

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0052225</u></p> <p><b>Facility Name:</b> <u>Cornerstone Rehab &amp; HC</u></p> <p><b>Address:</b> <u>5533 North Galena Rd</u> <u>Peoria Heights</u> <u>61616</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Peoria</u></p> <p><b>Telephone Number:</b> <u>(309)682-5428</u> <b>Fax # (</b> <u>(309)682-8478</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>02/01/2013</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Cornerstone Rehab & HC

# 0052225 Report Period Beginning: 1/1/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,681	7,857	3,574	26,112	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,681	7,857	3,574	26,112	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.00%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 02/01/2013

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/2013 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 94 and days of care provided 3,078

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number

Cornerstone Rehab & HC

# 0052225

Report Period Beginning:

1/1/14

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	214,404	19,285		233,689		233,689	8,825	242,514		1
2	Food Purchase		225,472		225,472		225,472	(6,664)	218,808		2
3	Housekeeping	125,818	34,728		160,546		160,546	54	160,600		3
4	Laundry	48,164	7,955		56,119		56,119		56,119		4
5	Heat and Other Utilities			93,638	93,638		93,638	331	93,969		5
6	Maintenance	36,717	11,513	37,591	85,821		85,821	3,318	89,139		6
7	Other (specify):* Home Off. Ben. All.										7
8	<b>TOTAL General Services</b>	425,103	298,953	131,229	855,285		855,285	5,864	861,149		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000	31	6,031		9
10	Nursing and Medical Records	1,318,368	154,436	76,822	1,549,626		1,549,626	25	1,549,651		10
10a	Therapy	35,964	53	516,904	552,921		552,921		552,921		10a
11	Activities	131,646	744	11,812	144,202		144,202	(1,060)	144,202		11
12	Social Services	99,473	75		99,548		99,548		99,548		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	1,585,451	155,308	611,538	2,352,297		2,352,297	(1,004)	2,352,353		16
	<b>C. General Administration</b>										
17	Administrative			226,600	226,600		226,600	(146,452)	80,148		17
18	Directors Fees										18
19	Professional Services			3,031	3,031		3,031	23,729	26,760		19
20	Dues, Fees, Subscriptions & Promotions			7,674	7,674		7,674	(189)	7,485		20
21	Clerical & General Office Expenses	99,523	6,920	14,750	121,193		121,193	95,882	217,075		21
22	Employee Benefits & Payroll Taxes			284,377	284,377		284,377	20,828	305,205		22
23	Inservice Training & Education							40	40		23
24	Travel and Seminar							35	35		24
25	Other Admin. Staff Transportation			5,898	5,898		5,898	5,359	11,257		25
26	Insurance-Prop.Liab.Malpractice			34,334	34,334		34,334	773	35,107		26
27	Other (specify):* Home Off. Ben. All.										27
28	<b>TOTAL General Administration</b>	99,523	6,920	576,664	683,107		683,107	5	683,112		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,110,077	461,181	1,319,431	3,890,689		3,890,689	4,865	3,896,614		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 &amp; ID Number

Cornerstone Rehab &amp; HC

#0052225

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			166,035	166,035		166,035	(10,252)	155,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,651	196,651		196,651	(35,432)	161,219			32
33	Real Estate Taxes			27,115	27,115		27,115	308	27,423			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,371	23,371		23,371	1,306	24,677			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			413,172	413,172		413,172	(44,070)	369,102			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,292		108,292		108,292		108,292			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,908	194,908		194,908		194,908			42
43	Other (specify):*		517	181,135	181,652		181,652	(181,135)	517			43
44	<b>TOTAL Special Cost Centers</b>		108,809	376,043	484,852		484,852	(181,135)	303,717			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,110,077	569,990	2,108,646	4,788,713		4,788,713	(220,340)	4,569,433			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,767)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,051)	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	(16,761)	30		9
10	Interest and Other Investment Income	(1,286)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(656)	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	(34,149)	43		18
19	Entertainment				19
20	Contributions	(308)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,999)	43		24
25	Fund Raising, Advertising and Promotional	(2,395)	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	(57,110)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (246,482)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	26,142	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 26,142		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (220,340)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Cornerstone Rehab & HC

ID# 0052225

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (8,618)	43	1
2	X-Rays-Part A	(5,240)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(2,062)	21	3
4	Resident Flower	(1,268)	43	4
5	Disallowed Special Events	(536)	43	5
6	Offset Transportation Revenue	(1,060)	11	6
7	Disallowed Chamber of Commerce Dues	(700)	20	7
8	Offset Miscellaneous Land Usage Revenue		32	8
9	Disallowed Mortgage Interest	(36,711)	32	9
10	Disallowed Pet Expense	(915)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(57,110)	49

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.  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, Inc.	100.00%	\$ 3,844	\$ 3,844	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	92	92	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	20	20	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	259	259	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,459	1,459	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	31	31	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A TherUy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,315	3,315	12
13	V							13
14	Total		\$			\$ 9,021	\$ * 9,021	14

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

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.  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 <u>Dues, Fees, Subs &amp; Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 185	\$	185	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	43,273		43,273	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,968		1,968	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	22		22	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	14		14	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,500		3,500	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	617		617	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,534		3,534	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,247		2,247	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	174		174	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	889		889	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	<b>Total</b>		\$			\$ 56,423	\$ *	56,423	39

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

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.  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	10A Therapy		Midwest Health Operations, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		24	
25	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0		25	
26	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	12,925	12,925	26	
27	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	266	266	27	
28	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		28	
29	V	22 Employee Benefits & Payroll		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	27 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	2,736	2,736	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		\$			\$ 15,927	\$ *	15,927	39

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

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.  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	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,981	\$ 4,981
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	11	11
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	34	34
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	72	72
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,859	1,859
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	24	24
23	V	10A TherUy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	226,600	Petersen Health Care Management, Inc.	100.00%	80,148	(146,452)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	7,489	7,489
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	60	60
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	54,671	54,671
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	18,860	18,860
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	18	18
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	21	21
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,859	1,859
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	156	156
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	239	239
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	318	318
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	134	134
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	417	417
39	Total		\$ 226,600			\$ 171,371	\$ * (55,229)

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

Facility Name &amp; ID Number

Cornerstone Rehab &amp; HC

# 0052225

Report Period Beginning:

1/1/14

Ending:

12/31/14

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	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 System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 &amp; ID Number

Cornerstone Rehab &amp; HC

# 0052225

Report Period Beginning:

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## 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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name &amp; ID Number

Cornerstone Rehab &amp; HC

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Report Period Beginning:

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## 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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Cornerstone Rehab & HC

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Report Period Beginning:

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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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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 &amp; ID Number

Cornerstone Rehab &amp; HC

#

0052225

Report Period Beginning:

1/1/14

Ending:

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## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6	N/A										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:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	1	Dietary	Resident Days	1,572,338	77	\$ 231,473	\$ 220,289	26,112	\$ 3,844	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	26,112	92	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	26,112	20	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	26,112	259	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	26,112	1,459	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	26,112	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	26,112	31	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	26,112	1	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	26,112	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	26,112	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	26,112	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	26,112	3,315	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	26,112	185	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	26,112	43,273	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	26,112	1,968	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	26,112	22	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	26,112	14	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	26,112	3,500	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	26,112	617	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	26,112	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	26,112	3,534	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	26,112	2,247	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	26,112	174	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	26,112	889	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 65,444	25

Facility Name & ID Number Cornerstone Rehab & HC

# 0052225

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	143,856	10		26,112		1
2	2	Food	Resident Days	143,856	10		26,112		2
3	3	Housekeeping	Resident Days	143,856	10		26,112		3
4	4	Laundry	Resident Days	143,856	10		26,112		4
5	5	Utilities	Resident Days	143,856	10		26,112		5
6	6	Maintenance	Resident Days	143,856	10		26,112		6
7	7	Mgmt. Allocation of Benefits	Resident Days	143,856	10		26,112		7
8	10	Nursing and Medical Records	Resident Days	143,856	10		26,112		8
9	10A	Therapy	Resident Days	143,856	10		26,112		9
10	15	Mgmt. Allocation of Benefits	Resident Days	143,856	10		26,112		10
11	17	Administrative	Resident Days	143,856	10		26,112		11
12	19	Professional Services	Resident Days	143,856	10	71,207	26,112	12,925	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	143,856	10	1,462	26,112	266	13
14	21	Clerical and General Office	Resident Days	143,856	10		26,112		14
15	22	Employee Benefits & Payroll	Resident Days	143,856	10		26,112		15
16	24	Travel and Seminar	Resident Days	143,856	10		26,112		16
17	25	Other Admin. Staff Transport.	Resident Days	143,856	10		26,112		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	143,856	10		26,112		18
19	27	Mgmt. Allocation of Benefits	Resident Days	143,856	10		26,112		19
20	30	Depreciation	Resident Days	143,856	10	15,073	26,112	2,736	20
21	32	Interest	Resident Days	143,856	10		26,112		21
22	33	Real Estate Taxes	Resident Days	143,856	10		26,112		22
23	34	Rent-Facility and Grounds	Resident Days	143,856	10		26,112		23
24	35	Rent-Equipment & Vehicles	Resident Days	143,856	10		26,112		24
25	TOTALS					\$ 87,742	\$	\$ 15,927	25

Facility Name & ID Number Cornerstone Rehab & HC

# 0052225

Report Period Beginning:

1/1/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	1	Dietary	Resident Days	1,572,338	77	\$ 231,473	\$ 294,997	26,112	\$ 4,981	1
2	2	Food	Resident Days	1,572,338	77	5,537		26,112	11	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	558	26,112	34	3
4	5	Utilities	Resident Days	1,572,338	77	15,618		26,112	72	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	94,000	26,112	1,859	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			26,112		6
7	9	Medical Director	Resident Days	1,572,338	77	1,878		26,112		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71		26,112	24	8
9	10A	TherUy	Resident Days	1,572,338	77			26,112		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			26,112		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	26,112	80,148	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631		26,112	7,489	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115		26,112	60	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	3,146,898	26,112	54,671	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476		26,112	18,860	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316		26,112	18	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811		26,112	21	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720		26,112	1,859	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141		26,112	156	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			26,112		20
21	30	Depreciation	Resident Days	1,572,338	77	212,800		26,112	239	21
22	32	Interest	Resident Days	1,572,338	77	135,328		26,112	318	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451		26,112	134	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540		26,112	417	24
25	TOTALS					\$ 8,517,291	\$ 8,113,127		\$ 171,371	25

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Cornerstone Rehab & HC

# 0052225

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	OSF Healthcare System		X	Mortgage	\$21,134.72	2/1/14	\$ 2,950,000	\$ 2,809,084	1/30/44	Varies	\$ 196,651	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$21,134.72		\$ 2,950,000	\$ 2,809,084			\$ 196,651	9						
<b>B. Non-Facility Related*</b>																		
10									Home Office Allocation-PHCM		318	10						
11									Interest Income Offset		(1,286)	11						
12									Home Office Allocation-PHC		2,247	12						
13									Miscellaneous Income Offset		(36,711)	13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (35,432)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,950,000	\$ 2,809,084			\$ 161,219	15						

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

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

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



## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cornerstone Rehab & HC COUNTY Peoria  
 FACILITY IDPH LICENSE NUMBER 0052225  
 CONTACT PERSON REGARDING THIS REPORT Mark Petersen  
 TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-14-353-011</u>	<u>Long-Term Care Facility</u>	\$ <u>1,038.70</u>	\$ <u>1,038.70</u>
2. <u>14-15-479-026</u>	<u></u>	\$ <u>60,766.64</u>	\$ <u>60,766.64</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u><u>61,805.34</u></u>	\$ <u><u>61,805.34</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Cornerstone Rehab & HC

# 0052225 Report Period Beginning:

1/1/14 Ending:

12/31/14

**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?  (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).

N/A

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>2013</u>	<u>\$ 116,300</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 116,300</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	2013	1998	\$ 2,459,000	\$	25	\$ 98,360	\$ 98,360	\$ 147,540	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Electrical Repair	2013		2,643		7	378	378	567	9
10	Water Heater	2013		5,125		7	732	732	1,098	10
11	Furnace Repair	2014		2,686		7	384	384	767	11
12	Generator	2014		30,881		15	2,059	2,059	3,774	12
13	Water Damage Repairs-Kitchen, Common Area, Resident Room:	2014		47,051		15	4,705	4,705	8,234	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

\*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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64					98,360		(98,360)	64				
65					8,257		(8,257)	65				
66								66				
67			12,189		292		292	67				
68			1,138		62		62	68				
69								69				
70		\$	2,560,713	\$	106,617	\$	106,972	\$	355	\$	161,980	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 426,563	\$ 60,938	\$ 42,656	\$ (18,282)	5-10 yrs.	\$ 63,984	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,155	6,155			74
75	TOTALS	\$ 426,563	\$ 60,938	\$ 48,811	\$ (12,127)		\$ 63,984	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	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)	\$ 3,103,576	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,783	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,772)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 225,964	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	N/A		93
94			94
95		\$	95

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

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

Facility Name & ID Number Cornerstone Rehab & HC

# 0052225

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 24,677 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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**Cornerstone Rehab & HC**

**0052225**

**Period Beginning** 1/1/2014

**Period End** 12/31/2014

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 11,903
Dishwasher	605
Laundry Equipment	118
Generator	5,745
Copier	5,000
Home Office Allocation	1,306
	<u>24,677</u>

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8				
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service			Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	12,727	\$	190,905	\$	12,727	\$	190,905	1			
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,198		47,964		3,198		47,964	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	10A(1), 10A(2), 10A(3)	1907 hrs		35,964		18,536		278,035	53	20,443	314,052	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 prescripts						108,292		108,292	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	<b>TOTAL</b>			\$	35,964		34,460	\$	516,904	\$	108,345	36,367	\$	661,213	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# 0052225Report Period Beginning: 1/1/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,047,545	\$ 2,047,545	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>179,260</u> )	778,569	778,569	3
4	Supply Inventory (priced at <u>Cost</u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,851	35,851	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(238)	(238)	8
9	Other(specify):	4,540	4,540	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,866,267	\$ 2,866,267	10
	<b>B. Long-Term Assets</b>			
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	2,471,189	14
15	Leasehold Improvements, at Historical Cost	88,386	89,524	15
16	Equipment, at Historical Cost	426,563	426,563	16
17	Accumulated Depreciation (book methods)	(312,470)	(225,964)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,777,779	\$ 2,877,612	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,644,046	\$ 5,743,879	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,294,477	\$ 1,294,477	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,676	70,676	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,617	48,617	31
32	Accrued Real Estate Taxes(Sch.IX-B)	(34,690)	(34,690)	32
33	Accrued Interest Payable	16,386	16,386	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	182,854	182,854	36
37	<u>Accrued Management Fees</u>	194,115	194,115	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,772,435	\$ 1,772,435	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,809,084	2,809,084	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due To Due From</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,809,084	\$ 2,809,084	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,581,519	\$ 4,581,519	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,062,527	\$ 1,162,360	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,644,046	\$ 5,743,879	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>673,160</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>673,161</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>389,366</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>389,366</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,062,527</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,477,276	1
2	Discounts and Allowances for all Levels	(521,905)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,955,371</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	939,493	6
7	Oxygen	1,797	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 941,290</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,767	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	196,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,950	20
21	Other Medical Services	20,947	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 240,299</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,286	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,286</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	1,060	28
28a	Transportation Revenue	38,773	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 39,833</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,178,079</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	855,285	31
32	Health Care	2,352,297	32
33	General Administration	683,107	33
<b>B. Capital Expense</b>			
34	Ownership	413,172	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	289,944	35
36	Provider Participation Fee	194,908	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,788,713</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>389,366</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 389,366</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	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:

1/1/14

Ending:

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**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	65,111	\$ 31.30	1
2	Assistant Director of Nursing	693	693	15,947	23.00	2
3	Registered Nurses	5,005	5,006	122,663	24.50	3
4	Licensed Practical Nurses	17,159	17,492	379,290	21.68	4
5	CNAs & Orderlies	55,248	56,343	673,905	11.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,802	1,907	35,964	18.86	8
9	Activity Director	2,080	2,080	43,867	21.09	9
10	Activity Assistants	1,412	1,553	15,253	9.82	10
11	Social Service Workers	4,310	4,438	99,473	22.41	11
12	Dietician					12
13	Food Service Supervisor	1,795	1,887	28,370	15.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,949	16,488	186,034	11.28	15
16	Dishwashers					16
17	Maintenance Workers	2,245	2,274	36,717	16.15	17
18	Housekeepers	9,674	9,916	125,818	12.69	18
19	Laundry	3,885	4,129	48,164	11.66	19
20	Administrator	1,884	2,021	80,148	39.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,748	5,925	99,523	16.80	23
24	Clerical					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) <u>See PG20A</u>	5,975	6,191	133,978	21.64	33
34	TOTAL (lines 1 - 33)	136,944	140,423	\$ 2,190,225 *	\$ 15.60	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	5,491	L10, C3	39
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant	1	74	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)	1	\$ 11,565		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	322	\$ 11,696	L10, C3	50
51	Licensed Practical Nurses	1,609	54,556	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,931	\$ 66,252		53

Cornerstone Rehab & HC

0052225

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Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,562	2,602	61,452	23.62
Transportation	1,333	1,509	17,727	11.75
Pastoral care	2,080	2,080	54,799	26.34
<b>TOTAL</b>	<b>5,975</b>	<b>6,191</b>	<b>133,978</b>	

**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	
Corrie Magee	Administrator	0	\$ 73,708	Workers' Compensation Insurance	\$ 47,116	IDPH License Fee	\$ 1,990	
Brent Morgan	Administrator	0	6,440	Unemployment Compensation Insurance	79,737	Advertising: Employee Recruitment	2,423	
				FICA Taxes	161,445	Health Care Worker Background Check		
				Employee Health Insurance	(6,692)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	637	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	150	
				Employee Relations	2,771	Miscellaneous Dues & Subscriptions	2,474	
				Employee Retirement		Home Office Allocation	511	
				Home Office Allocation	20,828			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 80,148					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 226,600					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 226,600					
(Attach a copy of any management service agreement)								
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
E-Health Data Solutions	Computer Services		\$ 1,841				Out-of-State Travel	\$
Comcast	Computer Services		1,150					
Peoria County Circuit Clerk	Filing Fees		40				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	35
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 3,031				TOTAL	\$ 35

\* Attach copy of IMRF notifications

\*\*See instructions.

**Cornerstone Rehab & HC**

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**Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		3,031

**Home Office Allocation**

Lexis Nexis	Legal	9
GoffWilson	Legal	608
Illinois Secretary of State	Legal	55
Bank of America	Legal	184
Healthcare Resources International	Legal	110
Miscellaneous	Legal	24
Addy, Bush	Legal	16
Hall, Rustom, and Fritz	Legal	18
Black, Hedin, Ballard	Legal	32
SmithAmundsen	Legal	32
CliftonLarson Allen	Accountants	1,294
Ginoli & Co.	Accountants	2,711
Miscellaneous	Computer Services	24
Odessian LLC	Computer Services	8
Optimizer	Computer Services	52
Allpayer Exchange	Computer Services	16
CCH	Computer Services	27
Prism Software	Computer Services	82
Macquarie Technology Services	Computer Services	72
Advanced Answers on Demand	Computer Services	3,835
Stratus Networks	Computer Services	506
Kemper Technology	Computer Services	1,742
AT&T	Computer Services	6
Ability Network	Computer Services	580
Barracuda	Computer Services	132
CIAN	Computer Services	158
Comcast	Computer Services	40

Emdeon	Computer Services	102
Charter Communications	Computer Services	6
Crawford County Title Co.	Other Prof Fees	7
Better Banks	Other Prof Fees	5
David Budde	Other Prof Fees	45
All Scripts	Other Prof Fees	30
Miscellaneous	Other Prof Fees	6
Marotta Gund Budd Derza	Other Prof Fees	11,155
Total (agree to Schedule V, line 19, column 8)		<u>26,760</u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Cornerstone Rehab &amp; HC

# 0052225

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## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,511 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 194,908  
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. \$ 6,767
- (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. \$ 1,060
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adquate 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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (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 of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.