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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0049999

Facility Name: CROSSROADS CARE CTR WOODSTCK

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: 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: Mendel S. Schneider **Telephone Number:** (847)933-1274
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 01/01/2015 to 12/31/2015 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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	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		307	9,456	9,763	8
9	SNF/PED					9
10	ICF	20,022	3,000		23,022	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,022	3,307	9,456	32,785	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.11%

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 6,041

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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	178,124	17,458	4,850	200,432		200,432		200,432			1
2	Food Purchase		169,281		169,281		169,281		169,281			2
3	Housekeeping	121,806	35,870	20,692	178,368		178,368		178,368			3
4	Laundry	34,479	28,452		62,931		62,931		62,931			4
5	Heat and Other Utilities			98,331	98,331		98,331		98,331			5
6	Maintenance	56,400	108,139		164,539		164,539	8	164,547			6
7	Other (specify):*											7
8	**TOTAL General Services**	390,809	359,200	123,873	873,882		873,882	8	873,890			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,839,969	335,809	15,787	2,191,565		2,191,565		2,191,565			10
10a	Therapy			660,135	660,135		660,135		660,135			10a
11	Activities	61,756	18,710	1,087	81,553		81,553		81,553			11
12	Social Services	41,876		1,235	43,111		43,111		43,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,943,601	354,519	690,244	2,988,364		2,988,364		2,988,364			16
	C. General Administration											
17	Administrative	130,531		477,316	607,847		607,847	(231,746)	376,101			17
18	Directors Fees											18
19	Professional Services			105,465	105,465		105,465	22,975	128,440			19
20	Dues, Fees, Subscriptions & Promotions			115,129	115,129		115,129	(44,082)	71,047			20
21	Clerical & General Office Expenses	188,667	17,309	192,590	398,566		398,566	158,648	557,214			21
22	Employee Benefits & Payroll Taxes			494,697	494,697		494,697		494,697			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,540	5,540		5,540	16,341	21,881			24
25	Other Admin. Staff Transportation			23	23		23	12,638	12,661			25
26	Insurance-Prop.Liab.Malpractice			190,849	190,849		190,849	6,209	197,058			26
27	Other (specify):* **Allocated benefits**							17,602	17,602			27
28	**TOTAL General Administration**	319,198	17,309	1,581,609	1,918,116		1,918,116	(41,415)	1,876,701			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,653,608	731,028	2,395,726	5,780,362		5,780,362	(41,407)	5,738,955			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 CTR WOODSTCK #0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			58,973	58,973		58,973	196,595	255,568			30
31	Amortization of Pre-Op. & Org.							149,801	149,801			31
32	Interest			64,948	64,948		64,948	817,845	882,793			32
33	Real Estate Taxes			2,477	2,477		2,477	70,932	73,409			33
34	Rent-Facility & Grounds			717,612	717,612		717,612	(703,438)	14,174			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							1,148	1,148			36
37	**TOTAL Ownership**			844,010	844,010		844,010	532,883	1,376,893			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			283,277	283,277		283,277		283,277			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,176	225,176		225,176		225,176			42
43	Other (specify):* **Bad debt**			492,967	492,967		492,967	(492,967)				43
44	**TOTAL Special Cost Centers**			1,001,420	1,001,420		1,001,420	(492,967)	508,453			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,653,608	731,028	4,241,156	7,625,792		7,625,792	(1,491)	7,624,301			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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	43,196	30		9
10	Interest and Other Investment Income	(1,037)	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	(67,425)	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	(492,967)	43		24
25	Fund Raising, Advertising and Promotional	(44,082)	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)**	$ (562,315)		$	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)	560,824		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 560,824		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,491)		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 CARE CTR WOODSTCK

ID# 0049999

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	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 CARE CTR WOODSTCK # 0049999 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	8	0	0	0	0	0	0	0	0	8	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	8	0	0	0	0	0	0	0	0	8	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	(231,746)	0	0	0	0	0	0	0	0	(231,746)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,500	15,475	0	0	0	0	0	0	0	0	22,975	19
20	Fees, Subscriptions & Promotions	(44,082)	0	0	0	0	0	0	0	0	0	0	(44,082)	20
21	Clerical & General Office Expenses	(67,425)	823	225,250	0	0	0	0	0	0	0	0	158,648	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	16,341	0	0	0	0	0	0	0	0	16,341	24
25	Other Admin. Staff Transportation	0	0	12,638	0	0	0	0	0	0	0	0	12,638	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,209	0	0	0	0	0	0	0	0	6,209	26
27	Other (specify):*	0	0	17,602	0	0	0	0	0	0	0	0	17,602	27
28	**TOTAL General Administration**	(111,507)	8,323	61,769	0	0	0	0	0	0	0	0	(41,415)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,507)	8,323	61,777	0	0	0	0	0	0	0	0	(41,407)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	43,196	153,208	191	0	0	0	0	0	0	0	0	196,595	30
31	Amortization of Pre-Op. & Org.	0	149,801	0	0	0	0	0	0	0	0	0	149,801	31
32	Interest	(1,037)	818,882	0	0	0	0	0	0	0	0	0	817,845	32
33	Real Estate Taxes	0	70,932	0	0	0	0	0	0	0	0	0	70,932	33
34	Rent-Facility & Grounds	0	(717,612)	14,174	0	0	0	0	0	0	0	0	(703,438)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	1,148	0	0	0	0	0	0	0	0	0	1,148	36
37	TOTAL Ownership	42,159	476,359	14,365	0	0	0	0	0	0	0	0	532,883	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):*	(492,967)	0	0	0	0	0	0	0	0	0	0	(492,967)	43
44	TOTAL Special Cost Centers	(492,967)	0	0	0	0	0	0	0	0	0	0	(492,967)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(562,315)	484,682	76,142	0	0	0	0	0	0	0	0	(1,491)	45

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	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. [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	$ 717,612	CCCW Realty	100.00%	$	$ (717,612)	1
2	V	33	Real estate Tax		CCCW Realty		70,932	70,932	2
3	V	32	interest		CCCW Realty		818,882	818,882	3
4	V	30	depreciation		CCCW Realty		153,208	153,208	4
5	V	31	Amortization		CCCW Realty		149,801	149,801	5
6	V	36	MIP Insurance		CCCW Realty		1,148	1,148	6
7	V	21	Office		CCCW Realty		823	823	7
8	V	19	Prof fees		CCCW Realty		7,500	7,500	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 717,612			$ 1,202,294	$ * 484,682	14

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 354,960	AA HELTHCARE MANAGEMENT	100.00%	$	$ (354,960)	15
16	V	34	Rent		AA HELTHCARE MANAGEMENT		14,174	14,174	16
17	V	17	Owners Compensation		AA HELTHCARE MANAGEMENT		123,214	123,214	17
18	V	6	Repairs & Maintenace		AA HELTHCARE MANAGEMENT		8	8	18
19	V	19	Professional fees		AA HELTHCARE MANAGEMENT		15,475	15,475	19
20	V	21	Office expense		AA HELTHCARE MANAGEMENT		41,053	41,053	20
21	V	21	Clerical Salaries		AA HELTHCARE MANAGEMENT		184,197	184,197	21
22	V	27	Employee Benefits		AA HELTHCARE MANAGEMENT		17,602	17,602	22
23	V	30	Depreciation		AA HELTHCARE MANAGEMENT		191	191	23
24	V	25	Transportation		AA HELTHCARE MANAGEMENT		12,638	12,638	24
25	V	26	Insurance		AA HELTHCARE MANAGEMENT		6,209	6,209	25
26	V	24	Travel & Seminar		AA HELTHCARE MANAGEMENT		16,341	16,341	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			$ 354,960			$ 431,102	$ * 76,142	39

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1	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	241,342	20	40.00	Mgmt fees	$ 214,981	17-3	1
2	Joseph Brandman	Manager	Management	25.00	88,030	15	38.00	Mgmt Fees	30,589	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	$ 245,570		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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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		$ 240,000	$ 240,000	115	$ 123,214	1
2	34	Rent	Number of Beds	224		27,609		115	14,174	2
3	6	Repairs & maintenance	Number of Beds	224		15		115	8	3
4	19	Professional fees	Number of Beds	224		30,143		115	15,475	4
5	21	Clerical salaries	Number of Beds	224		358,784	358,784	115	184,197	5
6	27	Employee Benefits & Pr Taxes	Number of Beds	224		34,286		115	17,602	6
7	30	Depreciation	Number of Beds	224		372		115	191	7
8	25	Transportation	Number of Beds	224		24,617		115	12,638	8
9	26	Insurance	Number of Beds	224		12,095		115	6,209	9
10	24	Travel & Seminars	Number of Beds	224		31,830		115	16,341	10
11	21	Office expenses	Number of Beds	224		79,965		115	41,053	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					$ 839,716	$ 598,784		$ 431,102	25

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	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	$	08/01/2041	2.8600	$ 385,300	1
2	Bank Leumi		X	Mortgage	$66,128.28	03/30/15	11,200,000	11,083,428	03/30/20	5.1000	433,582	2
3												3
4												4
5												5
	Working Capital											
6	Private bank		X	Working Capital						5.0000	18,981	6
7	Bank Leumi		X	Working Capital				1,075,083		5.0000	45,967	7
8												8
9	TOTAL Facility Related				$95,489.28		$ 15,713,800	$ 12,158,511			$ 883,830	9
	B. Non-Facility Related*											
10	Interest income										(1,037)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,037)	14
15	TOTALS (line 9+line14)						$ 15,713,800	$ 12,158,511			$ 882,793	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 1,148 **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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)		$ 73,409	2
3. Under or (over) accrual (line 2 minus line 1).		$ 73,409	3
4. Real Estate Tax accrual used for 2015 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.		$ 73,409	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	60,030	8
	2011	62,918	9
	2012	65,735	10
	2013	70,617	11
	2014	73,409	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CROSSROADS CARE CTR WOODSTCK COUNTY MCHENRY

FACILITY IDPH LICENSE NUMBER 0049999

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-05-254-015	Facility	$ 70,932.00	$ 70,932.00
2.	13-05-254-011	Facility	$ 2,477.00	$ 2,477.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,409.00	$ 73,409.00

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

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [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: 221,734 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 149,801 4. Dates Incurred: 01/31/13 03/30/15

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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	$ 406,841	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			2008	9,250	273	10	925	652	6,860	9
10	LANDSCAPING			2008	3,145	93	10	315	222	2,308	10
11	WINDOW TINTING			2009	2,597		5	519	519	3,548	11
12	Dialysis plumbing			2009	46,831	809	40	1,171	362	7,708	12
13	REPLACEMENT PART-GENERATOR			2009	3,247		10	325	325	2,139	13
14	A/C UNIT			2009	4,880		10	488	488	3,172	14
15	WATER HEATER			2009	13,687		10	1,369	1,369	8,897	15
16	REMODELING			2009	2,506		40	63	63	408	16
17	DIALYSIS STATION & ELEC			2009	2,394	87	40	60	(27)	384	17
18	DIALYSIS ROOM COSTS			2009	290	10	39	7	(3)	46	18
19	PLUMBING			2009	2,516	91	30	84	(7)	511	19
20	SIGNAGE			2009	6,254		10	625	625	4,012	20
21	REMODELING- FLOORING			2009	99,038		10	9,904	9,904	63,550	21
22	DRAPERIES & CUBICLE CURTAINS			2009	22,171		5	4,434	4,434	28,452	22
23	NURSES STATION			2009	26,145		15	1,743	1,743	11,184	23
24	WALLCOVERING			2009	64,464		5	12,893	12,893	82,730	24
25	HANDRAILS & BUMPER GUARDS			2009	32,751		15	2,183	2,183	14,009	25
26	RECESSED CANNED LIGHTING			2009	37,123	1,350	30	1,237	(113)	7,939	26
27	SHOWER/GUEST BATHROOM REMODELING			2009	39,205	1,426	39	1,005	(421)	6,031	27
28	LIGHTING			2009	427		10	43	43	261	28
29	PARKING LOT LIGHTS			2009	570	17	20	29	12	173	29
30	RESIDENT ROOMS- NEW LIGHTING			2009	1,930		39	49	49	300	30
31	DOORS			2010	4,957	180	15	330	150	1,844	31
32	HANDICAP RAMP			2010	4,926	179	15	328	149	1,832	32
33	RETUBING BOILER			2010	5,122		15	341	341	1,763	33
34	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT			2010	31,892	1,160	39	818	(342)	4,839	34
35	Skylight			2011	825	30	39	21	(9)	105	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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	$ 300	37
38	WATER HEATER GAS CONTROL	2011	1,074	107	10	107		491	38
39	VALVE REPLACEMENT	2011	2,295	230	10	230		1,034	39
40	REPAIR HOT WATER LINE IN FLOOR	2011	1,532	153	10	153		689	40
41	BRONZE BODY PUMP	2011	867	87	10	87		384	41
42	ROOM 301 & 303 REMODELING-CONTRACT	2011	5,366	134	40	134		581	42
43	HALL OF 300 WING- PLUMBING- JENSENS PLUMBING	2011	763	19	40	19		82	43
44	REPAIR LEAK UNDER FLOOR	2011	3,187	80	40	80		340	44
45	ROOM 301 & 303 REMODELING- MATERIAL- MENARDS	2011	1,127	113	10	113		480	45
46	NEW OVERLOAD CONTRACTOR	2011	944	94	10	94		384	46
47	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	20,920	536	39	536		2,189	47
48	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	3,518	176	20	176		719	48
49	CONCRETE PATIOS- CONTRACT- BOB'S REMODELING	2011	10,300	515	20	515		2,103	49
50	PATIENT ROOM REMODELING-CONTRACT BOB'S	2011	21,290	546	39	546		2,457	50
51	BOILER REPAIR	2011	2,568	257	10	257		1,178	51
52	1/2 " COPPER LINE	2012	788	20	40	20		78	52
53	3 SOLID WOOD DOORS	2012	1,255	125	10	125		480	53
54	BATHROOM VANITY TOE KICKS	2012	565	57	10	57		213	54
55	HOT WATER HEATER COUPLING	2012	1,605	161	10	161		590	55
56	LIGHTING FIXTURES	2012	318	32	10	32		117	56
57	KITCHEN EXHAUST	2012	18,800	470	40	470		1,723	57
58	DINING ROOM AC UNIT	2012	7,587	759	10	759		2,783	58
59	ROOF REPAIRS	2012	1,825	46	40	46		165	59
60	ENERGY EFFICIENT LIGHTING	2012	7,034	176	40	176		631	60
61	PANIC BAR	2012	596	60	10	60		195	61
62	AUTO OPERATING DOOR SYSTEM	2012	8,225	548	15	548		2,147	62
63	BOILER VALVE	2012	594	30	20	30		117	63
64	DOORS	2013	3,336	120	27.5	120		300	64
65	SURVEY AND ARCHITECT OF PARKING LOT	2013	1,175	43	27.5	43		129	65
66	ENERGY EFFICIENT LIGHTING	2013	6,851	250	27.5	250		625	66
67	WIRING & INSTALLATION OF COMPUTER NETWORK	2013	6,266	228	27.5	228		570	67
68	REPLACE BOILER	2013	11,072	402	27.5	402		1,005	68
69	GENERATOR	2013	78,644	3,149	27.5	3,149		7,013	69
70	TOTAL (lines 4 thru 69)		$ 4,483,942	$ 153,013		$ 188,617	$ 35,604	$ 704,138	70

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 153,013		$ 188,617	$ 35,604	$ 704,138	1
2	TIE IN WATER	2013	5,538	202	27.5	202		505	2
3	REMODEL THERAPY ROOM	2013	3,010	110	27.5	110		275	3
4	KITCHEN EXHAUST	2013	13,022	474	27.5	474		1,185	4
5	SPRINKLERS	2013	89,134	3,241	27.5	3,241		8,103	5
6	INSTALLATION OF NEW VINYL FLOOR IN CORRIDOR								6
7	AND RESIDENT BATHROOMS	2014	30,775	1,119	27.5	1,119		1,352	7
8	SPRINKLERS	2014	3,372	123	27.5	123		241	8
9	FLOORING	2014	2,355	86	27.5	86		161	9
10	NEW SIGN	2014	9,280	337	27.5	337		604	10
11	EXIT DOOR SERVICE	2014	572	21	27.5	21		36	11
12	RECIRCULATION PIPE	2014	700	25	27.5	25		43	12
13	COPPER PIPE	2014	2,149	78	27.5	78		133	13
14	A/C CONDENSOR	2014	4,917	179	27.5	179		276	14
15	Generator	2014	2,441	89	27.5	89		89	15
16	Window treatments	2015	7,542	377	15	377		377	16
17	New Boiler	2015	41,448	2,072	15	2,072		2,072	17
18	Water heater	2015	10,820	541	15	541		541	18
19	Call Light	2015	1,253	63	15	63		63	19
20	Parking Lot	2015	975	49	15	49		49	20
21	Aquarium Design	2015	17,043	852	15	852		852	21
22	Roofing	2015	1,095	55	15	55		55	22
23	New piping	2015	8,752	438	15	438		438	23
24	Replace ball valve	2015	1,414	71	15	71		71	24
25	Build New Closets in 28 patient rooms	2015	29,855	1,493	15	1,493		1,493	25
26	Remodel New dining room, Replace windows,	2015	163,500	8,175	15	8,175		8,175	26
27	Update Baseboard heaters in all rooms,Install oak Headboards in allRooms								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,934,904	$ 173,283		$ 208,887	$ 35,604	$ 731,327	34

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 442,946	$ 16,948	$ 44,295	$ 27,347	10	$ 227,698	71
72	Current Year Purchases	21,950	21,950	2,195	(19,755)	10	2,195	72
73	Fully Depreciated Assets							73
74	Alloc from AA HC Mgmt		191	191			283	74
75	TOTALS	$ 464,896	$ 39,089	$ 46,681	$ 7,592		$ 230,176	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)	$ 5,849,800	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,372	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 255,568	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,196	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 961,503	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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc from Home Office				14,174			5
6								6
7	TOTAL				$ 14,174 **			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.	/2016	$
13.	/2017	$
14.	/2018	$

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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$		$ 284,001	$		$ 284,001	1
2	Licensed Speech and Language Development Therapist		hrs			32,665			32,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			343,469			343,469	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				207,620		207,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis						75,657		75,657	12
13	Other (specify):									13
14	TOTAL			$		$ 660,135	$ 283,277		$ 943,412	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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ (148,845)	$ (133,139)	1
2	Cash-Patient Deposits	9,889	9,889	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,901,649	2,901,649	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,706	43,706	6
7	Other Prepaid Expenses	80,586	80,586	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related Home	883	883	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,887,868	$ 2,903,574	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	919,840	1,289,844	15
16	Equipment, at Historical Cost	462,641	462,641	16
17	Accumulated Depreciation (book methods)	(464,792)	(1,037,584)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		221,734	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(172,401)	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)**	$ 917,689	$ 4,996,134	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,805,557	$ 7,899,708	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,573,795	$ 1,604,999	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,531	17,531	28
29	Short-Term Notes Payable	1,075,083	1,075,083	29
30	Accrued Salaries Payable	146,295	146,295	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,549	22,549	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,483	14,781	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Homes	617,386	708,467	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,457,122	$ 3,589,705	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		11,038,428	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)**	$	$ 11,038,428	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,457,122	$ 14,628,133	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 348,435	$ (6,728,425)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,805,557	$ 7,899,708	48

***(See instructions.)**

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 690,586	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 690,586	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	257,849	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	(600,000)	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)**	$ (342,151)	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)**	$ 348,435	24	*

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,882,604	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,882,604	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***	1,037	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,037	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)**	$ 7,883,641	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,882	31
32	Health Care	2,988,364	32
33	General Administration	1,918,116	33
	B. Capital Expense		
34	Ownership	844,010	34
	C. Ancillary Expense		
35	Special Cost Centers	776,244	35
36	Provider Participation Fee	225,176	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,625,792	40
41	**Income before Income Taxes (line 30 minus line 40)****	257,849	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 257,849	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,017,355	44
45	Private Pay - Net Inpatient Revenue	626,975	45
46	Medicare - Net Inpatient Revenue	3,354,043	46
47	Other-(specify) managed Care, Ins, Med b	884,231	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,882,604	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 CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,768	2,922	$ 168,905	$ 57.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,086	17,206	479,399	27.86	3
4	Licensed Practical Nurses	17,695	18,954	452,683	23.88	4
5	CNAs & Orderlies	57,764	62,564	738,982	11.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,851	5,122	61,756	12.06	10
11	Social Service Workers	1,968	2,160	41,876	19.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,383	19,324	178,124	9.22	15
16	Dishwashers					16
17	Maintenance Workers	2,631	2,860	56,400	19.72	17
18	Housekeepers	13,354	14,396	121,806	8.46	18
19	Laundry	3,559	3,955	34,479	8.72	19
20	Administrator	1,936	2,305	130,531	56.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,292	11,203	188,667	16.84	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)	151,287	162,971	$ 2,653,608 *	$ 16.28	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	105	$ 4,850	1-3	35
36	Medical Director		12,000		36
37	Medical Records Consultant	120	3,528	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,889	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		2,370	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,087	11-3	44
45	Social Service Consultant	32	1,235	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 34,959		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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LYNETTER RUGG	Administration		$ 130,531
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,531

B. Administrative - Other

Description	Amount
Home Office	$ 354,960
Management fees- Brandman	30,589
Management fees- Topper	91,767
TOTAL (agree to Schedule V, line 17, col. 3)	$ 477,316
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	$ 12,000
Rehab management Systems	Reimbursement Consulting	31,200
Meyer Magence	Legal	8,193
Mcdermott, Will, & Emery	Legal	10,000
Howard Rigsby	Legal	1,950
Daniel Parsons	Legal	3,275
Stephen Sher	Legal	2,603
Seyfarth Shaw	Legal	18,340
Misc Legal	Legal	364
Achieve	Consultants	12,909
Mpro	consultants	3,845
Misc consultants	Consultants	786
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 105,465

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,479
Unemployment Compensation Insurance	97,933
FICA Taxes	203,001
Employee Health Insurance	125,284
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 494,697

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,400
Advertising: Employee Recruitment	61,039
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Illinois council on Long term care	7,013
Advertising	44,082
Misc License	595
Less: Public Relations Expense	(44,082)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,047

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Illiois council	2,655
Allocated from AA management	16,341
Misc Seminars	2,885
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,881

**See instructions.

Facility Name & ID Number CROSSROADS CARE CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 CTR WOODSTCK # 0049999 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **illinois Council on long term care 7013**

(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. $ **225,176**
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.