,870	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)**	$ 107,870	$ 107,870	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,513,943	$ 1,429,365	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,621,813	$ 1,537,235	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,017,934	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,017,934	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	298,519	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	(804,617)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Record Invest. SI Management**	2,107	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (503,991)	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)**	$ 1,513,943	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 3,255,303	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,255,303	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	46,530	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 46,530	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***	11,023	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,023	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	1,746	28
28a	**SI Mgmt Income/(Loss)**	(858)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 888	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,313,744	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	653,584	31
32	Health Care	992,930	32
33	General Administration	752,981	33
	B. Capital Expense		
34	Ownership	105,174	34
	C. Ancillary Expense		
35	Special Cost Centers	374,534	35
36	Provider Participation Fee	136,022	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,015,225	40
41	**Income before Income Taxes (line 30 minus line 40)****	298,519	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 298,519	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,258,508	44
45	Private Pay - Net Inpatient Revenue	887,490	45
46	Medicare - Net Inpatient Revenue	935,674	46
47	Other-(specify) **Insurance**	173,631	47
48	Other-(specify) **VA**		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,255,303	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' PREPARATION REPORT

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,928	2,088	$ 59,453	$ 28.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,220	6,416	155,915	24.30	3
4	Licensed Practical Nurses	9,938	10,340	209,725	20.28	4
5	CNAs & Orderlies	42,426	43,541	474,831	10.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,617	2,741	25,260	9.22	9
10	Activity Assistants	2,617				10
11	Social Service Workers	1,919	2,079	22,207	10.68	11
12	Dietician					12
13	Food Service Supervisor	2,085	2,252	25,587	11.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,874	12,404	109,524	8.83	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,091	32,497	15.54	17
18	Housekeepers	12,066	12,767	116,930	9.16	18
19	Laundry	8,759	8,960	82,201	9.17	19
20	Administrator	1,672	1,672	44,494	26.61	20
21	Assistant Administrator					21
22	Other Administrative			120,000		22
23	Office Manager					23
24	Clerical	1,762	1,922	26,532	13.80	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)	107,885	109,273	$ 1,505,156 *	$ 13.77	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

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	110	$ 5,350	L1, C3	35
36	Medical Director	Monthly	6,050	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	31	1,876	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	141	$ 14,476		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

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ian Perkins	Administrator	0	$ 31,749
Tracy Garrett	Administrator	0	12,745
Steven B Herrin	Owner	95	120,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 164,494

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 218,792
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 218,792

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Office	Legal	$ 27
Lawler Brown Law Firm	Legal	1,015
Sandburg, Phoenix & von	Legal	3,992
Thomas Wolf Jr, PC	Legal	105
Templin Healthcare Accounting	Accounting	4,694
James Henson PC	Accounting	7,706
Payroll Services by Extra Help	Payroll Service	1,274
Galaxy Hosted Software	Web Hosting Service	400
Information Controls	LTC Software	1,285
IT Next Gen	Web Hosting Service	190
See Attached Sch 21C		15,254
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 35,942

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,191
Unemployment Compensation Insurance	14,572
FICA Taxes	103,487
Employee Health Insurance	24,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Incentive Expenses	3,439
Life/Disability Insurance	4,340
Other Employee Benefits	2,249
TOTAL (agree to Schedule V, line 22, col.8)	$ 201,931

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	$
Advertising: Employee Recruitment	295
Health Care Worker Background Check	
(Indicate # of checks performed 28)	855
Patient Background Checks 74	1,120
License & Permits	1,241
Dues & Subcriptions	479
IHCA	5,280
Allocated From RDK/SI Management	511
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,781

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,755
Seminar Expense	1,572
Allocated From RDK/SI Management	56
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,383

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Stonebridge Nursing & Rehab**
IDPH License ID Number: **0054494**
Fiscal Year End: **12/31/16**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
American Health Tech	LTC Software	13,614
Esolutions	Health Info Management	1,256
Passport Software	Accounting Software	384
	Total	**15,254**

Facility Name & ID Number Stonebridge Nursing & Rehab # 0054494 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **5,280 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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,698** 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. $ **136,022**
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' PREPARATION 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 Nursing & Rehab

Period Beginning	**1/1/16**
Period End	**12/31/16**

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Mileage reimbursement for allowable travel	**1,569**
Fuel, repairs and miscellaneous supplies	**7,924**
Allocated from Mgmt Co	**4,129**
	13,622