

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 0035477

Facility Name: Cornerstone Special Care

Address: 2601 Woodlawn Road Sterling 61081
Number City Zip Code

County: Whiteside

Telephone Number: (815) 626-8520 Fax #: (815) 626-5822

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1989

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501(c)(3)

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Chris Louder Telephone Number: (615) 917-4020
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2024 to 6/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Chris Louder

(Title) VP of Finance - HutsonWood (Manager)

Paid Preparer

(Signed)

(Print Name and Title) Eric Neidig Partner

(Firm Name & Address) Bradley Associates 201 S. Capitol Ave. Suite 700, Indianapolis, IN 46225

(Telephone) (317) 237-5500 Fax #: (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

Cornerstone Special Care

#

0035477

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

III. STATISTICAL DATA

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

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	85	Skilled Pediatric (SNF/PED)	85	31,025	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	85	TOTALS	85	31,025	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
8	SNF									8
9	SNF/PED	27,892							27,892	9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	27,892							27,892	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

89.90%

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

42

(Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

X

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

YES

NO

X

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

Date started

8/15/1989

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

YES

X

Date

8/15/1989

NO

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

YES

NO

X

If YES, enter certified beds.

number of certified beds

Medicare Intermediary

N/A

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

6/30/2025

Fiscal Year:

6/30/2025

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

Facility Name & ID Number Cornerstone Special Care # 0035477 Report Period Beginning: 7/1/2024 Ending: 6/30/2025
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	296,644	11,201	11,035	318,880		318,880	(106,293)	212,587			1
2	Food Purchase		177,285		177,285		177,285	(59,821)	117,464			2
3	Housekeeping	205,293	27,095	0	232,388		232,388	(61,451)	170,937			3
4	Laundry	210,807	17,012	182	228,001		228,001	0	228,001			4
5	Heat and Other Utilities			133,780	133,780		133,780	(35,376)	98,404			5
6	Maintenance	66,146	21,976	73,614	161,736	51	161,787	(41,804)	119,983			6
7	Other (specify):*				0		0	0	0			7
8	TOTAL General Services	778,890	254,569	218,611	1,252,070	51	1,252,121	(304,745)	947,376			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000	0	21,000			9
10	Nursing and Medical Records	2,897,498	228,877	23,880	3,150,255	(25)	3,150,230	(36,003)	3,114,227			10
10a	Therapy	8,526	2,478	5,108	16,112		16,112	0	16,112			10a
11	Activities	224,999	7,155		232,154		232,154	0	232,154			11
12	Social Services				0		0	0	0			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	3,131,023	238,510	49,988	3,419,521	(25)	3,419,496	(36,003)	3,383,493			16
	C. General Administration											
17	Administrative	213,441	163		213,604		213,604	(41,515)	172,089			17
18	Directors Fees			80,364	80,364		80,364	(15,619)	64,745			18
19	Professional Services			676,660	676,660	(2,579)	674,081	(232,790)	441,291			19
20	Dues, Fees, Subscriptions & Promotions			21,552	21,552	706	22,258	(8,645)	13,613			20
21	Clerical & General Office Expenses	112,965	15,544	133,348	261,857	378	262,235	(95,622)	166,613			21
22	Employee Benefits & Payroll Taxes			1,016,287	1,016,287		1,016,287	(211,488)	804,799			22
23	Inservice Training & Education			18,319	18,319	(175)	18,144	(3,827)	14,317			23
24	Travel and Seminar			11,421	11,421		11,421	(8,066)	3,355			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			121,734	121,734		121,734	(3,177)	118,557			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	326,406	15,707	2,079,685	2,421,798	(1,670)	2,420,128	(620,749)	1,799,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,236,319	508,786	2,348,284	7,093,389	(1,644)	7,091,745	(961,497)	6,130,248			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation				0		0	134,452	134,452			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			308	308		308	(308)	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			455,939	455,939		455,939	(455,939)	0			34
35	Rent-Equipment & Vehicles			8,488	8,488	1,644	10,132	(2,534)	7,598			35
36	Other (specify):*				0		0	22,916	22,916			36
37	TOTAL Ownership			464,735	464,735	1,644	466,379	(301,413)	164,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		18,326	9,694	28,020		28,020	0	28,020			39
40	Barber and Beauty Shops		1,203		1,203		1,203	0	1,203			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			536,692	536,692		536,692	0	536,692			42
43	Other (specify):* Day Training	811,956	5,622		817,578		817,578	(817,578)	0			43
44	TOTAL Special Cost Centers	811,956	25,151	546,386	1,383,493	0	1,383,493	(817,578)	565,915			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,048,275	533,937	3,359,405	8,941,617	0	8,941,617	(2,080,488)	6,861,129			45

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

Exceptional Care & Training Center
Schedule V - Line 23 Detailed Schedule

Purpose of Seminar	Name of Attendee	Title of Attendee	Expense Amount
1 IHCA Convention LTCNA	Various	Various	180
2 Relias Annual - Regulation of HHS	All Employees	Various	16,385
3 ILANFP	Sheila Hamilton	Dietary Director	65 @
4 Leading in the 21st Century	Deb Arellano	Human Resources	126
5 CPR Training	Various	Various Nursing Staff	1,319
6 2024 Momentum Academy	McFadden	Staff Development	69
7 Reclassed Chamber of Commerce Expense	N/A	N/A	175 !
Line 23 Column 4 Total			18,319
Line 23 Column 5 Total			(175) !
Non-Allowable Amounts Above Removed through Schedule 5 Adjustments: Line 23 Column 7 Adjustments			
Non-Care Related Amount Above			(65) @
Allocation for Non-Care Related Education and Day Training (see Page 5A & 11.1)			(3,762)
Rounding			
Line 23 Column 7 Total			(3,827)
Line 23 Column 8 Total			14,317

Description	Increase/Decrease	Schedule V Line
1 Reclassification of Chamber of Commerce Dues		
Inservice Training & Education	(175)	23
Dues, Fees, Subscriptions & Promotions	175	20
2 Reclassification of Copier Rental and Pump Lease Costs		
Professional Services	(1,619)	19
Nursing and Medical Records	(25)	10
Rent-Equipment & Vehicles	1,644	35
3 Reclassification of Patient Background Check Costs		
Professional Services	(960)	19
Dues, Fees, Subscriptions & Promotions	960	20
4 Reclassification of Vehicle Expense		
Dues, Fees, Subscriptions & Promotions	(51)	20
Maintenance	51	6
5 Reclassification of Amazon Prime Membership		
Dues, Fees, Subscriptions & Promotions	(139)	20
Clerical & General Office Expenses	139	21
6 Reclassification of Miscellaneous Administrative Expenses		
Dues, Fees, Subscriptions & Promotions	(239)	20
Clerical & General Office Expenses	239	21

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$ (817,578)	43	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(120,550)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(308)	32		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(870)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,312)	20		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	(900,220)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,841,838)		\$ 0	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(238,650)	19, 34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (238,650)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,080,488)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (2,726)	20	1
2	Other Expenses Related to Lobbying Activities	0		2
3	Non-Care Portion of Travel	(7,184)	24	3
4	Vendor Discounts	(345)	21	4
5	Medical Supply Rebates (DSSI & Medline)	(9,170)	10	5
6	Food Supply Rebates (GFS)	(1,089)	2	6
7	Marketing	(26,833)	10	7
8	Depreciation Expense Adjustment	(39,297)	30	8
9	Flowers	(8,091)	21	9
10	Goodwill Amortization	(39,615)	21	10
11	Advertising	(2,264)	21	11
12	Non-Operating	(4,243)	21	12
13	Non-Allowable Day TrngAlloc - Dietary	(106,293)	1	13
14	Non-Allowable Day Trng Alloc - Food Purchase	(58,732)	2	14
15	Non-Allowable Day Trng Alloc - Housekeeping	(61,451)	3	15
16	Non-Allowable Day Trng Alloc - Utilities	(35,376)	5	16
17	Non-Allowable Day Trng Alloc - Maintenance	(41,804)	6	17
18	Non-Allowable Day Trng Alloc - Admin	(41,515)	17	18
19	Non-Allowable Day Trng Alloc - Directors	(15,619)	18	19
20	Non-Allowable Day Trng Alloc - Prof Svcs	(103,850)	19	20
21	Non-Allowable Day Trng Alloc - Dues/Fees	(3,312)	20	21
22	Non-Allowable Day Trng Alloc - Clerical	(40,194)	21	22
23	Non-Allowable Day Trng Alloc - Benefits	(211,488)	22	23
24	Non-Allowable Day Trng Alloc - Inservice Training	(3,762)	23	24
25	Non-Allowable Day Trng Alloc - Travel/Seminar	(882)	24	25
26	Non-Allowable Day Trng Alloc - Insurance	(32,191)	26	26
27	Non-Allowable Day Trng Alloc - Equip/Vehicle Rent	(2,534)	35	27
28	Non-Allowable CoC Expense	(295)	20	28
29	Non-Allowable Dietary	(65)	23	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	(900,220)		49

Summary A

6/30/2025

[illegible]

Summary B

Facility Name & ID Number	Cornerstone Special Care	#	0035477	Report Period Beginning:	7/1/2024	Ending:	6/30/2025
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
Hoosier Care, Inc.	100	Walter Lawson Children's Home	Loves Park, IL	Sterling Facility Comp	Sterling, IL	Property Co.
		Swann Special Care Center	Champaign, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Exceptional Living of Brazil	Brazil, IN	HHSS Management	Nashville, TN	Management Co.
		Richland Bean-Blossom Healthcare	Ellettsville, IN			
		Vernon Health & Rehabilitation	Wabash, IN			
		Emerald Spring Hill	Nashville, TN			

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	18	Group Mgmt/Dir Fees	\$ 80,364	Hoosier Care Investments	100.00%	\$ 80,364	\$	1
2	V				Note: See Schedule VII Section C for description.				2
3	V	19	Management Fees	597,755	HHSS Management	100.00%	458,000	(139,755)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 678,119			\$ 538,364	\$ * (139,755)	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.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Related Party Building/Equip. Rental	\$ 455,939	Sterling Facility Company, LLC	100.00%	\$	\$ (455,939)	15
16	V				This facility company is under 100% common ownership				16
17	V				with ECTC, and therefore the "rent" paid to the facility				17
18	V				company has been removed from this report and the				18
19	V				actual expenses of the facility company have been				19
20	V				added here:				20
21	V	30	Related Party Depreciation		Sterling Facility Company, LLC		173,749	173,749	21
22	V	32	Related Party Interest (Net)		Sterling Facility Company, LLC		114,088	114,088	22
23	V	32	Related Party Amortization of Debt Cost		Sterling Facility Company, LLC		6,462	6,462	23
24	V	26	Related Party Insurance		Sterling Facility Company, LLC		29,014	29,014	24
25	V	19	Related Party Accounting Fees		Sterling Facility Company, LLC		10,815	10,815	25
26	V	36	Related Party Mortgage Insurance		Sterling Facility Company, LLC		22,916	22,916	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			\$ 455,939			\$ 357,044	\$ * (98,895)	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	John Foos	Board Member	Governance	0.00					\$		1
2	Jim Ridenour	Board Member	Governance	0.00							2
3	Jo Anne Corbitt	Board Member	Governance	0.00							3
4	Douglass Smith	Board Member	Governance	0.00							4
5	Laura Hawken	Board Member	Governance	0.00							5
6	Stephen Wood Jr	Board Member	Governance	0.00							6
7	Chris Hodges	Board Member	Governance	0.00							7
8	Note: Fees are paid by ECTC to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-profit) which go toward fees for members of the Board of HCI affiliated										8
9	facilities, ECTC being one of many. Therefore, no Board Fees or compensation paid directly by ECTC to the Directors, but rather the fees paid by ECTC to HCI are										9
10	combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight, including payment by HCI to Board members of each legal										10
11	entity. Fees paid by other IL facilities are shown on Page 7.1 The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the										11
12	facility:							Admin Fees	80,364	18.3	12
13								TOTAL	\$ 80,364		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

VII. RELATED PARTIES (continued)

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

* 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.

Amounts Paid for Directors/Administration Fees by Other Nursing Homes

Walter Lawson Children's Home	94,440
Swann Special Care Center	116,976
Exceptional Care & Training Center	80,364

Facility Name & ID Number Cornerstone Special Care # 0035477 Report Period Beginning: 7/1/2024 Ending: 5/30/2025

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

Street Address

City / State / Zip Code

Phone Number

Fax Number

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LP Mortgage HUD Loan		X	Facility Purchase Financing	\$26,513.35	11/1/2012	\$ 6,675,000	\$ 4,491,244	11/1/2042	0.0254	\$ 0	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$26,513.35		\$ 6,675,000	\$ 4,491,244			\$ 0	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14	
15	TOTALS (line 9+line14)						\$ 6,675,000	\$ 4,491,244			\$ 0	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,916 Line # 36

* 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.)

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.

FACILITY NAME Cornerstone Special Care COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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 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.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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: 25,148 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (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 (X) (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).
ECTC Developmental Day Training Program; cost removal adjustments and allocation to remove associated costs shown on Sch. V; See PG11.1 attachment for further detail.

F. List the bed capacity for the building if it differs from the licensed total. 85
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	SNF/PED	63,598	1989	\$ 414,085	1
2					2
3	TOTALS	63,598		\$ 414,085	3

Exceptional Care & Training Center
Schedule X Supplemental Schedule
Allocation of Non-Long Term Care Costs

E. Exceptional Care & Training Center operates a Developmental Day Training program in dedicated classroom space at the skilled nursing facility. All costs specifically attributable to this program in dedicated GL accounts, including wages/salaries, supplies, rent, and occupancy costs, have been grouped to line 43 of Schedule V, "Other Cost Centers," and are removed via adjustment on Schedule VI, Line 3. In addition, a portion of all other cost centers and expense items which provide benefits and support to the Day Training program are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

The percentage of costs identified for each program are utilized to allocate other non-specific/overhead/administrative items attributable to Day Training, and such identified and allocated costs are removed on Schedule VI. Allocation bases utilizing program statistics (direct labor hours, program hours of operation, square footage, etc.) are applied to shared costs to determine the portion to be disallowed and offset via adjustments on Schedule VI. The results of these allocations appear on Schedule VI as adjustments to remove shared costs attributable to non-long term care services.

Facility Name & ID Number Cornerstone Special Care

0035477

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	64		1989		\$ 2,334,000	\$ 9,667	10-40	\$ 9,667		\$ 2,334,000
5	15			1991	358,311	0	30	0		358,311
6	5			2004						
7										
8										
	Improvement Type**									
9	GATE & FENCE SCARS			5/29/1992	4,038	0	10	0		4,038
10	INSTALL NEW SEWER LINES			7/14/1993	4,105	0	10	0		4,105
11	NEW WATER MAIN			10/11/1993	12,204	0	10	0		12,204
12	REPLACE PARTS ON 2 SUMP P			5/24/1994	4,034	0	10	0		4,034
13	TILE FOR FLOORS IN TUB RO			2/16/1995	4,405	0	10	0		4,405
14	THERMOCOUPLE ON BOILER			3/8/1995	2,550	0	10	0		2,550
15	REPLACE FIRE ALARM			6/30/1995	3,743	0	10	0		3,743
16	RESEAL PARKING AREA			6/7/1997	2,845	0	10	0		2,845
17	PART:GENERATOR,TRANSFER S			9/11/1998	2,746	0	10	0		2,746
18	TANK REPLACEMENT - PIPECO			9/28/1998	9,890	0	20	0		9,890
19	INSTALL TILE:WALLS,STAIRC			12/2/1998	4,495	0	10	0		4,495
20	2 HOT WATER TANKS			3/5/1999	7,119	0	10	0		7,119
21	COOLING SYSTEM-LAUNDRY/KI			1/22/2000	4,650	0	20	0		4,650
22	NEW TILE IN DINING RM/CLA			4/11/2000	4,770	0	15	0		4,770
23	FURNISH & INSTALL AWNING.			4/6/2001	2,771	0	15	0		2,771
24	LABOR & MAT-BREAKER PANEL			4/12/2001	3,930	0	15	0		3,930
25	EXCAVATION OF NEW PARKING			5/11/2001	12,415	0	20	0		12,415
26	INSTALL WATER HEATER			7/5/2001	3,341	0	15	0		3,341
27	WALKWAY			8/28/2001	4,119	0	15	0		4,119
28	INTERNET SET-UP-WIRING CA			2/21/2002	3,061	0	15	0		3,061
29	PRIVACY FENCE			6/20/2002	2,550	0	10	0		2,550
30	STORM WINDOW PROJECT			6/24/2002	8,937	0	20	0		8,937
31	New Electrical System (Mulit Purpose Rm			9/9/2004	6,637	0	7	0		6,637
32	Parking Lot Renovation			9/11/2004	3,499	0	10	0		3,499
33	34 heat/smoke detectors			12/2/2004	2,800	0	7	0		2,800
34	replace compressor in lobby			8/9/2005	11,445	0	15	0		11,445
35	Water heater			6/16/2006	4,717	0	10	0		4,717
36	Sprinkler system-Phase I			6/30/2006	33,165	0	15	0		33,165

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Cornerstone Special Care

0035477

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sprinkler system-Phase II	6/30/2006	\$ 7,920	\$ 0	15	\$ 0	\$	\$ 7,920	37
38	Sprinkler system-Phase III	9/21/2006	13,365	0	15	0		13,365	38
39	Light fixtures (24) and new wiring	1/22/2007	6,434	0	15	0		6,434	39
40	Ductwork & roof exhaust for new dryer	3/15/2007	3,498	0	15	0		3,498	40
41	Brake assembly on dumbwaiter	7/24/2007	4,389	0	15	0		4,389	41
42	Privacy wall in day rooms (2)	6/6/2008	3,297	0	15	0		3,297	42
43	Wiring & outlets for kitchen & dayrooms	9/26/2008	3,434	0	15	0		3,434	43
44	Portions of parking lot replaced/resurfa	10/20/2008	3,670	0	10	0		3,670	44
45	Exit & boiler room doors replaced	12/18/2008	2,712	0	15	0		2,712	45
46	Sewage pump	2/7/2009	4,133	0	10	0		4,133	46
47	Avaya phone system for day training	5/21/2009	7,010	0	10	0		7,010	47
48	5 ton rooftop hvac unit	7/9/2009	6,485	36	15	36		6,485	48
49	26 x 12 storage shed	7/12/2009	8,280	46	15	46		8,280	49
50	Concrete sidewalk for emergency exit	7/26/2009	7,119	40	15	40		7,119	50
51	Water heaters (2)	8/13/2009	11,250	0	10	0		11,250	51
52	Trex security fence	9/28/2009	9,142	152	15	152		9,142	52
53	Grease trap replaced and electric & tile	5/20/2010	7,217	441	15	441		7,217	53
54	Roof for courtyard pavillion	5/28/2010	6,657	407	15	407		6,657	54
55	Tile work for walls in south & east hall	7/15/2010	11,594	0	10	0		11,594	55
56	Misc electrical work	10/6/2010	4,915	328	15	328		4,806	56
57	Main drain line replaced	10/9/2010	2,818	188	15	188		2,755	57
58	Parapet wall on roof	10/28/2010	8,215	411	20	411		6,024	58
59	Greenhouse for therapy use	12/22/2010	12,475	0	10	0		12,475	59
60	Remodel restroom for isolation room	2/28/2011	2,556	0	10	0		2,556	60
61	Rentention pond	6/6/2011	7,273	0	10	0		7,273	61
62	Hardscape & landscape for rentention pon	6/6/2011	3,936	0	10	0		3,936	62
63	Vinyl coated chain link fence	6/7/2011	6,475	0	10	0		6,475	63
64	Tile in lobby and surrounding areas	6/14/2011	3,274	0	10	0		3,274	64
65	Replace sidewalks	9/20/2011	6,617	0	10	0		6,617	65
66	Roof hvac units (2)	10/3/2011	8,173	0	10	0		8,173	66
67	Water heater for south wing	10/4/2011	7,937	0	10	0		7,937	67
68	Replace header on basement door	12/7/2011	4,870	325	15	325		4,383	68
69	Medical room remodel	12/1/2012	8,082	0	10	0		8,082	69
70	TOTAL (lines 4 thru 69)		\$ 3,082,514	\$ 12,041		\$ 12,041	\$ 0	\$ 3,079,664	70

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

Facility Name & ID Number Cornerstone Special Care

0035477

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,082,514	\$ 12,041		\$ 12,041	\$	\$ 3,079,664	1
2	Boiler	3/1/2013	22,525	1,502	15	1,502		18,395	2
3	Bryant a/c units (2) and dishwasher hood	4/12/2013	13,875	925	15	925		11,254	3
4	Boiler Repair/Replacement	7/23/2013	29,683	0	10	0		29,683	4
5	Nurses Station Remodel	8/15/2013	19,747	0	10	0		19,747	5
6	Nurses Station Remodel	10/2/2013	19,748	0	10	0		19,748	6
7	Replaced Fire Door	10/3/2013	5,615	0	10	0		5,615	7
8	Repave Parking Lot	11/1/2013	54,183	0	10	0		54,183	8
9	Repave Parking Lot	11/1/2013	49,636	0	10	0		49,636	9
10	New Dumbwaiter	12/20/2013	10,898	0	10	0		10,898	10
11	Installation of dumbwaiter	4/10/2014	21,797	0	10	0		21,797	11
12	New Tile	6/12/2014	2,578	0	10	0		2,578	12
13	Emergency Generator	7/31/2014	12,810	107	10	107		12,810	13
14	Emergency Generator	7/31/2014	10,775	90	10	90		10,775	14
15	Emergency Generator	7/31/2014	10,775	90	10	90		10,775	15
16	Concrete Dumpster Pad	10/8/2014	8,970	299	10	299		8,970	16
17	Replace Dry Wall in 3 Rooms	11/7/2014	2,950	123	10	123		2,950	17
18	New Metal Doors	11/19/2014	5,635	235	10	235		5,635	18
19	Replaced Drain Line in Kitchen	11/19/2014	2,700	113	10	113		2,700	19
20	3 Bathroom Remodels	12/10/2014	4,185	209	10	209		4,185	20
21	New Roof	12/30/2014	7,350	368	10	368		7,350	21
22	New Roof	12/30/2014	6,000	300	10	300		6,000	22
23	New Roof	12/30/2014	5,950	297	10	297		5,950	23
24	Installed FRP Board in Several areas	3/19/2015	3,010	226	10	226		3,010	24
25	Bedroom/Bath Remodel	5/20/2015	60,000	5,500	10	5,500		60,000	25
26	Q Office & Conf Room Repairs	10/8/2015	3,341	334	10	334		3,229	26
27	Bedroom/Bath Remodel	11/19/2015	40,000	4,000	10	4,000		38,333	27
28	Bedroom/Bath Remodel	1/16/2016	28,040	2,804	10	2,804		26,405	28
29	Repairs to double fire doors	4/1/2016	2,752	275	10	275		2,523	29
30	Door Hardware, Wall/Door Panels-1st pmt	6/24/2016	15,000	1,500	10	1,500		13,500	30
31	Hallway Handrails - 1st Pmt	6/24/2016	5,000	500	10	500		4,500	31
32	Door Hardware, Wall/Door Panels-Final	7/12/2016	14,760	1,476	10	1,476		13,161	32
33	Hallway Handrails - Final pmt	7/12/2016	4,650	465	10	465		4,146	33
34	TOTAL (lines 1 thru 33)		\$ 3,587,452	\$ 33,779		\$ 33,779	\$ 0	\$ 3,570,105	34

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

Facility Name & ID Number Cornerstone Special Care

0035477

Report Period Beginning:

7/1/2024

Ending:

6/30/2025

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,587,452	\$ 33,779		\$ 33,779	\$	\$ 3,570,105	1
2	Fire Door Coolers	7/22/2016	2,880	288	10	288		2,568	2
3	Door Cooler	8/9/2016	3,250	325	10	325		2,871	3
4	Sidewalk Section Replaced	8/29/2016	3,299	330	10	330		2,914	4
5	Cabinets & Counters	9/26/2016	5,682	568	10	568		4,972	5
6	Compressor for HVAC Unit	10/27/2016	3,028	303	10	303		2,624	6
7	Tub Room Remodel - 50%	11/30/2016	26,530	2,653	10	2,653		22,772	7
8	Ceiling Lifts	11/30/2016	4,986	499	10	499		4,280	8
9	Tile Installation	12/7/2016	4,481	448	5	448		3,809	9
10	Replace Picture Windows	12/13/2016	21,730	2,173	10	2,173		18,471	10
11	Ceiling Lifts	12/21/2016	7,807	781	10	781		6,636	11
12	Ceiling Lifts	12/29/2016	6,800	680	5	680		5,780	12
13	Cabinets	2/16/2017	4,685	468	5	468		3,904	13
14	Windows Replaced	3/2/2017	10,532	1,053	10	1,053		8,689	14
15	Hopper Sink & Flush Valve Installed	4/20/2017	5,225	522	10	522		4,267	15
16	Fire Alarm	4/28/2017	4,598	460	10	460		3,755	16
17	Shower Renovation 40%	6/30/2017	19,973	1,997	10	1,997		15,979	17
18	Shower Renovation 30%	6/30/2017	14,980	1,498	10	1,498		11,984	18
19	Shower Renovations	6/30/2017	12,800	1,280	10	1,280		10,240	19
20	Shower Renovation	6/30/2017	12,483	1,248	10	1,248		9,986	20
21	Vinyl Flooring - Down payment	12/15/2017	80,937	8,094	10	8,094		60,703	21
22	Vinyl Flooring	12/15/2017	20,000	2,000	10	2,000		15,000	22
23	Vinyl Flooring	12/15/2017	20,000	2,000	10	2,000		15,000	23
24	install celing grid sprinklers	5/12/2018	2,564	256	10	256		1,816	24
25	New Cabinets	6/26/2018	7,576	758	10	758		5,303	25
26	Storage Shed final payment	10/18/2018	7,806	781	10	781		5,204	26
27	Water Softener	12/4/2018	6,000	600	7	600		3,900	27
28	new fire doors	12/20/2018	4,565	456	10	456		2,967	28
29	Office Remodel/Conversion	12/31/2018	3,403	340	10	340		2,212	29
30	Basement remodel	1/7/2019	2,808	281	10	281		1,802	30
31	Boiler repairs	1/8/2019	4,883	488	10	488		3,133	31
32	Water Heater	1/15/2019	6,800	680	10	680		4,363	32
33	New Shed	7/14/2019	2,875	288	10	288		1,701	33
34	TOTAL (lines 1 thru 33)		\$ 3,933,418	\$ 68,375		\$ 68,375	\$ 0	\$ 3,839,710	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,933,418	\$ 68,375		\$ 68,375	\$	\$ 3,839,710	1
2	Repair leak in Walls and Bathrooms of 2 resident rooms	7/21/2019	3,755	376	10	376		2,222	2
3	Cabinets for Classroom Remodel	11/21/2019	7,910	791	10	791		4,416	3
4	Plumbing Repair Work - Open sink drain, install fresh air lines, re	1/31/2020	7,712	771	10	771		4,177	4
5	Cabinets for Classroom Remodel	2/9/2020	9,438	944	10	944		5,034	5
6	New Fire Doors in Hallway	5/19/2021	3,918	196	10	196		800	6
7	Painting - Foyer, Lobby Halls in Resident Wings, Stairwells and K	1/26/2022	15,800	790	10	790		2,699	7
8	Parking Lot Seal & Crack Repair	9/13/2022	5,000	500	10	500		1,375	8
9	New Wall & Roll-up Doors	6/5/2023	13,440	672	10	672		1,344	9
10	Wall Panels	2/1/2024	17,023	2,432	10	2,432		3,242	10
11	Reaver Plumbing & Heating Water Heater Replacement	11/30/2024	14,500	423	10	423		423	11
12	Pioneer Technology, LLC-Wireless Access point installation/equip	5/1/2025	17,887	213	10	213		213	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	TOTAL (lines 1 thru 33)		\$ 4,049,801	\$ 76,483		\$ 76,483	\$ 0	\$ 3,865,655	34

**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	\$ 403,619	\$ 53,660	\$ 53,660	\$ 0	5-7	\$ 236,446	71
72	Current Year Purchases	17,000	283	283	0	5-10	283	72
73	Fully Depreciated Assets	1,109,539	4,026	4,026	0		1,109,539	73
74					0			74
75	TOTALS	\$ 1,530,158	\$ 57,969	\$ 57,969	\$ 0		\$ 1,346,268	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	Patient Transportation	2011 Ford E350 Van	2011	\$ 41,267	\$ 0	\$ 0	\$ 0	10	\$ 41,267	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 41,267	\$ 0	\$ 0	\$ 0		\$ 41,267	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)	\$ 6,035,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,452	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 134,452	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,253,190	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	Vehicles in Excess of 1 Allowed	\$ 317,895	\$ 7,377	\$ 251,501	86
87	Assets Below IL Capital Threshold/Other	616,183	7,915	600,296	87
88	Assets Disallowed by HFS Cap Review	654,912	24,006	518,497	88
89					89
90					90
91	TOTALS	\$ 1,588,990	\$ 39,298	\$ 1,370,294	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Facility and fixed equipment leased from 100% commonly-owned related party (see Sch VII).

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.

YESNO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO

16. Rental Amount for movable equipment: \$ 10,132 Description: See Page 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. /2026 \$

13. /2027 \$

14. /2028 \$

* 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.

Exceptional Care & Training Center

Moveable Equipment Rental Detail

Description	Amount	Schedule V Line
1 Copier Rental	7,876	35
2 Storage Unit	810	35
3 Postage Meter	419	35
3 Pump Lease	575	35
4 Generator Rental	183	35
5 Hardware Rental	269	35
Line 35 Column 6 Total	10,132	
Non-Allowable Amounts Above Removed through Schedule 5 Adjustments: Line 35 Column 7 Adjustments		
Allocation for Non-Care Related Education and Day Training (see Page 5A & 11.1)	(2,534)	
Line 35 Column 8 Total	7,598	

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (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.

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	

- (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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs			5,108			5,108	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	106 hrs	8,526				106	8,526	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$ 8,526		\$ 5,108	\$	106	\$ 13,634	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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$6,820,420	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	913,053		3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	148,399		6
7	Other Prepaid Expenses	14,516		7
8	Accounts Receivable (owners or related parties)	910,662		8
9	Other(specify): Goodwill	277,307		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$9,084,357	\$0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	127,520		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$127,520	\$0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$9,211,877	\$0	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$69,711	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	413,060		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Patient Trust Liability	127,320		36
37	Unclaimed Property	534		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$610,625	\$0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$0	\$0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$610,625	\$0	46
47	TOTAL EQUITY(page 18, line 24)	\$8,601,252	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$9,211,877	\$0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,704,347	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,704,347	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,235,681	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) Equity Withdrawals	(4,338,774)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,103,093)	17
	B. Transfers (Itemize):		
18	Rounding	(2)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,601,252	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cornerstone Special Care

0035477

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	\$ 9,264,295	1
2	Discounts and Allowances for all Levels	691	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,264,986	3
	B. Ancillary Revenue		
4	Day Care	2,679,748	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,679,748	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	221,960	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 221,960	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Page 19.1</u>	10,604	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,604	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,177,298	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,252,070	31
32	Health Care	3,419,521	32
33	General Administration	2,421,798	33
	B. Capital Expense		
34	Ownership	464,735	34
	C. Ancillary Expense		
35	Special Cost Centers	846,801	35
36	Provider Participation Fee	536,692	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,941,617	40
41	Income before Income Taxes (line 30 minus line 40)**	3,235,681	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,235,681	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 9,264,295.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) <u>Bad Debt</u>	691.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,264,986	56

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	
	E. Other Revenue (specify):****		
28.1	Refunds/Rebates	10,259	28.1
28.2	Vendor Discounts	87	28.2
28.3	Miscellaneous	257	28.3
	SUBTOTAL Other Revenue	\$ 10,603	

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,697	1,851	\$ 123,470	\$ 66.70	1
2	Assistant Director of Nursing	1,841	2,091	85,809	41.04	2
3	Registered Nurses	4,896	5,317	233,688	43.95	3
4	Licensed Practical Nurses	17,082	18,431	755,271	40.98	4
5	CNAs & Orderlies	64,864	69,174	1,584,722	22.91	5
6	CNA Trainees					6
7	Licensed Therapist	106	106	8,526	80.43	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,915	2,084	45,954	22.05	9
10	Activity Assistants	9,986	10,578	179,045	16.93	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,888	2,081	60,099	28.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,972	11,452	236,545	20.66	15
16	Dishwashers					16
17	Maintenance Workers	1,888	2,061	66,146	32.09	17
18	Housekeepers	9,689	10,337	205,293	19.86	18
19	Laundry	10,367	10,772	210,807	19.57	19
20	Administrator	2,044	2,080	213,441	102.62	20
21	Assistant Administrator					21
22	Other Administrative	3,895	4,160	112,965	27.16	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care QMA	3,762	4,192	114,538	27.32	32
33	Other(specify) DT	32,506	34,396	811,956	23.61	33
34	TOTAL (lines 1 - 33)	179,398	191,163	\$ 5,048,275 *	\$ 26.41	34

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	158	\$ 9,949	1.3	35
36	Medical Director	N/A	21,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	5,526	39.3	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) Psychiatric Consultant	N/A	4,168	39.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	158	\$ 40,643		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Melissa Franque	Administrator	0	\$ 213,441	Workers' Compensation Insurance	\$	56,966	IDPH License Fee	\$	
				Unemployment Compensation Insurance		7,837	Advertising: Employee Recruitment		
				FICA Taxes		369,409	Health Care Worker Background Check		
				Employee Health Insurance		504,204	(Indicate # of checks performed 4)	7,402	
				Employee Meals		2,828	Patient Background Checks	32 960	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	9,072	
				Employee Physicals		316	Marketing	2,312	
				Other		549	Other Dues & Subscriptions / Permits & Licenses	699	
				401k Retirement Plan		74,178	Bank Fees	2,068	
				Less PG5A Non-Allowable DT		(211,488)	Less Other Offsets and Reclasses	(3,862)	
							Less: Public Relations Expense	()	
							PAC and Lobbying payments	(2,726)	
							All non-allowable advertising	(2,312)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 213,441	TOTAL (agree to Schedule V, line 22, col.8)			\$ 804,799	TOTAL (agree to Sch. V, line 20, col. 8) \$ 13,613	
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	
			\$			\$	Out-of-State Travel	\$ 871	
							In-State Travel	6,356	
							Less PG5A Non-Allowable DT	(882)	
							Less Non-Care Amounts	(7,184)	
							Meals	4,194	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8) \$ 3,355	
C. Professional Services									
Vendor/Payee	Type		Amount						
See PG 21.1	Legal Services		\$ 8,214						
PayNW	Payroll Processing		35,932						
See PG 21.2	Accounting Services		15,865						
Various	Administrative Services		16,737						
Navex	Incident Management		2,156						
HHSS Support Fees	Management Services		597,755						
Rounding			1						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 676,660						

*** Attach copy of IMRF notifications**

****See instructions.**

XIX. SUPPORT SCHEDULES

Legal Fees Detail

Date	Vendor	Description	Amount
6/30/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	Annual Report, SOS Filing, Bankcard Center Filing, Par	625
8/29/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	Facility Name Change with various Reporting Agencies	3,149
9/30/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	NRAI, SOS, Vendor Filing Fees	815
10/31/2024	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	Annual Report	315
Multiple	Accurate Biometrics	Resident Background Checks Reclassed to Line 20	960
Multiple	Baker, Donelson, Bearman, Caldwell & Berkowitz PC	FEMA Matters	454
8/6/2024	POLSINELLI PC	IL Medicaid Bed Hold Matter	1,305
6/5/2025	POLSINELLI PC	Cornerstone Replacement CON	592
			8,214

See Schedule VI for adjustment for non-allowable portion.

XIX. SUPPORT SCHEDULES

Accounting Fees Detail

Date	Vendor	Description	Amount
7/12/2024	Crowe LLP	First Installment of 990 Prep	350
7/31/2024	Bradley & Associates	Progress Billing on Mcaid Cost Report	1,370
8/31/2024	Bradley & Associates	Progress Billing on Mcaid Cost Report	2,250
9/17/2024	Crowe LLP	Progress Billing for 6/30/24 Audit	4,200
10/1/2024	Bradley & Associates	Final Billing for Prep of the Mcaid Cost Report	1,081
10/15/2024	Crowe LLP	Progress Billing for 6/30/24 Audit	2,250
11/15/2024	Crowe LLP	2023 Tax Compliance 990 Review	245
2/12/2025	Crowe LLP	Progress Billing for 2023 Tax Compliance Services	1,085
6/3/2025	Crowe LLP	Audit Services for HW Health & Housing	2,300
6/16/2025	Crowe LLP	2023 Tax Compliance Services	735
			15,865

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	4,679
Other, please specify BBB, INHAA, AHCA, ILANFP	1,667
	6,346 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	2,644
0	
Other, please specify BBB, INHAA, AHCA, ILANFP	82
	2,726 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	7,323
0	0
Other, please specify BBB, INHAA, AHCA, ILANFP	1,749
	0
	9,072 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 76,611 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 536,692

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ No Has any meal income been offset against related costs? Indicate the amount. \$
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

\$ No
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: Crowe LLP Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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.