		FOR BHF USE					

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

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: 0052225

Facility Name: Cornerstone Rehab & HC

Address: 5533 North Galena Rd (Number) Peoria Heights (City) 61616 (Zip Code)

County: Peoria

Telephone Number: (309)682-5428 **Fax #** (309)682-8478

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2013

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
Email Address:

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 N/A

	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	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,460	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,091	4,924	2,173	22,188	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,091	4,924	2,173	22,188	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.03%

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 [X] NO [ ]

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 2/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 94 and days of care provided 2,002

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	204,394	17,500		221,894		221,894	4,558	226,452			1
2	Food Purchase		169,063		169,063		169,063	(1,937)	167,126			2
3	Housekeeping	129,243	30,057		159,300		159,300	80	159,380			3
4	Laundry	33,063	15,093		48,156		48,156		48,156			4
5	Heat and Other Utilities			99,160	99,160		99,160	266	99,426			5
6	Maintenance	42,021	15,780	27,394	85,195		85,195	2,488	87,683			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	408,721	247,493	126,554	782,768		782,768	5,455	788,223			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	909,461	134,038	564,460	1,607,959		1,607,959	(1,227)	1,606,732			10
10a	Therapy			376,672	376,672		376,672		376,672			10a
11	Activities	39,830	1,605	2,896	44,331		44,331	(962)	43,369			11
12	Social Services	85,046			85,046		85,046		85,046			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,034,337	135,643	950,028	2,120,008		2,120,008	(2,189)	2,117,819			16
	C. General Administration											
17	Administrative			306,800	306,800		306,800	(227,675)	79,125			17
18	Directors Fees											18
19	Professional Services			5,908	5,908		5,908	20,326	26,234			19
20	Dues, Fees, Subscriptions & Promotions			9,724	9,724		9,724	185	9,909			20
21	Clerical & General Office Expenses	74,079	3,335	24,776	102,190		102,190	53,050	155,240			21
22	Employee Benefits & Payroll Taxes			195,786	195,786		195,786	29,709	225,495			22
23	Inservice Training & Education							102	102			23
24	Travel and Seminar			95	95		95	49	144			24
25	Other Admin. Staff Transportation			4,749	4,749		4,749	4,180	8,929			25
26	Insurance-Prop.Liab.Malpractice			31,007	31,007		31,007	589	31,596			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	74,079	3,335	578,845	656,259		656,259	(119,485)	536,774			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,517,137	386,471	1,655,427	3,559,035		3,559,035	(116,219)	3,442,816			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Cornerstone Rehab & HC #0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			172,435	172,435		172,435	(5,736)	166,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,078	233,078		233,078	(787)	232,291			32
33	Real Estate Taxes			65,818	65,818		65,818	271	66,089			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,200	14,200		14,200	956	15,156			35
36	Other (specify):*											36
37	TOTAL Ownership			485,531	485,531		485,531	(5,296)	480,235			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,030		72,030		72,030		72,030			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,739	172,739		172,739		172,739			42
43	Other (specify):*		368	114,933	115,301		115,301	(115,301)				43
44	TOTAL Special Cost Centers		72,398	287,672	360,070		360,070	(115,301)	244,769			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,517,137	458,869	2,428,630	4,404,636		4,404,636	(236,816)	4,167,820			45

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	(2,020)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,084)	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	(20,818)	30		9
10	Interest and Other Investment Income	(1,132)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(17,755)	43		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	(78,300)	43		24
25	Fund Raising, Advertising and Promotional	(2,563)	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	(11,119)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (141,977)		$	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)	(94,839)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (94,839)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,816)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Cornerstone Rehab & HC

ID# 0052225

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,357)	43	1
2	X-Rays-Part A	(3,168)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(82)	21	3
4	Disallowed Marketing Expense	(368)	43	4
5	Disallowed Special Events	(617)	43	5
6	Offset Transportation Revenue	(962)	11	6
7	Offset Miscellaneous Nursing Supplies Revenue	(1,362)	10	7
8	Disallowed Pet Expense	(903)	43	8
9	Disallowed Chamber of Commerce Dues	(300)	20	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**	(11,119)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	4,558	0	0	0	0	0	0	0	0	0	4,558	1
2	Food Purchase	(2,020)	83	0	0	0	0	0	0	0	0	0	(1,937)	2
3	Housekeeping	0	80	0	0	0	0	0	0	0	0	0	80	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	266	0	0	0	0	0	0	0	0	0	266	5
6	Maintenance	0	2,488	0	0	0	0	0	0	0	0	0	2,488	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,020)	7,475	0	0	0	0	0	0	0	0	0	5,455	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	(1,362)	135	0	0	0	0	0	0	0	0	0	(1,227)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(962)	0	0	0	0	0	0	0	0	0	0	(962)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,324)	135	0	0	0	0	0	0	0	0	0	(2,189)	16
	C. General Administration													
17	Administrative	0	(227,675)	0	0	0	0	0	0	0	0	0	(227,675)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,607	0	8,719	0	0	0	0	0	0	0	20,326	19
20	Fees, Subscriptions & Promotions	(300)	0	485	0	0	0	0	0	0	0	0	185	20
21	Clerical & General Office Expenses	(82)	0	53,132	0	0	0	0	0	0	0	0	53,050	21
22	Employee Benefits & Payroll Taxes	0	0	29,709	0	0	0	0	0	0	0	0	29,709	22
23	Inservice Training & Education	0	0	102	0	0	0	0	0	0	0	0	102	23
24	Travel and Seminar	0	0	49	0	0	0	0	0	0	0	0	49	24
25	Other Admin. Staff Transportation	0	0	4,180	0	0	0	0	0	0	0	0	4,180	25
26	Insurance-Prop.Liab.Malpractice	0	0	589	0	0	0	0	0	0	0	0	589	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(382)	(216,068)	88,246	8,719	0	0	0	0	0	0	0	(119,485)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,726)	(208,458)	88,246	8,719	0	0	0	0	0	0	0	(116,219)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	(20,818)	0	11,757	3,325	0	0	0	0	0	0	0	(5,736)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,132)	0	345	0	0	0	0	0	0	0	0	(787)	32
33	Real Estate Taxes	0	0	271	0	0	0	0	0	0	0	0	271	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	956	0	0	0	0	0	0	0	0	956	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,950)	0	13,329	3,325	0	0	0	0	0	0	0	(5,296)	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):*	(115,301)	0	0	0	0	0	0	0	0	0	0	(115,301)	43
44	**TOTAL Special Cost Centers**	(115,301)	0	0	0	0	0	0	0	0	0	0	(115,301)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(141,977)	(208,458)	101,575	12,044	0	0	0	0	0	0	0	(236,816)	45

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,558	$ 4,558	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	83	83	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	80	80	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	266	266	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,488	2,488	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	135	135	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	306,800	Petersen Health Care Management, Inc.	100.00%	79,125	(227,675)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,607	11,607	12
13	V								13
14	Total			$ 306,800			$ 98,342	$ * (208,458)	14

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 485	$ 485	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	53,132	53,132	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	29,709	29,709	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	102	102	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	49	49	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,180	4,180	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	589	589	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	11,757	11,757	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	345	345	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	271	271	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	956	956	26
27	V								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			$			$ 101,575	$ * 101,575	39

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Midwest Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Midwest Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Midwest Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Midwest Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Midwest Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Midwest Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Midwest Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Midwest Health Operations, LLC	100.00%	8,719	8,719	25
26	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Midwest Health Operations, LLC	100.00%	3,325	3,325	33
34	V	31	Amortization		Midwest Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Midwest Health Operations, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38
39	Total			$			$ 12,044	$ * 12,044	39

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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: Petersen Health Care Management, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	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	1	Dietary	Resident Days	1,521,544	75	$ 312,540	$ 357,910	23,632	$ 4,558	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	23,632	83	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	23,632	80	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	23,632	266	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	23,632	2,488	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	23,632	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	23,632	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	23,632	135	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	23,632	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	23,632	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	23,632	79,125	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	23,632	11,607	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	23,632	485	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	23,632	53,132	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	23,632	29,709	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	23,632	102	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	23,632	49	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	23,632	4,180	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	23,632	589	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	23,632	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	23,632	11,757	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	23,632	345	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	23,632	271	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	23,632	956	24
25	TOTALS					$ 13,089,501	$ 11,510,481		$ 199,917	25

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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: Midwest Health Operations, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: ((309)691-8113
Fax Number: ((309)691-8622

	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	1	Dietary	Resident Days	101,374	8	$	$	23,632	$	1
2	2	Food	Resident Days	101,374	8			23,632		2
3	3	Housekeeping	Resident Days	101,374	8			23,632		3
4	4	Laundry	Resident Days	101,374	8			23,632		4
5	5	Utilities	Resident Days	101,374	8			23,632		5
6	6	Maintenance	Resident Days	101,374	8			23,632		6
7	7	Mgmt. Allocation of Benefits	Resident Days	101,374	8			23,632		7
8	10	Nursing and Medical Records	Resident Days	101,374	8			23,632		8
9	15	Mgmt. Allocation of Benefits	Resident Days	101,374	8			23,632		9
10	17	Administrative	Resident Days	101,374	8			23,632		10
11	19	Professional Services	Resident Days	101,374	8	39,835		23,632	8,719	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	101,374	8			23,632		12
13	21	Clerical and General Office	Resident Days	101,374	8			23,632		13
14	22	Employee Benefits & Payroll	Resident Days	101,374	8			23,632		14
15	23	Inservice Training & Education	Resident Days	101,374	8			23,632		15
16	24	Travel and Seminar	Resident Days	101,374	8			23,632		16
17	25	Other Admin. Staff Transport.	Resident Days	101,374	8			23,632		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	101,374	8			23,632		18
19	30	Depreciation	Resident Days	101,374	8	15,191		23,632	3,325	19
20	31	Amortization	Resident Days	101,374	8			23,632		20
21	32	Interest	Resident Days	101,374	8			23,632		21
22	33	Real Estate Taxes	Resident Days	101,374	8			23,632		22
23	34	Rent-Facility and Grounds	Resident Days	101,374	8			23,632		23
24	35	Rent-Equipment & Vehicles	Resident Days	101,374	8			23,632		24
25	TOTALS					$ 55,026	$		$ 12,044	25

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	OSF Healthcare System		X	Mortgage	$21,134.72	2/1/14	$ 2,950,000	$ 2,807,997	1/30/44	Varies	$ 233,078	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,134.72		$ 2,950,000	$ 2,807,997			$ 233,078	9
	B. Non-Facility Related*											
10								Home Office Allocation-PHCM			345	10
11								Interest Income Offset			(1,132)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (787)	14
15	TOTALS (line 9+line14)						$ 2,950,000	$ 2,807,997			$ 232,291	15

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

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

** 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 Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.**	$ 94,553	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.)		$ 63,598	2
3. Under or (over) accrual (line 2 minus line 1).		$ (30,955)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 96,773	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.	**Home Office Allocation**	271	
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.		$ 66,089	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	61,805	10
2014	61,446	11
2015	63,598	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cornerstone Rehab & HC COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0052225

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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.	14-14-353-011	Long-Term Care Facility	$ 1,068.56	$ 1,068.56
2.	14-15-479-026	Long-Term Care Facility	$ 62,529.72	$ 62,529.72
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,598.28	$ 63,598.28

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,500 B. General Construction Type: Exterior Brick/Wood Frame Wood 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2013	$ 116,300	1
2					2
3	TOTALS			$ 116,300	3

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	98		2013	1998	$ 2,459,000	$	25	$ 98,360	$ 98,360	$ 344,260	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Repair			2013	2,643		7	378	378	1,323	9
10	Water Heater			2013	5,125		7	732	732	2,562	10
11	Furnace Repair			2014	2,686		7	384	384	960	11
12	Generator			2014	30,881		15	2,059	2,059	5,148	12
13	Carpet/Drywall Replace, Painting-Kitchen, Commons, Res Rooms			2014	47,051		15	4,705	4,705	10,978	13
14	Blower Burner Assembly Kit			2015	2,636		7	376	376	564	14
15	Water Heater			2015	7,438		7	1,062	1,062	1,593	15
16	Boiler Repair			2016	4,057		7	290	290	290	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	Building Booked					98,360			(98,360)		31
32	Building Improvement Booked					9,890			(9,890)		32
33											33
34	2016-Home Office Allocation-Building Improvements				9,796			235	235		34
35	2016-Home Office Allocation-Land Improvements				901			59	59		35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			$	$		$	$	$	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)		$ 2,572,214	$ 108,250		$ 108,640	$ 390	$ 367,678	70

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 446,730	$ 63,818	$ 44,673	$ (19,145)	7-10 yrs.	$ 152,322	71
72	Current Year Purchases	3,426	367	245	(122)	7 yrs.	245	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			13,141	13,141			74
75	TOTALS	$ 450,156	$ 64,185	$ 58,059	$ (6,126)		$ 152,567	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,138,670	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 172,435	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,699	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,736)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 520,245	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	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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: $ 15,156 Description: See Attached Schedule 14A
(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	N/A				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.

Cornerstone Rehab & HC
0052225
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 10,493
Dishwasher	701
Copier	3,006
Home Office Allocation	956
	15,156

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

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.

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	5,474	$ 82,117	$	5,474	$ 82,117	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,993	59,892		3,993	59,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		15,644	234,663		15,644	234,663	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				72,030		72,030	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			$	25,111	$ 376,672	$ 72,030	25,111	$ 448,702	14

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 2,447,568	$ 2,447,568	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 101,017)	2,176,041	2,176,041	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,758	28,758	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Dep, Emp Loans	4,477	4,477	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,656,844	$ 4,656,844	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,300	116,300	13
14	Buildings, at Historical Cost	2,459,000	2,468,796	14
15	Leasehold Improvements, at Historical Cost	102,517	103,418	15
16	Equipment, at Historical Cost	450,156	450,156	16
17	Accumulated Depreciation (book methods)	(655,109)	(520,245)	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)**	$ 2,472,864	$ 2,618,425	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,129,708	$ 7,275,269	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,535,635	$ 1,535,635	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,847	30,847	30
31	Accrued Taxes Payable (excluding real estate taxes)	157,580	157,580	31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,773	96,773	32
33	Accrued Interest Payable	20,106	20,106	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	414,066	414,066	36
37	Accrued Management Fees	679,151	679,151	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,934,158	$ 2,934,158	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,807,997	2,807,997	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	795	795	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,808,792	$ 2,808,792	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,742,950	$ 5,742,950	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,386,758	$ 1,532,319	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,129,708	$ 7,275,269	48

*(See instructions.)

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,512,583	1
2	Restatements (describe):		2
3	**Prior Period Adjustments Made After Cost Report Was Filed**	13,593	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,526,176	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(139,418)	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)**	$ (139,418)	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)**	$ 1,386,758	24 *

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 3,635,662	1
2	Discounts and Allowances for all Levels	(208,351)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,427,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	684,336	6
7	Oxygen	13,458	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 697,794	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	796	13
14	Non-Patient Meals	2,020	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,026	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,740	20
21	Other Medical Services	18,993	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 136,575	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,132	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,132	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	962	28
28a	Miscellaneous Revenue	1,444	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,406	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,265,218	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,768	31
32	Health Care	2,120,008	32
33	General Administration	656,259	33
	B. Capital Expense		
34	Ownership	485,531	34
	C. Ancillary Expense		
35	Special Cost Centers	187,331	35
36	Provider Participation Fee	172,739	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,404,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	(139,418)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (139,418)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,051,421	44
45	Private Pay - Net Inpatient Revenue	924,828	45
46	Medicare - Net Inpatient Revenue	435,576	46
47	Other-(specify) Insurance Net Inpatient Revenue	15,486	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,427,311	49

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

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

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

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

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 68,869	$ 33.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,850	3,041	83,255	27.38	3
4	Licensed Practical Nurses	15,951	16,212	386,574	23.84	4
5	CNAs & Orderlies	28,359	29,035	324,433	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	39,830	19.15	9
10	Activity Assistants					10
11	Social Service Workers	4,167	4,231	85,046	20.10	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,485	14.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,237	16,788	174,909	10.42	15
16	Dishwashers					16
17	Maintenance Workers	2,787	2,787	42,021	15.08	17
18	Housekeepers	11,373	11,684	129,243	11.06	18
19	Laundry	3,212	3,348	33,063	9.88	19
20	Administrator	2,080	2,080	79,125	38.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,046	2,151	34,240	15.92	23
24	Clerical	3,772	3,836	39,839	10.39	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) CPC	1,879	1,879	46,330	24.66	33
34	TOTAL (lines 1 - 33)	100,953	103,312	$ 1,596,262 *	$ 15.45	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		$		35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,781	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2	$ 10,897		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	739	29,067	L10, C3	51
52	Certified Nurse Assistants/Aides	24,498	525,150	L10, C3	52
53	TOTAL (lines 50 - 52)	25,237	$ 554,217		53

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Benny Perkins	Administrator	0	$ 79,125
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 79,125

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 306,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 306,800

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 2,761
Comcast	Computer Services	1,258
Quinn, Johnston, Henderson	Legal Fees	1,019
Honkamp Krueger	Accounting Fees	768
Ability Network	Computer Services	102
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 5,908

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,248
Unemployment Compensation Insurance	42,235
FICA Taxes	114,828
Employee Health Insurance	4,959
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	516
Home Office Allocation	29,709
TOTAL (agree to Schedule V, line 22, col.8)	$ 225,495

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	1,305
Health Care Worker Background Check	
(Indicate # of checks performed 78)	
Patient Background Checks 41	417
Miscellaneous Licenses & Permits	950
Miscellaneous Dues & Subscriptions	3,072
Home Office Allocation	485
Less: Public Relations Expense	(300)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,909

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	95
Home Office Allocation	49
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 144

**See instructions.

Cornerstone Rehab & HC
0052225
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,908
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	52
Miscellaneous	Legal	18
Miller Hall and Triggs	Legal	90
Healthcare Resources International	Legal	447
Hunziker Law	Legal	107
Lexis Nexis	Legal	9
Illinois Secretary of State	Legal	55
Hughes, Socol, Piers	Legal	2189
SB2	Legal	2626
CliftonLarson Allen	Accountants	465
Ginoli & Co.	Accountants	5368
Miscellaneous	Computer Services	59
Change Healthcare	Computer Services	9
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	4086
Stratus Networks	Computer Services	416
Kemper Technology	Computer Services	274
AT&T	Computer Services	6
Ability Network	Computer Services	1742
CIAN	Computer Services	208
Comcast	Computer Services	34
CCH	Computer Services	14
Charter Communications	Computer Services	40
Allscripts	Computer Services	607
ATS	Computer Services	274
Allpayer Exchange	Computer Services	14
Optimizer	Other Prof Fees	42
Ankura	Other Prof Fees	317
David Budde	Other Prof Fees	36
Bruner, Cooper, Zuck	Other Prof Fees	92
Marotta, Gund, Budd, Dzerda	Other Prof Fees	571
Professional Software and Services	Other Prof Fees	23
Hughes Valuation Services	Other Prof Fees	29
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		26,234

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. **IHCA-$1,000**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,864** 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. $ **172,739**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,020**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **962**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **Yes**
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? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **No**
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT **Cornerstone Rehab & H** **09:48 AM** **7/7/2017**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-236,816	equal to	-236,816	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	232,291	equal to	232,291	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	66,089	equal to	66,089	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	166,699	equal to	166,699	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	15,156	equal to	15,156	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	376,672	equal to	376,672	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	72,030	equal to	72,030	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	782,768	equal to	782,768	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,120,008	equal to	2,120,008	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	656,259	equal to	656,259	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	485,531	equal to	485,531	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	187,331	equal to	187,331	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	172,739	equal to	172,739	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	909,461	equal to	909,461	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	39,830	equal to	39,830	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	85,046	equal to	85,046	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	204,394	equal to	204,394	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	42,021	equal to	42,021	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	129,243	equal to	129,243	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	33,063	equal to	33,063	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	79,125	equal to	79,125	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	74,079	equal to	74,079	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,596,262	equal to	1,517,137	79,125	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	559,114	< or = to	564,460	-5,346	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	2,896	-2,896	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	79,125	equal to	79,125	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	306,800	equal to	306,800	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	5,908	equal to	5,908	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	225,495	equal to	225,495	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,909	equal to	9,909	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	144	equal to	144	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	172,739	equal to	172,739	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,002	equal to	2,173	-171	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-94,839	equal to	-94,839	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,807,997	equal to	2,807,997	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	96,773	equal to	96,773	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	116,300	equal to	116,300	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,572,214	equal to	2,572,214	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	450,156	equal to	450,156	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	520,245	equal to	520,245	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,386,758	equal to	1,386,758	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-139,418	equal to	-139,418	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	7,129,708	equal to	7,129,708	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Con **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED**
**TO THE COST REPORT!!!

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	204,394	17,500	0	221,894	0	221,894	4,558	226,452
2. Food Purchase	0	169,063	0	169,063	0	169,063	-1,937	167,126
3. Housekeeping	129,243	30,057	0	159,300	0	159,300	80	159,380
4. Laundry	33,063	15,093	0	48,156	0	48,156	0	48,156
5. Heat and Other Utilities	0	0	99,160	99,160	0	99,160	266	99,426
6. Maintenance	42,021	15,780	27,394	85,195	0	85,195	2,488	87,683
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	408,721	247,493	126,554	782,768	0	782,768	5,455	788,223
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	909,461	134,038	564,460	1,607,959	0	1,607,959	-1,227	#######
10a. Therapy	0	0	376,672	376,672	0	376,672	0	376,672
11. Activities	39,830	1,605	2,896	44,331	0	44,331	-962	43,369
12. Social Services	85,046	0	0	85,046	0	85,046	0	85,046
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,034,337	135,643	950,028	2,120,008	0	2,120,008	-2,189	#######
17. Administrative	0	0	306,800	306,800	0	306,800	-227,675	79,125
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,908	5,908	0	5,908	20,326	26,234
20. Fees, Subscriptions & Promotion	0	0	9,724	9,724	0	9,724	185	9,909
21. Clerical & General Office	74,079	3,335	24,776	102,190	0	102,190	53,050	155,240
22. Employee Benefits & Payroll	0	0	195,786	195,786	0	195,786	29,709	225,495
23. Inservice Training & Education	0	0	0	0	0	0	102	102
24. Travel and Seminar	0	0	95	95	0	95	49	144
25. Other Admin. Staff Trans	0	0	4,749	4,749	0	4,749	4,180	8,929
26. Insurance-Prop.Liab.Malpractice	0	0	31,007	31,007	0	31,007	589	31,596
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	74,079	3,335	578,845	656,259	0	656,259	-119,485	536,774
29. Total General Administrative	1,517,137	386,471	1,655,427	3,559,035	0	3,559,035	-116,219	#######
30. Depreciation	0	0	172,435	172,435	0	172,435	-5,736	166,699
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	233,078	233,078	0	233,078	-787	232,291
33. Real Estate	0	0	65,818	65,818	0	65,818	271	66,089
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	14,200	14,200	0	14,200	956	15,156
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	485,531	485,531	0	485,531	-5,296	480,235
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	72,030	0	72,030	0	72,030	0	72,030
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	172,739	172,739	0	172,739	0	172,739
43. Other (specify):*	0	368	114,933	115,301	0	115,301	-115,301	0
44. Total Special Cost Ce	0	72,398	287,672	360,070	0	360,070	-115,301	244,769
45. Grand Total	1,517,137	458,869	2,428,630	4,404,636	0	4,404,636	-236,816	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	2,447,568	2,447,568
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,176,041	2,176,041
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,758	28,758
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	4,477	4,477
10. Total current assets	4,656,844	4,656,844
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	116,300	116,300
14. Buildings, at Historical Cost	2,459,000	2,468,796
15. Leasehold Improvements, Historical Cost	102,517	103,418
16. Equipment, at Historical Cost	450,156	450,156
17. Accumulated Depreciation (book methods)	-655,109	-520,245
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	2,472,864	2,618,425
25. Total Assets	7,129,708	7,275,269
CURRENT LIABILITIES		
26. Accounts Payable	1,535,635	1,535,635
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	30,847	30,847
31. Accrued Taxes Payable	157,580	157,580
32. Accrued Real Estate Taxes	96,773	96,773
33. Accrued Interest Payable	20,106	20,106
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	414,066	414,066
37. Other Current Liabilities (specify):	679,151	679,151
38. Total Current Liabilities	2,934,158	2,934,158
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	2,807,997	2,807,997
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	795	795
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,808,792	2,808,792
46.Total Liabilities	5,742,950	5,742,950
47.Total Equity	1,386,758	1,532,319
48.Total Liabilities and Equity	7,129,708	7,275,269

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,635,662
2. Discounts and Allowances for all Levels	-208,351
Subtotal - Inpatient Care	3,427,311
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	684,336
7. Oxygen	13,458
Subtotal - Anciliary Revenue	697,794
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	796
14. Non-Patient Meals	2,020
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	109,026
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	5,740
21. Other Medical Services	18,993
22. Laundry	0
Subtotal - Other Operating Revenue	136,575
24. Contributions	0
25. Interest and Other Investments Income	1,132
Subtotal - Non-Operating Revenue	1,132
27. Other Revenue (specify):	962
28. Other Revenue (specify):	1,444
Subtotal - Other Revenue	2,406
30. Total Revenue	4,265,218
31. General Services	742,887
32. Health Care	2,176,825
33. General Administration	631,393
34. Ownership	494,823
35. Special Cost Centers	122,645
35. Provider Participation Fee	175,065
37. Other	0
40. Total Expenses	4,343,638
41. Income Before Income Taxes	-78,420
42. Income Taxes	0
43. Net Income or Loss for the Year	-78,420