

Facility Name & ID Number Cornerstone Rehab & HC

0052225 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	14,786	5,672	3,174	23,632	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,786	5,672	3,174	23,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.07%

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 2/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2013 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 2,589

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	185,438	16,792		202,230		202,230	4,580	206,810		1
2	Food Purchase		176,853		176,853		176,853	(3,765)	173,088		2
3	Housekeeping	116,148	35,843		151,991		151,991	36	152,027		3
4	Laundry	41,405	10,521		51,926		51,926		51,926		4
5	Heat and Other Utilities			84,021	84,021		84,021	264	84,285		5
6	Maintenance	35,034	8,871	31,961	75,866		75,866	1,816	77,682		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	378,025	248,880	115,982	742,887		742,887	2,931	745,818		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,075,158	78,717	336,097	1,489,972		1,489,972	58	1,490,030		10
10a	Therapy	30,807	20	486,057	516,884		516,884		516,884		10a
11	Activities	71,416	1,574	5,763	78,753		78,753	(606)	78,147		11
12	Social Services	85,216			85,216		85,216		85,216		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	1,262,597	80,311	833,917	2,176,825		2,176,825	(548)	2,176,277		16
	C. General Administration										
17	Administrative			259,500	259,500		259,500	(179,455)	80,045		17
18	Directors Fees										18
19	Professional Services			8,205	8,205		8,205	17,764	25,969		19
20	Dues, Fees, Subscriptions & Promotions			11,326	11,326		11,326	598	11,924		20
21	Clerical & General Office Expenses	64,456	6,079	11,610	82,145		82,145	51,229	133,374		21
22	Employee Benefits & Payroll Taxes			232,957	232,957		232,957	34,338	267,295		22
23	Inservice Training & Education			225	225		225	353	578		23
24	Travel and Seminar							80	80		24
25	Other Admin. Staff Transportation			6,143	6,143		6,143	3,604	9,747		25
26	Insurance-Prop.Liab.Malpractice			30,892	30,892		30,892	554	31,446		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	64,456	6,079	560,858	631,393		631,393	(70,935)	560,458		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,705,078	335,270	1,510,757	3,551,105		3,551,105	(68,552)	3,482,553		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:

1/1/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			170,203	170,203		170,203	(7,846)	162,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			218,980	218,980		218,980	(37)	218,943			32
33	Real Estate Taxes			97,619	97,619		97,619	600	98,219			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,021	8,021		8,021	695	8,716			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			494,823	494,823		494,823	(6,588)	488,235			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,636		81,636		81,636		81,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			175,065	175,065		175,065		175,065			42
43	Other (specify):* Home Office Ben. Allocati		101	40,908	41,009		41,009	(41,009)				43
44	TOTAL Special Cost Centers		81,737	215,973	297,710		297,710	(41,009)	256,701			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,705,078	417,007	2,221,553	4,343,638		4,343,638	(116,149)	4,227,489			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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,772)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,868)	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	(19,202)	30		9
10	Interest and Other Investment Income	(302)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(319)	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	(21,236)	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	(101)	43		24
25	Fund Raising, Advertising and Promotional	(1,884)	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	(11,406)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,090)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(51,059)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (51,059)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (116,149)		37

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

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

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

Cornerstone Rehab & HC

ID# 0052225

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (6,315)	43	1
2	X-Rays-Part A	(2,582)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(117)	21	3
4	Resident Flower	(466)	43	4
5	Disallowed Special Events	(470)	43	5
6	Offset Transportation Revenue	(606)	11	6
7	Offset Miscellaneous Nursing Supplies Revenue	(82)	10	7
8	Disallowed Pet Expense	(768)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(11,406)	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	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)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		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%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8	
9	V	10A Therapy		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%	231	231	12	
13	V							13	
14	Total		\$			\$ 231	\$ *	231	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 & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 62	\$	62	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	895		895	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			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		\$			\$ 957	\$ *	957	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	12 Social Services		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%	9,432	9,432	25
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	391	391	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	27 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	2,236	2,236	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		\$			\$ 12,059	\$ * 12,059	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%	\$ 4,580	\$ 4,580
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	7	7
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	36	36
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	264	264
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,816	1,816
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%	140	140
23	V	10A Therapy		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	259,500	Petersen Health Care Management, Inc.	100.00%	80,045	(179,455)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	8,101	8,101
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	145	145
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	51,346	51,346
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	34,338	34,338
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	353	353
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	80	80
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,604	3,604
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	554	554
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%	8,225	8,225
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	265	265
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	600	600
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	695	695
39	Total		\$ 259,500			\$ 195,194	\$ * (64,306)

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

Facility Name & ID Number

Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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 Syste	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	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	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	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 & ID Number

Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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:

1/1/2015

Ending:

12/31/2015

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:

1/1/2015

Ending:

12/31/2015

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								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Cornerstone Rehab & HC

#

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	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:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	23,632	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	23,632	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	23,632	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	23,632	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	23,632	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,632	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	23,632	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	23,632	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	23,632	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,632	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	23,632	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	23,632	231	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	23,632	62	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	23,632	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	23,632	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	23,632	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	23,632	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	23,632	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	23,632	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	23,632	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	23,632	895	21
22	32	Interest	Resident Days	1,553,881	75	0	0	23,632	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	23,632	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	23,632	0	24
25	TOTALS					\$ 78,110	\$		\$ 1,188	25

Facility Name & ID Number Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	160,585	10		23,632		1
2	2	Food	Resident Days	160,585	10		23,632		2
3	3	Housekeeping	Resident Days	160,585	10		23,632		3
4	4	Laundry	Resident Days	160,585	10		23,632		4
5	5	Utilities	Resident Days	160,585	10		23,632		5
6	6	Maintenance	Resident Days	160,585	10		23,632		6
7	7	Mgmt. Allocation of Benefits	Resident Days	160,585	10		23,632		7
8	10	Nursing and Medical Records	Resident Days	160,585	10		23,632		8
9	15	Mgmt. Allocation of Benefits	Resident Days	160,585	10		23,632		9
10	17	Administrative	Resident Days	160,585	10		23,632		10
11	19	Professional Services	Resident Days	160,585	10	64,091	23,632	9,432	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	160,585	10	2,658	23,632	391	12
13	21	Clerical and General Office	Resident Days	160,585	10		23,632		13
14	22	Employee Benefits & Payroll	Resident Days	160,585	10		23,632		14
15	23	Inservice Training & Education	Resident Days	160,585	10		23,632		15
16	24	Travel and Seminar	Resident Days	160,585	10		23,632		16
17	25	Other Admin. Staff Transport.	Resident Days	160,585	10		23,632		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	160,585	10		23,632		18
19	27	Mgmt. Allocation of Benefits	Resident Days	160,585	10		23,632		19
20	30	Depreciation	Resident Days	160,585	10	15,190	23,632	2,236	20
21	32	Interest	Resident Days	160,585	10		23,632		21
22	33	Real Estate Taxes	Resident Days	160,585	10		23,632		22
23	34	Rent-Facility and Grounds	Resident Days	160,585	10		23,632		23
24	35	Rent-Equipment & Vehicles	Resident Days	160,585	10		23,632		24
25	TOTALS					\$ 81,939	\$	\$ 12,059	25

Facility Name & ID Number Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 301,135	\$ 292,840	23,632	\$ 4,580	1
2	2	Food	Resident Days	1,553,881	75	480		23,632	7	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	23,632	36	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		23,632	264	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	23,632	1,816	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,632		6
7	9	Medical Director	Resident Days	1,553,881	75			23,632		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		23,632	140	8
9	10A	Therapy	Resident Days	1,553,881	75			23,632		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,632		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	23,632	80,045	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		23,632	8,101	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		23,632	145	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	23,632	51,346	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		23,632	34,338	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		23,632	353	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		23,632	80	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		23,632	3,604	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		23,632	554	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			23,632		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		23,632	8,225	21
22	32	Interest	Resident Days	1,553,881	75	17,439		23,632	265	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		23,632	600	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		23,632	695	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 195,194	25

Facility Name & ID Number

Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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		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	\$ 2,729,425	1/30/44	Varies	\$ 218,980	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	\$ 2,729,425			\$ 218,980	9						
B. Non-Facility Related*																		
10									Home Office Allocation-PHCM		265	10						
11									Interest Income Offset		(302)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			(37)	14						
15	TOTALS (line 9+line14)						\$ 2,950,000	\$ 2,729,425			\$ 218,943	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2014 report.		\$	63,708		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.)		\$	61,446		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,262)		3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	99,881		4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation		600		6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	98,219		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	_____	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____ 14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____ 15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13	14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14	15	LESS REFUND FROM LINE 6 \$ _____ 15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____ 13														
14	PLUS APPEAL COST FROM LINE 5 \$ _____ 14														
15	LESS REFUND FROM LINE 6 \$ _____ 15														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____ 16														
	2011	_____	9												
	2012	_____	10												
	2013	61,805	11												
	2014	61,446	12												
Accrual based on prior year tax bill.															

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.

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

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

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	TOTALS			\$ 116,300	3

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	\$ 245,900
5									
6									
7									
8									
Improvement Type**									
9	Electrical Repair	2013		2,643		7	378	378	945
10	Water Heater	2013		5,125		7	732	732	1,830
11	Furnace Repair	2014		2,686		7	384	384	576
12	Generator	2014		30,881		15	2,059	2,059	3,089
13	Carpet/Drywall Replace, Painting-Kitchen, Commons, Res Rooms	2014		47,051		15	4,705	4,705	6,273
14	Blower Burner Assembly Kit	2015		2,636		7	188	188	188
15	Water Heater	2015		7,437		7	531	531	531
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Building Booked				98,360			(98,360)	
31	Building Improvement Booked				9,311			(9,311)	
32									
33	2015-Home Office Allocation-Building Improvements			10,340			248	248	
34	2015-Home Office Allocation-Land Improvements			965			62	62	
35									
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									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,568,764	\$ 107,671		\$ 107,647	\$ (24)	\$ 259,332	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	\$ 426,564	\$ 60,937	\$ 42,656	\$ (18,281)	5-10 yrs.	\$ 106,641	71
72	Current Year Purchases	20,166	1,595	1,008	(587)	10 yrs.	1,008	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,046	11,046			74
75	TOTALS	\$ 446,730	\$ 62,532	\$ 54,710	\$ (7,822)		\$ 107,649	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)	\$ 3,131,794	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,203	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,357	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,846)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 366,981	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: 1/1/2015

Ending: 12/31/2015

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 8,716 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	<u>N/A</u>				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 1/1/2015

Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 3,859
Dishwasher	712
Laundry Equipment	552
Copier	2,898
Home Office Allocation	695
	<u>8,716</u>

Facility Name & ID Number Cornerstone Rehab & HC # 0052225 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	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.

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	\$	11,751	\$	176,268	\$	11,751	\$	176,268	1			
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,318		49,775		3,318		49,775	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	10A(1,2,3)	1730 hrs		30,807		17,334		260,014	20	19,064	290,841	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						81,636			81,636	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			\$	30,807		32,403	\$	486,057	\$	81,656	34,133	\$	598,520	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.

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	\$ 2,191,304	\$ 2,191,304	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>73,244</u>)	1,485,598	1,485,598	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,162	32,162	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	4,540	4,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,713,604	\$ 3,713,604	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	2,469,340	14
15	Leasehold Improvements, at Historical Cost	98,459	99,424	15
16	Equipment, at Historical Cost	446,730	446,730	16
17	Accumulated Depreciation (book methods)	(482,673)	(366,981)	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)	\$ 2,637,816	\$ 2,764,813	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,351,420	\$ 6,478,417	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,233,160	\$ 1,233,160	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,419	56,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	119,272	119,272	31
32	Accrued Real Estate Taxes(Sch.IX-B)	99,881	99,881	32
33	Accrued Interest Payable	18,196	18,196	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	181,812	181,812	36
37	<u>Accrued Management Fees</u>	399,877	399,877	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,108,617	\$ 2,108,617	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,729,425	2,729,425	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	795	795	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,730,220	\$ 2,730,220	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,838,837	\$ 4,838,837	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,512,583	\$ 1,639,580	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,351,420	\$ 6,478,417	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,062,527	1
2	Restatements (describe):		2
3	Correction of Accrued RE Taxes Made After Cost Report Filed	(98,398)	3
4	Prior Period Adjustments Made After Cost Report Was Filed	1,530	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 965,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	546,924	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)	\$ 546,924	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)	\$ 1,512,583	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cornerstone Rehab & HC# 0052225Report Period Beginning: 1/1/2015Ending: 12/31/2015

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,145,263	1
2	Discounts and Allowances for all Levels	(326,958)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,818,305	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	915,306	6
7	Oxygen	2,774	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 918,080	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	546	13
14	Non-Patient Meals	3,772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,243	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,705	20
21	Other Medical Services	19,804	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,070	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	302	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 302	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	606	28
28a	Miscellaneous Revenue	199	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 805	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,890,562	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	742,887	31
32	Health Care	2,176,825	32
33	General Administration	631,393	33
B. Capital Expense			
34	Ownership	494,823	34
C. Ancillary Expense			
35	Special Cost Centers	122,645	35
36	Provider Participation Fee	175,065	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,343,638	40
41	Income before Income Taxes (line 30 minus line 40)**	546,924	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 546,924	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,034,479	44
45	Private Pay - Net Inpatient Revenue	1,025,574	45
46	Medicare - Net Inpatient Revenue	583,567	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	180,457	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(5,772)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,818,305	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:

1/1/2015

Ending:

12/31/2015

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	2,112	2,112	\$ 67,000	\$ 31.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,234	5,438	139,574	25.67	3
4	Licensed Practical Nurses	13,522	13,904	311,499	22.40	4
5	CNAs & Orderlies	42,508	43,167	513,352	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,533	1,730	30,807	17.81	8
9	Activity Director	2,080	2,080	39,733	19.10	9
10	Activity Assistants					10
11	Social Service Workers	3,964	4,012	85,216	21.24	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,457	13.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,476	15,075	157,981	10.48	15
16	Dishwashers					16
17	Maintenance Workers	2,052	2,089	35,034	16.77	17
18	Housekeepers	9,736	10,098	116,148	11.50	18
19	Laundry	3,780	4,031	41,405	10.27	19
20	Administrator	2,087	2,087	80,045	38.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,821	5,188	64,456	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,602	1,634	43,733	26.76	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral Care</u>	1,213	1,213	31,683	26.12	33
34	TOTAL (lines 1 - 33)	112,800	115,938	\$ 1,785,123 *	\$ 15.40	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	5,049	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 11,049		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,075	\$ 37,485	L10, C3	50
51	Licensed Practical Nurses	2,667	90,185	L10, C3	51
52	Certified Nurse Assistants/Aides	8,875	200,749	L10, C3	52
53	TOTAL (lines 50 - 52)	12,617	\$ 328,419		53

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	\$ 52,067	Workers' Compensation Insurance	\$ 49,802	IDPH License Fee	\$ 1,990	
Benny Perkins	Administrator	0	27,978	Unemployment Compensation Insurance	75,571	Advertising: Employee Recruitment	4,404	
				FICA Taxes	128,370	Health Care Worker Background Check		
				Employee Health Insurance	(22,808)	(Indicate # of checks performed <u>174</u>)	1,607	
				Employee Meals		Miscellaneous Licenses & Permits	1,045	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	2,280	
				Employee Relations	2,022	Home Office Allocation	598	
				Home Office Allocation	34,338			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 80,045					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 259,500				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 259,500				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			(agree to Sch. V, line 20, col. 8)	
Vendor/Payee	Type	Amount						
E-Health Data Solutions	Computer Services	\$ 6,442						
Comcast	Computer Services	1,234						
Pro Title USA	Legal Fees-Title Searches	192						
Sorling Northrup	Legal Fees	115						
Honkamp Krueger	Accounting Fees	222						
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 8,205					

* Attach copy of IMRF notifications

**See instructions.

Cornerstone Rehab & HC

0052225

Period Beginning

1/1/2015

Period End

12/31/2015

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

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,205

Home Office Allocation

Denton's US LLP	Legal	115
Applegate and Thorne	Legal	18
Miller Hall and Triggs	Legal	17
Healthcare Resources International	Legal	94
Lexis Nexis	Legal	7
GoffWilson	Legal	788
CliftonLarson Allen	Accountants	3,451
Ginoli & Co.	Accountants	738
Miscellaneous	Computer Services	55
CCH	Computer Services	14
PTC Select	Computer Services	19
Advanced Answers on Demand	Computer Services	2522
Stratus Networks	Computer Services	459
Kemper Technology	Computer Services	675
AT&T	Computer Services	6
Ability Network	Computer Services	649
CIAN	Computer Services	457
Comcast	Computer Services	17
Emdeon	Computer Services	38
Charter Communications	Computer Services	31
Allscripts	Computer Services	23
Allpayer Exchange	Computer Services	15
E-Health Technologies	Computer Services	10
Macquarie Technology Services	Computer Services	15
Optimizer	Other Prof Fees	44

D.J. Howard Appraisers	Other Prof Fees	40
Key Corporate Services	Other Prof Fees	134
Consolidated Land Surveying	Other Prof Fees	84
Alan Litwiller	Other Prof Fees	18
Marotta Gund Budd Derza	Other Prof Fees	7211

Total (agree to Schedule V, line 19, column 8)		<u>25,969</u>
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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												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Cornerstone Rehab & HC

0052225

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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-\$795
- (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. \$ 24,171 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. \$ 175,065
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. \$ 3,772
- (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. \$ 606
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? 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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.