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.

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

I. IDPH License ID Number: 0049999

Facility Name: CROSSROADS C CTR WOODSTOCK

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

County: MCHENRY

Telephone Number: 8153381700 **Fax #** 8153381765

HFS ID Number:

Date of Initial License for Current Owners: 01/01/2012

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: Mnedel S. Schneider **Telephone Number:** 847-933-12741
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 01/0/2014 to 12/31/2014 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) See Accountant's Report Attached
(Firm Name & Address) Mendel S. Schneider C.P.A. & Associates, 4051 Old Orchard Rd
(Telephone) 847-933-1274 Fax # 847-933-1283

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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	41,975	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	41,975	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		250	7,740	7,990	8
9	SNF/PED					9
10	ICF	22,433	2,215	1,650	26,298	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,433	2,465	9,390	34,288	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.69%

D. How many bed-hold days during this year were paid by the Department?
0 (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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2012 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 5,654

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 Fiscal Year: 12/31

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	165,449	19,072	5,025	189,546		189,546		189,546			1
2	Food Purchase		187,316		187,316		187,316		187,316			2
3	Housekeeping	91,675	26,477		118,152		118,152		118,152			3
4	Laundry	49,419	4,800	7,860	62,079		62,079		62,079			4
5	Heat and Other Utilities			81,665	81,665		81,665		81,665			5
6	Maintenance	47,701		80,306	128,007		128,007		128,007			6
7	Other (specify):*											7
8	TOTAL General Services	354,244	237,665	174,856	766,765		766,765		766,765			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,817,101	329,682	22,091	2,168,874		2,168,874		2,168,874			10
10a	Therapy		595,284		595,284		595,284		595,284			10a
11	Activities	63,456	7,934	310	71,700		71,700		71,700			11
12	Social Services	38,433		481	38,914		38,914		38,914			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,918,990	932,900	35,882	2,887,772		2,887,772		2,887,772			16
	C. General Administration											
17	Administrative	160,213		398,700	558,913		558,913	(201,143)	357,770			17
18	Directors Fees											18
19	Professional Services			67,321	67,321		67,321	49,851	117,172			19
20	Dues, Fees, Subscriptions & Promotions			75,821	75,821		75,821	(40,236)	35,585			20
21	Clerical & General Office Expenses	181,286	11,841	121,099	314,226		314,226	104,567	418,793			21
22	Employee Benefits & Payroll Taxes			437,929	437,929		437,929		437,929			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,076	4,076		4,076	7,902	11,978			24
25	Other Admin. Staff Transportation							11,403	11,403			25
26	Insurance-Prop.Liab.Malpractice			176,942	176,942		176,942	8,780	185,722			26
27	Other (specify):*							9,326	9,326			27
28	TOTAL General Administration	341,499	11,841	1,281,888	1,635,228		1,635,228	(49,550)	1,585,678			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,614,733	1,182,406	1,492,626	5,289,765		5,289,765	(49,550)	5,240,215			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 C CTR WOODSTOCK #0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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			101,268	101,268		101,268	136,641	237,909			30
31	Amortization of Pre-Op. & Org.							11,300	11,300			31
32	Interest			65,519	65,519		65,519	124,550	190,069			32
33	Real Estate Taxes			2,382	2,382		2,382	68,235	70,617			33
34	Rent-Facility & Grounds			375,396	375,396		375,396	(361,690)	13,706			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP Insurance							23,936	23,936			36
37	TOTAL Ownership			544,565	544,565		544,565	2,972	547,537			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			365,393	365,393		365,393		365,393			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			236,771	236,771		236,771		236,771			42
43	Other (specify):* Bad Debt Expense			220,618	220,618		220,618	(220,618)				43
44	TOTAL Special Cost Centers			822,782	822,782		822,782	(220,618)	602,164			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,614,733	1,182,406	2,859,973	6,657,112		6,657,112	(267,196)	6,389,916			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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	(7,598)	30		9
10	Interest and Other Investment Income	(76)	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				17
18	Fines and Penalties	(8,293)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,618)	43		24
25	Fund Raising, Advertising and Promotional	(64,066)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (300,651)		$	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)	33,455		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 33,455		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (267,196)		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

CROSSROADS C CTR WOODSTOCK

ID# 0049999

Report Period Beginning: 01/0/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 **Report Period Beginning:** 01/0/2014 **Ending:** 12/31/2014

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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	(201,143)	0	0	0	0	0	0	0	0	(201,143)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,822	22,029	0	0	0	0	0	0	0	0	49,851	19
20	Fees, Subscriptions & Promotions	(64,066)	0	23,830	0	0	0	0	0	0	0	0	(40,236)	20
21	Clerical & General Office Expenses	(8,293)	0	112,860	0	0	0	0	0	0	0	0	104,567	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	7,902	0	0	0	0	0	0	0	0	7,902	24
25	Other Admin. Staff Transportation	0	0	11,403	0	0	0	0	0	0	0	0	11,403	25
26	Insurance-Prop.Liab.Malpractice	0	7,449	1,331	0	0	0	0	0	0	0	0	8,780	26
27	Other (specify):*	0	0	9,326	0	0	0	0	0	0	0	0	9,326	27
28	**TOTAL General Administration**	(72,359)	35,271	(12,462)	0	0	0	0	0	0	0	0	(49,550)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,359)	35,271	(12,462)	0	0	0	0	0	0	0	0	(49,550)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 **Report Period Beginning:** 01/0/2014 **Ending:** 12/31/2014

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	(7,598)	144,147	92	0	0	0	0	0	0	0	0	136,641	30
31	Amortization of Pre-Op. & Org.	0	11,300	0	0	0	0	0	0	0	0	0	11,300	31
32	Interest	(76)	124,626	0	0	0	0	0	0	0	0	0	124,550	32
33	Real Estate Taxes	0	68,235	0	0	0	0	0	0	0	0	0	68,235	33
34	Rent-Facility & Grounds	0	(375,396)	13,706	0	0	0	0	0	0	0	0	(361,690)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	23,936	0	0	0	0	0	0	0	0	0	23,936	36
37	TOTAL Ownership	(7,674)	(3,152)	13,798	0	0	0	0	0	0	0	0	2,972	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):*	(220,618)	0	0	0	0	0	0	0	0	0	0	(220,618)	43
44	TOTAL Special Cost Centers	(220,618)	0	0	0	0	0	0	0	0	0	0	(220,618)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(300,651)	32,119	1,336	0	0	0	0	0	0	0	0	(267,196)	45

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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 Wakegan	Waukegan	CCCW Realty	Woodstock	Bldg Rental
Joseph Brandman	25	Park Place of Belvidere	Belvidere	AA Management	Skokie	Management

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 375,396	CCCW Realty	100.00%	$	$ (375,396)	1
2	V	33	Real Estate Tax		CCCW Realty		68,235	68,235	2
3	V	32	Interest		CCCW Realty		124,626	124,626	3
4	V	30	Depreciation		CCCW Realty		144,147	144,147	4
5	V	31	Amortization		CCCW Realty		11,300	11,300	5
6	V	36	MIP Insurance		CCCW Realty		23,936	23,936	6
7	V	26	Insurance		CCCW Realty		7,449	7,449	7
8	V	19	Prof Fees		CCCW Realty		27,822	27,822	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 375,396			$ 407,515	$ * 32,119	14

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	$ 330,005	AA Healthcare Management	100.00%	$	$ (330,005)	15
16	V	34	Rent		AA Healthcare Management		13,706	13,706	16
17	V	19	Professional Fees		AA Healthcare Management		22,029	22,029	17
18	V	20	Fees, Subscriptions		AA Healthcare Management		23,830	23,830	18
19	V	21	Clerical Salaries		AA Healthcare Management		96,586	96,586	19
20	V	21	Office Expenses		AA Healthcare Management		16,274	16,274	20
21	V	24	Travel & Seminars		AA Healthcare Management		7,902	7,902	21
22	V	25	Transportation		AA Healthcare Management		11,403	11,403	22
23	V	27	Employee Benefits		AA Healthcare Management		9,326	9,326	23
24	V	30	Depreciation		AA Healthcare Management		92	92	24
25	V	17	Owners Compensation		AA Healthcare Management		128,862	128,862	25
26	V	26	Insurance		AA Healthcare Management		1,331	1,331	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			$ 330,005			$ 331,341	$ * 1,336	39

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	Manager	Management	75.00	214,073	20	40.00	Mgmt Fees	$ 180,383	17-3	1
2	Joseph Brandman	Manager	Management	25.00	83,223	15	38.00	Mgmt Fees	17,174	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 197,557		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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 2/31/2014

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: 8140 N . Mccormick Blvd, ste 131
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	17	Owners compensation	Number of Beds	224		$ 251,000	$ 251,000	115	$ 128,862	1
2	34	Rent	Number of Beds	224		26,696		115	13,706	2
3	19	Professional fees	Number of Beds	224		42,908		115	22,029	3
4	20	Fees, Subscriptions	Number of Beds	224		46,417		115	23,830	4
5	21	Clerical Salaries	Number of Beds	224		188,133	188,133	115	96,586	5
6	21	Office Expenses	Number of Beds	224		31,698		115	16,274	6
7	24	Travel & Seminars	Number of Beds	224		15,392		115	7,902	7
8	25	Transportation	Number of Beds	224		22,212		115	11,403	8
9	27	Employee Benefits	Number of Beds	224		18,165		115	9,326	9
10	30	Depreciation	Number of Beds	224		180		115	92	10
11	26	Insurance	Number of Beds	224		2,593		115	1,331	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					$ 645,394	$ 439,133		$ 331,341	25

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Heartland Bank		X	Mortgage	$29,361.00	01/30/13	$ 4,513,800	$ 4,320,760	08/01/2041	2.8600	$ 124,626	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Working Capital				965,000		5.0000	65,519	6
7												7
8												8
9	TOTAL Facility Related				$29,361.00		$ 4,513,800	$ 5,285,760			$ 190,145	9
	B. Non-Facility Related*											
10	Interest Income										(76)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (76)	14
15	TOTALS (line 9+line14)						$ 4,513,800	$ 5,285,760			$ 190,069	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 23,936 **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.)**

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 70,617	2
3. Under or (over) accrual (line 2 minus line 1).		$ 70,617	3
4. Real Estate Tax accrual used for 2014 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.		$ 70,617	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	57,028	8
	2010	60,030	9
	2011	62,918	10
	2012	65,735	11
	2013	70,617	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CROSSROADS C CTR WOODSTOCK COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0049999

CONTACT PERSON REGARDING THIS REPORT Aaron Topper

TELEPHONE 847-983-4860 FAX #: 847-673-3379

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-05-254-015	Facility	$ 68,235.00	$ 68,235.00
2.	13-05-254-011	Facility	$ 2,382.00	$ 2,382.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,617.00	$ 70,617.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 169,499 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 11,300 4. Dates Incurred: 01/31/13

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	2013	$ 450,000	1
2					2
3	TOTALS	179,865		$ 450,000	3

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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		2013		$ 3,781,900	$ 137,524	27.5	$ 137,524	$	$ 269,317	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			2008	9,250	925	10	925		5,935	9
10	LANDSCAPING			2008	3,145	315	10	315		1,993	10
11	WINDOW TINTING			2009	2,597	519	5	519		3,029	11
12	Dialysis plumbing			2009	46,831	1,171	40	1,171		6,537	12
13	REPLACEMENT PART-GENERATOR			2009	3,247	325	10	325		1,814	13
14	A/C UNIT			2009	4,880	488	10	488		2,684	14
15	WATER HEATER			2009	13,687	1,369	10	1,369		7,528	15
16	REMODELING			2009	2,506	63	40	63		345	16
17	DIALYSIS STATION & ELEC			2009	2,394	60	40	60		324	17
18	DIALYSIS ROOM COSTS			2009	290	7	39	7		39	18
19	PLUMBING			2009	2,516	84	30	84		427	19
20	SIGNAGE			2009	6,254	625	10	625		3,387	20
21	REMODELING- FLOORING			2009	99,038	9,904	10	9,904		53,646	21
22	DRAPERIES & CUBICLE CURTAINS			2009	22,171	4,434	5	4,434		24,018	22
23	NURSES STATION			2009	26,145	1,743	15	1,743		9,441	23
24	WALLCOVERING			2009	64,464	12,893	5	12,893		69,837	24
25	HANDRAILS & BUMPER GUARDS			2009	32,751	2,183	15	2,183		11,826	25
26	RECESSED CANNED LIGHTING			2009	37,123	1,237	30	1,237		6,702	26
27	SHOWER/GUEST BATHROOM REMODELING			2009	39,205	1,005	39	1,005		5,026	27
28	LIGHTING			2009	427	43	10	43		218	28
29	PARKING LOT LIGHTS			2009	570	29	20	29		144	29
30	RESIDENT ROOMS- NEW LIGHTING			2009	1,930	49	39	49		251	30
31	DOORS			2010	4,957	330	15	330		1,514	31
32	HANDICAP RAMP			2010	4,926	328	15	328		1,504	32
33	RETUBING BOILER			2010	5,122	341	15	341		1,422	33
34	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT			2010	31,892	818	39	818		4,021	34
35	SKYLIGHT			2011	825	21	39	21		84	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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	EXHAUST FAN MOTOR	2011	$ 612	$ 61	10	$ 61	$	$ 239	37
38	WATER HEATER GAS CONTROL	2011	1,074	107	10	107		384	38
39	VALVE REPLACEMENT	2011	2,295	230	10	230		804	39
40	REPAIR HOT WATER LINE IN FLOOR	2011	1,532	153	10	153		536	40
41	BRONZE BODY PUMP	2011	867	87	10	87		297	41
42	ROOM 301 & 303 REMODELING-CONTRACT	2011	5,366	134	40	134		447	42
43	HALL OF 300 WING- PLUMBING- JENSENS PLUMBING	2011	763	19	40	19		63	43
44	REPAIR LEAK UNDER FLOOR	2011	3,187	80	40	80		260	44
45	ROOM 301 & 303 REMODELING- MATERIAL- MENARDS	2011	1,127	113	10	113		367	45
46	NEW OVERLOAD CONTRACTOR	2011	944	94	10	94		290	46
47	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	20,920	536	39	536		1,653	47
48	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	3,518	176	20	176		543	48
49	CONCRETE PATIOS- CONTRACT- BOB'S REMODELING	2011	10,300	515	20	515		1,588	49
50	PATIENT ROOM REMODELING-CONTRACT BOB'S	2011	21,290	546	39	546		1,911	50
51	BOILER REPAIR	2011	2,568	257	10	257		921	51
52	1/2 " COPPER LINE	2012	788	20	40	20		58	52
53	3 SOLID WOOD DOORS	2012	1,255	125	10	125		355	53
54	BATHROOM VANITY TOE KICKS	2012	565	57	10	57		156	54
55	HOT WATER HEATER COUPLING	2012	1,605	161	10	161		429	55
56	LIGHTING FIXTURES	2012	318	32	10	32		85	56
57	KITCHEN EXHAUST	2012	18,800	470	40	470		1,253	57
58	DINING ROOM AC UNIT	2012	7,587	759	10	759		2,024	58
59	ROOF REPAIRS	2012	1,825	46	40	46		119	59
60	ENERGY EFFICIENT LIGHTING	2012	7,034	176	40	176		455	60
61	PANIC BAR	2012	596	60	10	60		135	61
62	AUTO OPERATING DOOR SYSTEM	2012	8,225	548	15	548		1,599	62
63	BOILER VALVE	2012	594	30	20	30		87	63
64	DOORS	2013	3,336	120	27.5	120		180	64
65	SURVEY AND ARCHITECT OF PARKING LOT	2013	1,175	43	27.5	43		86	65
66	ENERGY EFFICIENT LIGHTING	2013	6,851	250	27.5	250		375	66
67	WIRING & INSTALLATION OF COMPUTER NETWORK	2013	6,266	228	27.5	228		342	67
68	REPLACE BOILER	2013	11,072	402	27.5	402		603	68
69	GENERATOR	2013	78,644	3,149	27.5	3,149		3,864	69
70	TOTAL (lines 4 thru 69)		$ 4,483,942	$ 188,617		$ 188,617	$	$ 515,521	70

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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		$ 4,483,942	$ 188,617		$ 188,617	$	$ 515,521	1
2	TIE IN WATER	2013	5,538	202	27.5	202		303	2
3	REMODEL THERAPY ROOM	2013	3,010	110	27.5	110		165	3
4	KITCHEN EXHAUST	2013	13,022	474	27.5	474		711	4
5	SPRINKLERS	2013	89,134	3,241	27.5	3,241		4,862	5
6	INSTALLATION OF NEW VINYL GLOOR IN CORRIDOR								6
7	AND RESIDENT BATHROOMS	2014	30,775	233	27.5	233		233	7
8	SPRINKLERS	2014	3,372	118	27.5	118		118	8
9	FLOORING	2014	2,355	75	27.5	75		75	9
10	NEW SIGN	2014	9,280	267	27.5	267		267	10
11	EXIT DOOR SERVICE	2014	572	15	27.5	15		15	11
12	RECIRCULATION PIPE	2014	700	18	27.5	18		18	12
13	COPPER PIPE	2014	2,149	55	27.5	55		55	13
14	A/C CONDENSOR	2014	4,917	97	27.5	97		97	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)		$ 4,648,766	$ 193,522		$ 193,522	$	$ 522,440	34

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	$ 394,568	$ 3,515	$ 39,457	$ 35,942	10	$ 178,565	71
72	Current Year Purchases	48,378	48,378	4,838	(43,540)	10	4,838	72
73	Fully Depreciated Assets							73
74	Alloc from AA HC Mgmt		92	92			92	74
75	TOTALS	$ 442,946	$ 51,985	$ 44,387	$ (7,598)		$ 183,495	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)	$ 5,541,712	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 245,507	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,909	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,598)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 705,935	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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ Description:
    (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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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		hrs	$		$ 219,523	$		$ 219,523	1
2	Licensed Speech and Language Development Therapist		hrs			43,028			43,028	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			332,733			332,733	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				236,987		236,987	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis						128,406		128,406	12
13	Other (specify):									13
14	TOTAL			$		$ 595,284	$ 365,393		$ 960,677	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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ (145,214)	$ (145,167)	1
2	Cash-Patient Deposits	6,736	6,736	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,108,905	3,108,905	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,699	30,699	6
7	Other Prepaid Expenses	38,473	38,473	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Homes,Escrow	31,012	168,168	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,070,611	$ 3,207,814	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		3,781,900	14
15	Leasehold Improvements, at Historical Cost	779,095	985,599	15
16	Equipment, at Historical Cost	440,163	440,163	16
17	Accumulated Depreciation (book methods)	(405,815)	(825,403)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		169,499	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,600)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 813,443	$ 4,979,158	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,884,054	$ 8,186,972	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,570,766	$ 1,574,816	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,256	21,256	28
29	Short-Term Notes Payable	965,000	965,000	29
30	Accrued Salaries Payable	130,571	130,571	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,241	20,241	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,602	13,900	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Others	482,032	571,727	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,193,468	$ 3,297,511	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,320,760	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)**	$	$ 4,320,760	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,193,468	$ 7,618,271	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 690,586	$ 568,701	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,884,054	$ 8,186,972	48

***(See instructions.)**

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (271,223)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (271,223)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,321,809	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	(360,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 961,809	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)**	$ 690,586	24 *

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	$ 7,978,845	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,978,845	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	76	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 76	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,978,921	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	766,765	31
32	Health Care	2,887,772	32
33	General Administration	1,635,228	33
	B. Capital Expense		
34	Ownership	544,565	34
	C. Ancillary Expense		
35	Special Cost Centers	586,011	35
36	Provider Participation Fee	236,771	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,657,112	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,321,809	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,321,809	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,482,767	44
45	Private Pay - Net Inpatient Revenue	457,105	45
46	Medicare - Net Inpatient Revenue	3,155,210	46
47	Other-(specify) Hospice,Insurance,Managed Care,Medicare B	883,763	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,978,845	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash basi If not, please attach a reconciliation.**

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

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

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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	2,646	2,949	$ 108,066	$ 36.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,432	16,046	454,074	28.30	3
4	Licensed Practical Nurses	13,978	16,022	399,712	24.95	4
5	CNAs & Orderlies	62,642	67,750	855,249	12.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,596	4,983	63,456	12.73	10
11	Social Service Workers	1,892	2,200	38,433	17.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,972	17,245	165,449	9.59	15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,080	47,701	22.93	17
18	Housekeepers	9,657	10,563	91,675	8.68	18
19	Laundry	4,684	5,120	49,419	9.65	19
20	Administrator	1,960	2,080	160,213	77.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,784	10,651	181,286	17.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,195	157,689	$ 2,614,733 *	$ 16.58	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	110	$ 5,025	1-3	35
36	Medical Director		13,000	9-3	36
37	Medical Records Consultant	120	3,530	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,824	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	9	310	11-3	44
45	Social Service Consultant	13	481	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	252	$ 32,170		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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LYNETTE RUGG	Administartion		$ 160,213
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 160,213

B. Administrative - Other

Description	Amount
Home Office	$ 330,005
Management Fees- Brandman	17,174
Management Fees-Topper	51,521
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 398,700

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	$ 12,000
Rehab Management Systems	Reimbursement Consulting	24,000
Stephen Sher	Legal	7,416
Meyer Magence	Legal	1,500
Filler & Associates	Legal	1,275
Field Goldberg	Legal	21,130
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 67,321

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,052
Unemployment Compensation Insurance	81,823
FICA Taxes	200,027
Employee Health Insurance	97,027
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,929

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 30)	300
Patient Background Checks 100	1,000
Advertising	40,236
Illinois Council on Long Term Care	12,213
Classified Advertising	16,548
Chamber of Commerce	721
Misc licenses	823
Less: Public Relations Expense	(40,236)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,585

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Misc Seminars	1,178
Relias Learning	2,898
Allocated from AA Management	7,902
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,978

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CROSSROADS C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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 C CTR WOODSTOCK # 0049999 Report Period Beginning: 01/0/2014 Ending: 12/31/2014

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. **Illinois Council on Long Term care 12213**

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

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,000** 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. $ **236,771**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(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? **0**
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? **No**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(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 of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.