FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0049999

Facility Name: CROSSROADS CARE CENTER WOODSTOCK

Address: 309 MCHENRY AVENUE (Number) WOODSTOCK (City) 60098 (Zip Code)

County: MCHENRY

Telephone Number: (815) 338-1700 **Fax #** (815) 338-1765

HFS ID Number:

Date of Initial License for Current Owners: 1/1/12

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: PAMELA PHILLIPS **Telephone Number:** (417) 865-8701
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 1/1/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	42,090	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,697		7,088	28,785	8
9	SNF/PED					9
10	ICF		1,805		1,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,697	1,805	7,088	30,590	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.68%

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 [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 1/1/12

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 4,303

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODST(# 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	279,643	47,753	5,662	333,058		333,058		333,058			1
2	Food Purchase		194,191		194,191		194,191	(57)	194,134			2
3	Housekeeping	95,797	39,647		135,444		135,444		135,444			3
4	Laundry	55,205	15,057		70,262		70,262		70,262			4
5	Heat and Other Utilities			99,999	99,999		99,999		99,999			5
6	Maintenance	36,486	9,408	55,205	101,099		101,099		101,099			6
7	Other (specify):*											7
8	**TOTAL General Services**	467,131	306,056	160,866	934,053		934,053	(57)	933,996			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	1,578,042	190,420	10,490	1,778,952		1,778,952		1,778,952			10
10a	Therapy	97,357	125	403,674	501,156		501,156		501,156			10a
11	Activities	54,003	1,732	8,035	63,770		63,770		63,770			11
12	Social Services	36,300		3,030	39,330		39,330		39,330			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,765,702	192,277	441,229	2,399,208		2,399,208		2,399,208			16
	C. General Administration											
17	Administrative	111,293		240,000	351,293		351,293	(142,469)	208,824			17
18	Directors Fees											18
19	Professional Services			160,352	160,352		160,352	(22,732)	137,620			19
20	Dues, Fees, Subscriptions & Promotions			67,774	67,774		67,774	(15,244)	52,530			20
21	Clerical & General Office Expenses	130,007	13,907	63,684	207,598		207,598	59,518	267,116			21
22	Employee Benefits & Payroll Taxes			469,770	469,770		469,770		469,770			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,432	4,432		4,432		4,432			24
25	Other Admin. Staff Transportation			12,924	12,924		12,924	11,687	24,611			25
26	Insurance-Prop.Liab.Malpractice			116,168	116,168		116,168	1,743	117,911			26
27	Other (specify):*							8,849	8,849			27
28	**TOTAL General Administration**	241,300	13,907	1,135,104	1,390,311		1,390,311	(98,648)	1,291,663			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,474,133	512,240	1,737,199	4,723,572		4,723,572	(98,705)	4,624,867			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 CROSSROADS CARE CENTER WOODSTOCK #0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			85,915	85,915		85,915	5,164	91,079			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,946	22,946		22,946	1,271	24,217			32
33	Real Estate Taxes			64,285	64,285		64,285	(1,367)	62,918			33
34	Rent-Facility & Grounds			372,055	372,055		372,055	4,596	376,651			34
35	Rent-Equipment & Vehicles			107,109	107,109		107,109	5,104	112,213			35
36	Other (specify):*											36
37	**TOTAL Ownership**			652,310	652,310		652,310	14,768	667,078			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			212,733	212,733		212,733		212,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			350,276	350,276		350,276		350,276			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			563,009	563,009		563,009		563,009			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,474,133	512,240	2,952,518	5,938,891		5,938,891	(83,937)	5,854,954			45

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(560)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	2		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	(22,228)	21		18
19	Entertainment	(203)	21		19
20	Contributions	(11,990)	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	(15,793)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,174)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (91,005)		$	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)	7,068		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,068		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (83,937)		37

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

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

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

STATE OF ILLINOIS

CROSSROADS CARE CENTER WOODSTOCK

ID# 0049999

Report Period Beginning: 1/1/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$	20	1
2	MISC INCOME	(7,075)	21	2
3	RE TAX ADJ	(1,367)	33	3
4	MARKETING CONSULTANT	(30,592)	19	4
5	ADJ S/L DEPR	(1,140)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,174)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(57)	0	0	0	0	0	0	0	0	0	0	(57)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(57)	0	0	0	0	0	0	0	0	0	0	(57)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(142,469)	0	0	0	0	0	0	0	0	(142,469)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(30,592)	0	7,860	0	0	0	0	0	0	0	0	(22,732)	19
20	Fees, Subscriptions & Promotions	(15,793)	0	549	0	0	0	0	0	0	0	0	(15,244)	20
21	Clerical & General Office Expenses	(42,056)	0	101,574	0	0	0	0	0	0	0	0	59,518	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	11,687	0	0	0	0	0	0	0	0	11,687	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,743	0	0	0	0	0	0	0	0	1,743	26
27	Other (specify):*	0	0	8,849	0	0	0	0	0	0	0	0	8,849	27
28	**TOTAL General Administration**	(88,441)	0	(10,207)	0	0	0	0	0	0	0	0	(98,648)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,498)	0	(10,207)	0	0	0	0	0	0	0	0	(98,705)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(1,140)	0	6,304	0	0	0	0	0	0	0	0	5,164	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,271	0	0	0	0	0	0	0	0	1,271	32
33	Real Estate Taxes	(1,367)	0	0	0	0	0	0	0	0	0	0	(1,367)	33
34	Rent-Facility & Grounds	0	0	4,596	0	0	0	0	0	0	0	0	4,596	34
35	Rent-Equipment & Vehicles	0	0	5,104	0	0	0	0	0	0	0	0	5,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,507)	0	17,275	0	0	0	0	0	0	0	0	14,768	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(91,005)	0	7,068	0	0	0	0	0	0	0	0	(83,937)	45

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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
AARON TOPPER	75	PAVILION OF WAUKEGAN	WAUKEGAN	AA HEALTHCRE	SKOKIE	MANAGEMENT
ABRAHAM GUTNICKI	25			MGT LLC		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 372,055	CCCW REALTY, LLC [pass thru to Woodstock Residence		$ 372,055	$	1
2	V				Realty, LLC (unrelated party in 2012)]				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V	19	LEGAL FEES	2,394	LAW OFFICE OF ABRAHAM GUTNICKI		2,394		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 374,449			$ 374,449	$ *	14

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 240,000	AA HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (240,000)	15
16	V	5	Utilities		AA HEALTHCARE MANAGEMENT, LLC				16
17	V	6	Repairs & Maintenance		AA HEALTHCARE MANAGEMENT, LLC				17
18	V	17	Owners Compensation		AA HEALTHCARE MANAGEMENT, LLC		97,531	97,531	18
19	V	19	Professional Fees		AA HEALTHCARE MANAGEMENT, LLC		7,860	7,860	19
20	V	20	Fees, Subscriptions		AA HEALTHCARE MANAGEMENT, LLC		549	549	20
21	V	21	Clerical Salaries		AA HEALTHCARE MANAGEMENT, LLC		97,525	97,525	21
22	V	21	Office Expenses		AA HEALTHCARE MANAGEMENT, LLC		4,049	4,049	22
23	V	24	Travel & Seminars		AA HEALTHCARE MANAGEMENT, LLC				23
24	V	25	Transportation		AA HEALTHCARE MANAGEMENT, LLC		11,687	11,687	24
25	V	26	Insurance		AA HEALTHCARE MANAGEMENT, LLC		1,743	1,743	25
26	V	27	Employee Benefits		AA HEALTHCARE MANAGEMENT, LLC		8,849	8,849	26
27	V	30	Depreciation		AA HEALTHCARE MANAGEMENT, LLC		6,304	6,304	27
28	V	32	Interest		AA HEALTHCARE MANAGEMENT, LLC		1,271	1,271	28
29	V	34	Rent		AA HEALTHCARE MANAGEMENT, LLC		4,596	4,596	29
30	V	35	Equipment Rental		AA HEALTHCARE MANAGEMENT, LLC		5,104	5,104	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			$ 240,000			$ 247,068	$ * 7,068	39

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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								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

Facility Name & ID Number CROSSROADS CARE CENTER WOODST # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	OWNER	Administrative	75.00	SEE ATTACHED	10	20.00	Mgt Fees	$ 97,531	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 97,531		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 CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: AA HEALTHCARE MANAGEMENT
Street Address: 8170 N. MCCORMICK BLVD., ST 124
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 983-4860
Fax Number: (847) 673-3379

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	17	Owners Compensation	Patient Days	62,729	2	200,000		30,590	97,531	3
4	19	Professional Fees	Patient Days	62,729	2	16,117		30,590	7,860	4
5	20	Fees, Subscriptions	Patient Days	62,729	2	1,125		30,590	549	5
6	21	Clerical Salaries	Patient Days	62,729	2	199,988	199,988	30,590	97,525	6
7	21	Office Expenses	Patient Days	62,729	2	8,303		30,590	4,049	7
8	24	Travel & Seminars	Patient Days	62,729	2			30,590	0	8
9	25	Transportation	Patient Days	62,729	2	23,966		30,590	11,687	9
10	26	Insurance	Patient Days	62,729	2	3,574		30,590	1,743	10
11	27	Employee Benefits	Patient Days	62,729	2	18,146		30,590	8,849	11
12	30	Depreciation	Patient Days	62,729	2	12,928		30,590	6,304	12
13	32	Interest	Patient Days	62,729	2	2,607		30,590	1,271	13
14	34	Rent	Patient Days	62,729	2	9,425		30,590	4,596	14
15	35	Equipment Rental	Patient Days	62,729	2	10,466		30,590	5,104	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 506,645	$ 199,988		$ 247,068	25

Facility Name & ID Number CROSSROADS CARE CENTER WOODST(# 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4	EXT TERMS AMERICA		X	ENERGY EFF LIGHT FIX	$318.00		7,034	4,982			174	4
5												5
	Working Capital											
6	HP BANK		X	LINE OF CREDIT							5,982	6
7	HOUSING & HEALTHCARE		X	WORKING CAPITAL				250,000			16,783	7
8	MISC										7	8
9	TOTAL Facility Related				$318.00		$ 7,034	$ 254,982			$ 22,946	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET											10
11												11
12												12
13	ALLOCATION FROM AA HC MGT										1,271	13
14	TOTAL Non-Facility Related						$	$			$ 1,271	14
15	TOTALS (line 9+line14)						$ 7,034	$ 254,982			$ 24,217	15

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 62,918	2
3. Under or (over) accrual (line 2 minus line 1).		$ 62,918	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 62,918	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	67,605	8
	2008	62,764	9
	2009	57,028	10
	2010	60,030	11
	2011	62,918	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CROSSROADS CARE CENTER WOODSTOCK COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0049999

CONTACT PERSON REGARDING THIS REPORT PAMELA PHILLIPS

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-05-254-015	NURSING HOME	$ 60,592.48	$ 60,592.48
2.	13-05-254-011	NURSING HOME	$ 2,325.96	$ 2,325.96
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,918.44	$ 62,918.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,252 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

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

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

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

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	FACILITY	179,865		$	1
2					2
3	TOTALS	179,865		$	3

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			2008	9,250		10	925	925	4,085	9
10	LANDSCAPING			2008	3,145		10	315	315	1,363	10
11	WINDOW TINTING			2009	2,597		5	519	519	1,991	11
12	LANDSCAPING-BOXWOOD & STONE ($750 REMOVED-2011 CAP C			2009			15				12
13	DIALYSIS PLUMBING (24582 + 22249)			2009	46,831		40	1,171	1,171	4,195	13
14	REPLACEMENT PART-GENERATOR			2009	3,247		10	325	325	1,164	14
15	A/C UNIT			2009	4,880		10	488	488	1,708	15
16	WATER HEATER			2009	13,687		10	1,369	1,369	4,790	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BLOCK RETAINING WALL ($1,400 REMOVED-2011 CAP COS	2009	$	$	20	$	$	$	37
38	REMODELING	2009	2,506		40	63	63	219	38
39	DIALYSIS STATION & ELEC	2009	2,394		40	60	60	204	39
40	DIALYSIS ROOM COSTS	2009	290		39	7	7	25	40
41	GLASS ($424 REMOVED-2011 CAP COST DESK AUDIT)	2009			10				41
42	FLOOR FIXTURES ($514 REMOVED-2011 CAP COST DESK A	2009			7				42
43	GLASS ($460 REMOVED-2011 CAP COST DESK AUDIT)	2009			10				43
44	LIGHT FIXTURES & ELECTRICAL ($1489 REMOVED-2011 C	2009			10				44
45	PLUMBING	2009	2,516		30	84	84	259	45
46	STAINLESS STEEL SINK & ACCESSORIES ($1935 REMOVED	2009			20				46
47	SIGNAGE	2009	6,254		10	625	625	2,137	47
48	REMODELING - FLOORING	2009	99,038		10	9,904	9,904	33,838	48
49	DRAPERIES & CUBICLE CURTAINS	2009	22,171		5	4,434	4,434	15,150	49
50	NURSES STATION	2009	26,145		15	1,743	1,743	5,955	50
51	WALLCOVERING	2009	64,464		5	12,893	12,893	44,051	51
52	HANDRAILS & BUMPER GUARDS	2009	32,751		15	2,183	2,183	7,460	52
53	RECESSED CANNED LIGHTING	2009	37,123		30	1,237	1,237	4,228	53
54	SHOWER/GUEST BATHROOM REMODELING	2009	39,205		39	1,005	1,005	3,016	54
55	LIGHTING	2009	427		10	43	43	132	55
56	PARKING LOT LIGHTS	2009	570		20	29	29	86	56
57	RESIDENT ROOMS-NEW LIGHTING, ETC	2009	1,930		39	49	49	153	57
58	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT-BOI	2010	31,892		39	818	818	2,385	58
59	FIREDOORS ($1459 REMOVED-2011 CAP COST DESK AUDIT	2010			39				59
60	REMODELING-P/Y-ADD'L PMT ($426 REMOVED-2011 CAP C	2010			39				60
61	PLUMBING ($1249 REMOVED-2011 CAP COST DESK AUDIT	2010			39				61
62	DINING ROOM DOOR EQUIP ($2250 REMOVED-2011 CAP CO	2010			10				62
63	PLUMBING ($1953 REMOVED-2011 CAP COST DESK AUDIT)	2010			39				63
64	FIRE DAMPERS ($1250 REMOVED-2011 CAP COST DESK AU	2010			39				64
65	DOORS	2010	4,957		15	330	330	854	65
66	HANDICAP RAMP	2010	4,926		15	328	328	848	66
67	ROYAL CLOSET FLUSH VALVE ($696 REMOVED-2011 CAP (	2010			39				67
68	EDPM RUBBER FLAT ROOF ($1024 REMOVED-2011 CAP CO	2010			39				68
69	FIRE DOOR IMPROVEMENTS ($2100 REMOVED-2011 CAP C	2010			10				69
70	TOTAL (lines 4 thru 69)		$ 463,196	$		$ 40,947	$ 40,947	$ 140,296	70

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 12A, Carried Forward		$ 463,196	$		$ 40,947	$ 40,947	$ 140,296	1
2	DUCT WORK ($1023 REMOVED-2011 CAP COST DESK AUDI	2010			40				2
3	DIFFUSER INSTALLATION ($1575 REMOVED-2011 CAP COS	2010			40				3
4	FRONT DOOR EXIT DEVICE($605 REMOVED-2011 CAP COS	2010			10				4
5	THERAPY ROOM DIFFUSERS ($821 REMOVED-2011 CAP CO	2010			10				5
6	RELIEF VALVE ($1279 REMOVED-2011 CAP COST DESK AU	2010			10				6
7	RETUBING BOILER	2010	5,122		15	341	341	740	7
8	GAS VALVE ($1002 REMOVED-2011 CAP COST DESK AUDIT	2010			10				8
9	BOILER TUBES ($1536 REMOVED-2011 CAP COST DESK AU	2010			15				9
10	LIGHT FIXTURES ($558 REMOVED-2011 CAP COST DESK AU	2010			10				10
11	BOILER REPAIR-CONTRACT-ATLAS BOILER & WELDING	2011	2,568		10	257	257	407	11
12	PATIENT ROOM REMODELING-CONTRACT-BOB'S REMOD	2011	21,290		39	546	546	819	12
13	RANGE/OVEN ($4,781 MOVED TO EQUIP-2011 CAP COST DE	2011							13
14	SKYLIGHT	2011	825		39	21	21	42	14
15	EXHAUST FAN MOTOR	2011	612		10	61	61	117	15
16	WATER HEATER GAS CONTROL	2011	1,074		10	107	107	170	16
17	VALVE REPLACEMENT	2011	2,295		10	230	230	344	17
18	REPAIR HOT WATER LINE IN FLOOR	2011	1,532		10	153	153	230	18
19	BRONZE BODY PUMP	2011	867		10	87	87	123	19
20	ROOM 301 & 303 REMODELING-CONTRACT-BOB'S REMOD	2011	5,366		40	134	134	179	20
21	HALL OF 300 WING-PLUMBING-JENSENS PLUMBING	2011	763		40	19	19	25	21
22	REPAIR LEAK UNDER FLOOR	2011	3,187		40	80	80	100	22
23	ROOM 301 & 303 REMODEL-MATERIALS-MENARDS	2011	1,127		10	113	113	141	23
24	NEW OVERLOAD CONTRACTOR	2011	944		10	94	94	102	24
25	SHED REMODEL-CONTRACT-BOB'S REMODELING	2011	20,920		39	536	536	581	25
26	SHED REMODEL-CONTRACT-BOB'S REMODELING	2011	3,518		20	176	176	191	26
27	CONCRETE PATIOS-CONTRACT-BOB'S REMODELING	2011	10,300		20	515	515	558	27
28	BOILER VALVE	2012	594		20	27	27	27	28
29	AUTO OPERATOR DOOR SYSTEM	2012	8,225		15	503	503	503	29
30	1/2" COPPER LINE	2012	788		40	18	18	18	30
31	3 SOLID WOOD DOORS	2012	1,255		10	105	105	105	31
32	BATHROOM VANITY TOE KICKS	2012	565		10	42	42	42	32
33	HOT WATER HEATER COUPLING	2012	1,605		10	107	107	107	33
34	TOTAL (lines 1 thru 33)		$ 558,538	$		$ 45,219	$ 45,219	$ 145,967	34

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 12B, Carried Forward		$ 558,538	$		$ 45,219	$ 45,219	$ 145,967	1
2	LIGHTING FIXTURES	2012	318		10	21	21	21	2
3	KITCHEN EXHAUST, HOOD, FAN	2012	18,800		40	313	313	313	3
4	DINING ROOM AC UNIT	2012	7,587		10	506	506	506	4
5	ROOF REPAIRS	2012	1,825		40	27	27	27	5
6	ENERGY EFFICIENT LIGHTING	2012	7,034		40	103	103	103	6
7	PANIC BAR	2012	596		10	15	15	15	7
8				47,344			(47,344)		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	ALLOC FROM AA HC MGT			3		3			31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 594,698	$ 47,347		$ 46,207	$ (1,140)	$ 146,952	34

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	$ 288,535	$ 33,950	$ 33,950	$		$ 100,503	71
72	Current Year Purchases	40,844	4,621	4,621			4,621	72
73	Fully Depreciated Assets							73
74	ALLOC FROM AA HC MGT		6,301	6,301				74
75	TOTALS	$ 329,379	$ 44,872	$ 44,872	$		$ 105,124	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)	$ 924,077	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,219	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 91,079	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,140)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 252,076	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 107,109 Description: Med equip $105,084; Dish machine $600; Water softener $490; Storage 935
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 154,199	$		$ 154,199	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			38,982			38,982	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			210,493			210,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				115,992		115,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/Dialysis	39-02					96,741		96,741	13
14	TOTAL			$		$ 403,674	$ 212,733		$ 616,407	14

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (44,122)	$	1
2	Cash-Patient Deposits	12,164		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,541,594		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,418		6
7	Other Prepaid Expenses	6,015		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,575,069	$	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	624,058		15
16	Equipment, at Historical Cost	321,551		16
17	Accumulated Depreciation (book methods)	(255,899)		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):	180,365		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 870,075	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,445,144	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,704,842	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,760		28
29	Short-Term Notes Payable	3,517		29
30	Accrued Salaries Payable	129,159		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		95,529		36
37		986,180		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,981,987	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	251,465		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)**	$ 251,465	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,233,452	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (788,308)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,445,144	$	48

***(See instructions.)**

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(206,365)	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	(32,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PPA**	(549,693)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (788,308)	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)**	$ (788,308)	24 *

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,372,820	1
2	Discounts and Allowances for all Levels	934,229	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,307,049	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	228,366	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 228,366	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	174,129	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,347	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 189,476	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME & DISCOUNTS	7,635	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,635	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,732,526	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	934,053	31
32	Health Care	2,399,208	32
33	General Administration	1,390,311	33
	B. Capital Expense		
34	Ownership	652,310	34
	C. Ancillary Expense		
35	Special Cost Centers	212,733	35
36	Provider Participation Fee	350,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,938,891	40
41	**Income before Income Taxes (line 30 minus line 40)****	(206,365)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (206,365)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,611,608	44
45	Private Pay - Net Inpatient Revenue	326,046	45
46	Medicare - Net Inpatient Revenue	1,930,228	46
47	Other-(specify) Hospice, Managed Care, Insurance	478,000	47
48	Other-(specify) Part B, Bad Debts, Prior Year Adj	(38,833)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,307,049	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN FILED ON CASH BASIS**

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

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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,228	2,412	$ 92,248	$ 38.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,851	13,612	377,562	27.74	3
4	Licensed Practical Nurses	15,720	16,984	407,551	24.00	4
5	CNAs & Orderlies	52,196	54,761	671,274	12.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,082	5,664	97,357	17.19	8
9	Activity Director	2,088	2,160	37,598	17.41	9
10	Activity Assistants	1,838	1,981	16,405	8.28	10
11	Social Service Workers	2,064	2,160	36,300	16.81	11
12	Dietician					12
13	Food Service Supervisor	3,721	3,973	88,786	22.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,076	22,402	190,857	8.52	15
16	Dishwashers					16
17	Maintenance Workers	3,092	3,195	36,486	11.42	17
18	Housekeepers	10,692	11,266	95,797	8.50	18
19	Laundry	5,803	6,291	55,205	8.78	19
20	Administrator	2,200	2,480	111,293	44.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,059	9,679	130,007	13.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,036	2,160	29,407	13.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,746	161,180	$ 2,474,133 *	$ 15.35	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	113	$ 5,662	1.3	35
36	Medical Director		16,000	9.3	36
37	Medical Records Consultant	96	4,616	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant		5,004	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	2,760	11.3	44
45	Social Service Consultant	51	3,030	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	306	$ 37,072		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAMUEL BIBER	ADMINISTRATOR		$ 56,664
SUE BOHNE	ADMINISTRATOR		45,129
LYNETTE RUGG	ADMINISTRATOR		9,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,293

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ABRAHAM GUTNICKI	LEGAL	$ 2,394
MEYER MAGENCE		1,625
FRANKS GERKIN & MCKENNA		9,880
BKD	ACCOUNTING	33,985
A MEASURED SOLUTION		16,865
ORCHESTRAL		22,216
REHAB MGT SERVICES		10,000
TALX	UNEMP TAX CONSULTANT	375
VARIOUS	DATA PROC/COMP	32,152
ANTONIO NATAL	CONSULTING	250
ACTIVITY COLLECTION SERVICE		18
VARIOUS	MARKETING -OFFSET	30,592
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 160,352

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,164
Unemployment Compensation Insurance	138,363
FICA Taxes	182,217
Employee Health Insurance	67,475
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,551
TOTAL (agree to Schedule V, line 22, col.8)	$ 469,770

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	35,401
Health Care Worker Background Check	16
(Indicate # of checks performed)	
Patient Background Checks	
ADVERTISING & MARKETING	15,793
DUES & SUBSCRIPTIONS	12,764
LICENSES	3,800
ALLOC FROM AA HC MGT	549
Less: Public Relations Expense	( )
Non-allowable advertising	(15,793)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,530

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,432
ALLOC FROM AA HC MGT	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,432

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK # 0049999 Report Period Beginning: 1/1/12 Ending: 12/31/12

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CROSSROADS CARE CENTER WOODSTOCK **#** 0049999 **Report Period Beginning:** 1/1/12 **Ending:** 12/31/12

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. **IL HEALTH CARE ASSOC $12,764**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(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?

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,936** Line **10.2**

(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.

(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. $ **350,276**
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? **N/A**

(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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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? **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?
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.