

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

I. IDPH License ID Number: 0033837

Facility Name: Cornerstone Home

Address: 1009 South Irving Monticello 61856
 Number City Zip Code

County: Piatt

Telephone Number: (217) 762-5326 **Fax #** (217) 398-0944

HFS ID Number: 37-1225266001

Date of Initial License for Current Owners: 05/31/88

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Sherry Newton **Telephone Number:** (217) 398-0754

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/06 to 09/30/07 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) <u>Sherry Newton</u>	
	(Title) <u>Chief Executive Officer</u>	
Paid Preparer	(Signed) <u>See Attached Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>James B. Eisenmenger, MS, CPA</u> <u>Member</u>	
	(Firm Name & Address) <u>Martin, Hood, Friese & Associates, LLC</u> <u>2507 S. Neil Street, Champaign, IL 61820</u>	
	(Telephone) <u>(217) 351-2000</u> Fax # <u>(217) 351-7726</u>	

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 Cornerstone Home

0033837 Report Period Beginning: 10/01/06 Ending: 09/30/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,471</u>			<u>5,471</u>
14	TOTALS	<u>5,471</u>			<u>5,471</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.68%

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

330 (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

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

YES NO

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

Date started 05/31/88

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/31/88 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 09/30/2007

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

Facility Name & ID Number Cornerstone Home # 0033837 Report Period Beginning: 10/01/06 Ending: 09/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	54,699	45	1,552	56,296	56,296		56,296			1
2	Food Purchase		25,965		25,965	25,965		25,965			2
3	Housekeeping	29,085	3,004		32,089	32,089	50	32,139			3
4	Laundry	14,542	1,769		16,311	16,311		16,311			4
5	Heat and Other Utilities			16,653	16,653	16,653	1,883	18,536			5
6	Maintenance			33,781	33,781	33,781	9,971	43,752			6
7	Other (specify):*										7
8	TOTAL General Services	98,326	30,783	51,986	181,095	181,095	11,904	192,999			8
	B. Health Care and Programs										
9	Medical Director		1,997	2,400	4,397	4,397	6	4,403			9
10	Nursing and Medical Records	86,078	276	27,334	113,688	113,688	4,454	118,142			10
10a	Therapy										10a
11	Activities	10,907	3,233		14,140	14,140		14,140			11
12	Social Services						46	46			12
13	CNA Training	1,195			1,195	1,195		1,195			13
14	Program Transportation			1,925	1,925	1,925	2,756	4,681			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	98,180	5,506	31,659	135,345	135,345	7,262	142,607			16
	C. General Administration										
17	Administrative	36,696		130,369	167,065	167,065	(90,626)	76,439			17
18	Directors Fees						400	400			18
19	Professional Services			5,591	5,591	5,591	2,254	7,845			19
20	Dues, Fees, Subscriptions & Promotions			3,193	3,193	3,193	592	3,785			20
21	Clerical & General Office Expenses	14,543	354	3,060	17,957	17,957	17,293	35,250			21
22	Employee Benefits & Payroll Taxes			52,723	52,723	52,723	16,298	69,021			22
23	Inservice Training & Education			359	359	359	459	818			23
24	Travel and Seminar						945	945			24
25	Other Admin. Staff Transportation			825	825	825	5,072	5,897			25
26	Insurance-Prop.Liab.Malpractice			5,596	5,596	5,596	2,410	8,006			26
27	Other (specify):*										27
28	TOTAL General Administration	51,239	354	201,716	253,309	253,309	(44,903)	208,406			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	247,745	36,643	285,361	569,749	569,749	(25,737)	544,012			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 Cornerstone Home #0033837 Report Period Beginning: 10/01/06 Ending: 09/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			3,411	3,411	3,411	12,729	16,140			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,635	1,635	1,635	8,538	10,173			32
33	Real Estate Taxes			7,010	7,010	7,010	2,191	9,201			33
34	Rent-Facility & Grounds			45,900	45,900	45,900		45,900			34
35	Rent-Equipment & Vehicles			266	266	266	527	793			35
36	Other (specify):*										36
37	TOTAL Ownership			58,222	58,222	58,222	23,985	82,207			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			41,800	41,800	41,800		41,800			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			41,800	41,800	41,800		41,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	247,745	36,643	385,383	669,771	669,771	(1,752)	668,019			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 Cornerstone Home

0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule Schedule VIII	(1,752)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,752)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,752)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Cornerstone Home

ID# 0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning:

10/01/06

Ending:

09/30/07

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C		See Attached Schedule		Health Services Consu	Champaign, IL	Consulting
				Cobblestone Rehabilita	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long-Term Care
				Developmental Founda	Champaign, IL	Long-Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See Schedule VIII	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home # 0033837 Report Period Beginning: 10/01/06 Ending: 09/30/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	Chairman	Administrative	0.50	All related party wages are allocations from HSC. See attached allocation spreadsheet and explanation. These individuals receive no compensation from entities other than HSC.			Administrative	\$ 1,012	17-7	1
2	Lynn Ryle	Director	Administrative	0.50				Administrative	1,012	17-7	2
3											
4	Alan Ryle	Chairman	Directors Fees	0.50				Directors Fees	200	18-7	4
5	Lynn Ryle	Director	Directors Fees	0.50				Directors Fees	200	18-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,424		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 Cornerstone Home

0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing						(15,809)	1
2	6	Maintenance						(451)	2
3	17	Administrative						(130,369)	3
4									4
5	3	Housekeeping	Beds	384	207	1,195	16	50	5
6	5	Heat & Utilities	Beds	384	207	45,186	16	1,883	6
7	6	Maintenance	Beds	384	207	292,330	16	10,422	7
8	9	Medical Director	Beds	384	207	139	16	6	8
9	10	Nursing	Beds	384	207	326,838	16	20,263	9
10	11	Activities	Beds	384	207	0	16	0	10
11	12	Social	Beds	384	207	1,096	16	46	11
12	13	Nurse Training	Beds	384	207	0	16	0	12
13	14	Program Transportation	Beds	384	207	66,147	16	2,756	13
14	17	Administrative	Beds	384	207	948,537	16	39,743	14
15	18	Director Fees	Beds	384	207	9,600	16	400	15
16	19	Professional Fees	Beds	384	207	54,095	16	2,254	16
17	20	Dues & Subscriptions	Beds	384	207	14,211	16	592	17
18	21	Clerical	Beds	384	207	402,659	16	17,270	18
19	22	P/R Taxes & Benefits	Beds	384	207	561,524	16	16,096	19
20	23	Inservice	Beds	384	207	11,027	16	459	20
21	24	Travel & Seminar	Beds	384	207	22,691	16	945	21
22	25	Administrative Transportation	Beds	384	207	121,726	16	5,072	22
23	26	Insurance	Beds	384	207	57,282	16	2,387	23
24	30	Depreciation	Beds	384	207	305,085	16	12,712	24
25	TOTALS				\$ 3,241,368	\$ 1,803,652		\$ (13,273)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837 Report Period Beginning: 10/01/06

Ending: 09/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	32	Interest	Beds	384	207	\$ 190,751	\$ 16	\$ 7,948	1
2	33	Real Estate Tax	Beds	384	207	52,591	16	2,191	2
3	34	Building Lease	Beds	384	207		16	0	3
4	35	Equipment Lease	Beds	384	207	12,643	16	527	4
5	N/A	Salaries and Wages	Outside Consulting			1,013,476	1,013,476		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	TOTALS					\$ 4,510,829	\$ 2,817,128	\$ (2,607)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837 Report Period Beginning: 10/01/06

Ending: 09/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization The Residential Developers, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical and General Office	Beds	221	112	\$ 312	\$ 16	\$ 23	1
2	22	Employee Benefits and P/R Tax	Beds	221	112	2,796	16	202	2
3	26	Insurance	Beds	221	112	316	16	23	3
4	30	Depreciation	Beds	221	112	232	16	17	4
5	32	Interest	Beds	221	112	8,154	16	590	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	TOTALS					\$ 11,810	\$	\$ 855	25

SEE ACCOUNTANTS' COMPILATION REPORT

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										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Schedule VII Allocation		x							8,538	6									
7	Busey Bank		x	Working Capital	N/A	N/A	N/A	N/A		1,635	7									
8											8									
9	TOTAL Facility Related									10,173	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									10,173	15									

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

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

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 Cornerstone Home

0033837 Report Period Beginning: 10/01/06

Ending: 09/30/07

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 6,085	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.)		\$ 6,423	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 338	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 6,672	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 7,010	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	6,214	8
	2003	6,054	9
	2004	6,213	10
	2005	6,439	11
	2006	6,423	12
\$8,896 (estimated 2007 tax) x 9/12 = \$6,672			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cornerstone Home COUNTY Platt

FACILITY IDPH LICENSE NUMBER 0033837

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-00-54-001-314-01</u>	<u>Facility</u>	\$ <u>6,423.00</u>	\$ <u>6,423.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>6,423.00</u>	\$ <u>6,423.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Cornerstone Home

0033837 Report Period Beginning:

10/01/06 Ending:

09/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,600 B. General Construction Type: Exterior Aluminum Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning:

10/01/06

Ending:

09/30/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Leasehold Improvements		1995	5,591	207	27	207		2,612	9
10		Drywall Repair		1997	545	20	27	20		237	10
11		Flooring		1998	3,284	122	27	122		1,209	11
12		Bathroom Repairs		1999	1,319	49	27	49		433	12
13		Bathroom Repairs		1999	2,413	89	27	89		728	13
14		Heat Pump		2004	558	20	27.5	20		63	14
15		Tile		2004	641	128	5	128		384	15
16		Flooring		2004	538	108	5	108		315	16
17		Sidewalk/Step		2006	620	41	15	41		55	17
18		Bathroom Remodel		2006	1,623	59	27.5	59		64	18
19		Bathroom Remodel		2006	4,583	153	27.5	153		153	19
20		Bathroom Remodel		2007	830	20	27.5	20		20	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning:

10/01/06

Ending:

09/30/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 22,545	\$ 1,016		\$ 1,016	\$	\$ 6,273	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Cornerstone Home # 0033837 Report Period Beginning: 10/01/06 Ending: 09/30/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 9,287	\$ 1,413	\$ 1,413	\$	5/7	\$ 5,551	71
72	Current Year Purchases	6,872	982	982		7	982	72
73	Fully Depreciated Assets	19,052				5/7	19,052	73
74								74
75	TOTALS	\$ 35,211	\$ 2,395	\$ 2,395	\$		\$ 25,585	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1999 Savana Van	1999	\$ 28,561	\$	\$	\$	5	\$ 28,561	76
77										77
78										78
79										79
80	TOTALS			\$ 28,561	\$	\$	\$		\$ 28,561	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)	\$	86,317	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	3,411	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	3,411	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	60,419	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

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:	<u>1998</u>	<u>15</u>		\$ <u>45,900</u>	<u>15</u>	<u>15</u>	3
4	Additions	<u>1991</u>	<u>1</u>					4
5								5
6								6
7	TOTAL		16		\$ 45,900			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u>N/A-month to</u>	\$ _____
13.	<u>month lease</u>	\$ _____
14.		\$ _____

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: N/A *

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: \$ 266 Description: Office Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		398		398
4	Clinical Wages (b)		797		797
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,195	\$	\$ 1,195
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,195		

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home# 0033837Report Period Beginning: 10/01/06

Ending:

09/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 09/30/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	210,203		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 210,353	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	22,545		15
16	Equipment, at Historical Cost	63,772		16
17	Accumulated Depreciation (book methods)	(60,419)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 25,898	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 236,251	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,487		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,672		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)	\$ 12,159	\$	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)	\$ 12,159	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 224,092	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 236,251	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 126,718	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 126,718	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	35,195	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	()	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)	\$ 35,195	17
B. Transfers (Itemize):			
18	Transfers (to) from The Residential Developers, Inc.	62,179	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 62,179	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 224,092	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 704,966	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 704,966	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 704,966	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	181,095	31
32	Health Care	135,345	32
33	General Administration	253,309	33
B. Capital Expense			
34	Ownership	58,222	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	41,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 669,771	40
41	Income before Income Taxes (line 30 minus line 40)**	35,195	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,195	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax Return is on a 12/31 fiscal year and is on the cash basis.

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

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

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing				1	
2	Assistant Director of Nursing				2	
3	Registered Nurses				3	
4	Licensed Practical Nurses				4	
5	CNAs & Orderlies				5	
6	CNA Trainees	120	120	1,195	9.96	6
7	Licensed Therapist				7	
8	Rehab/Therapy Aides				8	
9	Activity Director				9	
10	Activity Assistants	1,095	1,095	10,907	9.96	10
11	Social Service Workers				11	
12	Dietician				12	
13	Food Service Supervisor				13	
14	Head Cook	1,957	2,080	36,521	17.56	14
15	Cook Helpers/Assistants	1,825	1,825	18,178	9.96	15
16	Dishwashers				16	
17	Maintenance Workers				17	
18	Housekeepers	2,920	2,920	29,085	9.96	18
19	Laundry	1,460	1,460	14,542	9.96	19
20	Administrator				20	
21	Assistant Administrator				21	
22	Other Administrative	2,648	2,648	36,696	13.86	22
23	Office Manager				23	
24	Clerical	1,460	1,460	14,543	9.96	24
25	Vocational Instruction				25	
26	Academic Instruction				26	
27	Medical Director				27	
28	Qualified MR Prof. (QMRP)	1,110	1,110	20,576	18.54	28
29	Resident Services Coordinator				29	
30	Habilitation Aides (DD Homes)	5,845	6,576	65,502	9.96	30
31	Medical Records				31	
32	Other Health Care(specify)				32	
33	Other(specify)				33	
34	TOTAL (lines 1 - 33)	20,440	21,294	\$ 247,745 *	\$ 11.63	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 1,552	1-3	35
36	Medical Director	2,400	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	14,976	10-3	38
39	Pharmacist Consultant	224	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	5,285	10-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	3,000	10-3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	Psychologist	895	10-3	47
48	Dentist Consultant	1,685	10-3	48
49	TOTAL (lines 35 - 48)	\$ 30,017		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cornerstone Home

0033837

Report Period Beginning: 10/01/06

Ending: 09/30/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Cynthia C. Rounds	QMRP/Admin		\$ 6,859	Workers' Compensation Insurance	\$ 8,861	IDPH License Fee	\$ 1,814	
John Knowles	Administration		29,837	Unemployment Compensation Insurance	5,683	Advertising: Employee Recruitment	160	
				FICA Taxes	18,952	Health Care Worker Background Check	(Indicate # of checks performed <u>10</u>)	
				Employee Health Insurance	12,559	Dues and Subscriptions	1,219	
				Employee Meals	4,869			
				Illinois Municipal Retirement Fund (IMRF)*				
				Other	1,799			
				Schedule VIII Allocation	16,298	Other		
						Schedule VIII Allocation	592	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 36,696			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management & Support Staff Fee			\$ 130,369					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 130,369					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Martin, Hood, Friese & Associates	Accounting		\$ 4,020	None			Out-of-State Travel	\$
Thomas, Mamer & Haughey	Legal		690					
Various	Other Prof. Services		880				In-State Travel	
							Schedule VIII Allocation	945
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,591	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 945

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Cornerstone Home

Report Period Beginning: 10/01/06 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

