

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0049999

Facility Name: CROSSROADS CRE CTR WOODSTOCK

Address: 309 MCHENRY AVENUE WOODSTOCK 60098
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mendel 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 01/01/2016 to 12/31/2016 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 CRE CTR WOODSTOCK

0049999 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>6,125</u>	<u>6,125</u>	8
9	SNF/PED					9
10	ICF	<u>19,786</u>	<u>4,484</u>	<u>3,628</u>	<u>27,898</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,786</u>	<u>4,484</u>	<u>9,753</u>	<u>34,023</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.83%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 01/01/2012 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 29 and days of care provided 5,344

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	215,349	17,395	4,900	237,644		237,644		237,644			1
2	Food Purchase		175,879		175,879		175,879		175,879			2
3	Housekeeping	121,646	25,585	15,987	163,218		163,218		163,218			3
4	Laundry	36,872	14,786		51,658		51,658		51,658			4
5	Heat and Other Utilities			87,467	87,467		87,467		87,467			5
6	Maintenance	50,919	17,057	59,677	127,653		127,653	3	127,656			6
7	Other (specify):*											7
8	TOTAL General Services	424,786	250,702	168,031	843,519		843,519	3	843,522			8
	B. Health Care and Programs											
9	Medical Director			50,000	50,000		50,000		50,000			9
10	Nursing and Medical Records	1,883,543	475,268	18,145	2,376,956		2,376,956		2,376,956			10
10a	Therapy			601,695	601,695		601,695		601,695			10a
11	Activities	65,622	23,194	847	89,663		89,663		89,663			11
12	Social Services	43,227		1,152	44,379		44,379		44,379			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,992,392	498,462	671,839	3,162,693		3,162,693		3,162,693			16
	C. General Administration											
17	Administrative	124,429		488,460	612,889		612,889	(360,112)	252,777			17
18	Directors Fees											18
19	Professional Services			88,580	88,580		88,580	11,418	99,998			19
20	Dues, Fees, Subscriptions & Promotions			94,485	94,485		94,485	(51,151)	43,334			20
21	Clerical & General Office Expenses	213,582	19,483	158,162	391,227		391,227	243,357	634,584			21
22	Employee Benefits & Payroll Taxes			512,274	512,274		512,274		512,274			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,948	7,948		7,948	25,426	33,374			24
25	Other Admin. Staff Transportation			285	285		285	9,934	10,219			25
26	Insurance-Prop.Liab.Malpractice			206,524	206,524		206,524	7,699	214,223			26
27	Other (specify):* Allocated Benefits							20,653	20,653			27
28	TOTAL General Administration	338,011	19,483	1,556,718	1,914,212		1,914,212	(92,776)	1,821,436			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,755,189	768,647	2,396,588	5,920,424		5,920,424	(92,773)	5,827,651			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			42,953	42,953		42,953	204,041	246,994			30
31	Amortization of Pre-Op. & Org.							3,482	3,482			31
32	Interest			64,948	64,948		64,948	563,572	628,520			32
33	Real Estate Taxes							74,076	74,076			33
34	Rent-Facility & Grounds			867,114	867,114		867,114	(852,819)	14,295			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			975,015	975,015		975,015	(7,648)	967,367			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			303,034	303,034		303,034		303,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			235,845	235,845		235,845		235,845			42
43	Other (specify):* Bad Debt			256,039	256,039		256,039	(256,039)				43
44	TOTAL Special Cost Centers			794,918	794,918		794,918	(256,039)	538,879			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,755,189	768,647	4,166,521	7,690,357		7,690,357	(356,460)	7,333,897			45

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

VI. ADJUSTMENT DETAIL

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

	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	43,160	30		9
10	Interest and Other Investment Income	(3,622)	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	(10,985)	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	(256,039)	43		24
25	Fund Raising, Advertising and Promotional	(51,151)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,713)	21		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)	\$ (281,350)		\$	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)	(75,110)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (75,110)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (356,460)		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

ID#0049999

Report Period Beginning:01/01/2016

Ending:12/31/2016

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 CRE CTR WOODSTOCK# 0049999

Report Period Beginning:

01/01/2016

Ending:

12/31/2016**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	3	0	0	0	0	0	0	0	0	3	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	3	0	0	0	0	0	0	0	0	3	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	(360,112)	0	0	0	0	0	0	0	0	(360,112)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,418	0	0	0	0	0	0	0	0	11,418	19
20	Fees, Subscriptions & Promotions	(51,151)	0	0	0	0	0	0	0	0	0	0	(51,151)	20
21	Clerical & General Office Expenses	(13,698)	24	257,031	0	0	0	0	0	0	0	0	243,357	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	25,426	0	0	0	0	0	0	0	0	25,426	24
25	Other Admin. Staff Transportation	0	0	9,934	0	0	0	0	0	0	0	0	9,934	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,699	0	0	0	0	0	0	0	0	7,699	26
27	Other (specify):*	0	0	20,653	0	0	0	0	0	0	0	0	20,653	27
28	TOTAL General Administration	(64,849)	24	(27,951)	0	0	0	0	0	0	0	0	(92,776)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(64,849)	24	(27,948)	0	0	0	0	0	0	0	0	(92,773)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CROSSROADS CRE CTR WOODSTOCK # 0049999 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	43,160	160,566	315	0	0	0	0	0	0	0	0	204,041	30
31	Amortization of Pre-Op. & Org.	0	3,482	0	0	0	0	0	0	0	0	0	3,482	31
32	Interest	(3,622)	567,194	0	0	0	0	0	0	0	0	0	563,572	32
33	Real Estate Taxes	0	74,076	0	0	0	0	0	0	0	0	0	74,076	33
34	Rent-Facility & Grounds	0	(867,114)	14,295	0	0	0	0	0	0	0	0	(852,819)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	39,538	(61,796)	14,610	0	0	0	0	0	0	0	0	(7,648)	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):*	(256,039)	0	0	0	0	0	0	0	0	0	0	(256,039)	43
44	TOTAL Special Cost Centers	(256,039)	0	0	0	0	0	0	0	0	0	0	(256,039)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(281,350)	(61,772)	(13,338)	0	0	0	0	0	0	0	0	(356,460)	45

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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 867,114	CCCW Realty	100.00%	\$	\$(867,114)	1
2	V	33	Real estate Tax		CCCW Realty	100.00%	74,076	74,076	2
3	V	32	interest		CCCW Realty	100.00%	567,194	567,194	3
4	V	30	depreciation		CCCW Realty	100.00%	160,566	160,566	4
5	V	31	Amortization		CCCW Realty	100.00%	3,482	3,482	5
6	V	21	Office expenses		CCCW Realty	100.00%	24	24	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 867,114			\$ 805,342	\$ * \$(61,772)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Home Office Exepnse	\$ 488,460	AA Healthcare Management	100.00%	\$	(488,460)	15
16	V	17	Owners Compensation		AA Healthcare Management	100.00%	128,348	128,348	16
17	V	34	Rent		AA Healthcare Management	100.00%	14,295	14,295	17
18	V	6	Repairs & Maintenance		AA Healthcare Management	100.00%	3	3	18
19	V	19	Professional fees		AA Healthcare Management	100.00%	11,418	11,418	19
20	V	21	Clerical Salaries		AA Healthcare Management	100.00%	222,366	222,366	20
21	V	27	Employee Benefits & PR taxes		AA Healthcare Management	100.00%	20,653	20,653	21
22	V	30	Depreciation		AA Healthcare Management	100.00%	315	315	22
23	V	25	Transportation		AA Healthcare Management	100.00%	9,934	9,934	23
24	V	26	Insurance		AA Healthcare Management	100.00%	7,699	7,699	24
25	V	24	Travel & Seminars		AA Healthcare Management	100.00%	25,426	25,426	25
26	V	21	Office expenses		AA Healthcare Management	100.00%	34,665	34,665	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			\$ 488,460			\$ 475,122	\$ * (13,338)	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL 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 CRE CTR WOODSTOCK # 0049999 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Aaron Topper	Manager	Management	75.00	329,495	20	40.00	Mgmt fees	\$ 128,348	17	1
2	Joseph Brandman	Manager	Management	25.00	69,281	20	40.00				2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 128,348		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 CRE CTR WOODSTOCK # 0049999 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization AA Healthcare
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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Owners Compensation	Number of Beds	224		\$ 250,000	\$ 250,000	115	\$ 128,348	1
2	34	Rent	Number of Beds	224		27,845		115	14,295	2
3	6	Repairs & Maintenance	Number of Beds	224		5		115	3	3
4	19	Professional Fees	Number of Beds	224		22,241		115	11,418	4
5	21	Clerical Salaries	Number of Beds	224		433,130	433,130	115	222,366	5
6	27	Employee Benfits & PR taxes	Number of Beds	224		40,228		115	20,653	6
7	30	Depreciation	Number of Beds	224		614		115	315	7
8	25	Transportation	Number of Beds	224		19,350		115	9,934	8
9	26	Insurance	Number of Beds	224		14,997		115	7,699	9
10	24	Travel & Seminrs	Number of Beds	224		49,525		115	25,426	10
11	21	Office Expenses	Number of Beds	224		67,521		115	34,665	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					\$ 925,456	\$ 683,130		\$ 475,122	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank Leumi		X	Bank Leumi	\$66,128.28	03/30/15	\$ 11,200,000	\$ 10,812,082	03/30/20	5.1000	\$ 567,194	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bank Leumi		X	Bank Leumi				702,083		5.0000	64,948	6	
7												7	
8												8	
9	TOTAL Facility Related				\$66,128.28		\$ 11,200,000	\$ 11,514,165			\$ 632,142	9	
	B. Non-Facility Related*												
10	Interest Income										(3,622)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (3,622)	14	
15	TOTALS (line 9+line14)						\$ 11,200,000	\$ 11,514,165			\$ 628,520	15	

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)			\$ 74,076	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 74,076	3
4. Real Estate Tax accrual used for 2016 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.			\$ 74,076	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	62,918	8	
	2012	65,735	9	
	2013	70,617	10	
	2014	73,409	11	
	2015	74,076	12	
				FOR BHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2015 \$ 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CROSSROADS CRE 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 2015 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 2015.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 13-05-254-015	Facility	\$ 71,577.00	\$ 71,577.00
2. 13-05-254-011	Facility	\$ 2,499.00	\$ 2,499.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 74,076.00	\$ 74,076.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 221,734

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 3,482

4. Dates Incurred: 01/31/13, 03/17/15

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	179,865	2013	\$ 450,000	1
2					2
3	TOTALS	179,865		\$ 450,000	3

Facility Name & ID Number CROSSROADS CRE CTR WOODSTOCK

0049999

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	115		2013		\$ 3,781,900	\$ 137,524	27.5	\$ 137,524	\$	\$ 544,365	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			2008	9,250	273	10	925	652	7,785	9
10	LANDSCAPING			2008	3,145	93	10	315	222	2,623	10
11	WINDOW TINTING			2009	2,597		5	519	519	4,067	11
12	Dialysis plumbing			2009	46,831	809	40	1,171	362	8,879	12
13	REPLACEMENT PART-GENERATOR			2009	3,247		10	325	325	2,464	13
14	A/C UNIT			2009	4,880		10	488	488	3,660	14
15	WATER HEATER			2009	13,687		10	1,369	1,369	10,266	15
16	REMODELING			2009	2,506		40	63	63	471	16
17	DIALYSIS STATION & ELEC			2009	2,394	87	40	60	(27)	444	17
18	DIALYSIS ROOM COSTS			2009	290	10	39	7	(3)	53	18
19	PLUMBING			2009	2,516	91	30	84	(7)	595	19
20	SIGNAGE			2009	6,254		10	625	625	4,637	20
21	REMODELING- FLOORING			2009	99,038		10	9,904	9,904	73,454	21
22	DRAPERIES & CUBICLE CURTAINS			2009	22,171		5			28,452	22
23	NURSES STATION			2009	26,145		15	1,743	1,743	12,927	23
24	WALLCOVERING			2009	64,464		5			82,730	24
25	HANDRAILS & BUMPER GUARDS			2009	32,751		15	2,183	2,183	16,192	25
26	RECESSED CANNED LIGHTING			2009	37,123	1,350	30	1,237	(113)	9,176	26
27	SHOWER/GUEST BATHROOM REMODELING			2009	39,205	1,426	39	1,005	(421)	7,036	27
28	LIGHTING			2009	427		10	43	43	304	28
29	PARKING LOT LIGHTS			2009	570	17	20	29	12	202	29
30	RESIDENT ROOMS- NEW LIGHTING			2009	1,930		39	49	49	349	30
31	DOORS			2010	4,957	180	15	330	150	2,174	31
32	HANDICAP RAMP			2010	4,926	179	15	328	149	2,160	32
33	RETUBING BOILER			2010	5,122		15	341	341	2,104	33
34	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT			2010	31,892	1,160	39	818	(342)	5,657	34
35	Skylight			2011	825	30	39	21	(9)	126	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 CRE CTR WOODSTOCK

0049999

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	EXHAUST FAN MOTOR	2011	\$ 612	\$ 61	10	\$ 61		\$ 361	37
38	WATER HEATER GAS CONTROL	2011	1,074	107	10	107		598	38
39	VALVE REPLACEMENT	2011	2,295	230	10	230		1,264	39
40	REPAIR HOT WATER LINE IN FLOOR	2011	1,532	153	10	153		842	40
41	BRONZE BODY PUMP	2011	867	87	10	87		471	41
42	ROOM 301 & 303 REMODELING-CONTRACT	2011	5,366	134	40	134		715	42
43	HALL OF 300 WING- PLUMBING- JENSENS PLUMBING	2011	763	19	40	19		101	43
44	REPAIR LEAK UNDER FLOOR	2011	3,187	80	40	80		420	44
45	ROOM 301 & 303 REMODELING- MATERIAL- MENARDS	2011	1,127	113	10	113		593	45
46	NEW OVERLOAD CONTRACTOR	2011	944	94	10	94		478	46
47	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	20,920	536	39	536		2,725	47
48	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	3,518	176	20	176		895	48
49	CONCRETE PATIOS- CONTRACT- BOB'S REMODELING	2011	10,300	515	20	515		2,618	49
50	PATIENT ROOM REMODELING-CONTRACT BOB'S	2011	21,290	546	39	546		3,003	50
51	BOILER REPAIR	2011	2,568	257	10	257		1,435	51
52	1/2 " COPPER LINE	2012	788	20	40	20		98	52
53	3 SOLID WOOD DOORS	2012	1,255	125	10	125		605	53
54	BATHROOM VANITY TOE KICKS	2012	565	57	10	57		270	54
55	HOT WATER HEATER COUPLING	2012	1,605	161	10	161		751	55
56	LIGHTING FIXTURES	2012	318	32	10	32		149	56
57	KITCHEN EXHAUST	2012	18,800	470	40	470		2,193	57
58	DINING ROOM AC UNIT	2012	7,587	759	10	759		3,542	58
59	ROOF REPAIRS	2012	1,825	46	40	46		211	59
60	ENERGY EFFICIENT LIGHTING	2012	7,034	176	40	176		807	60
61	PANIC BAR	2012	596	60	10	60		255	61
62	AUTO OPERATING DOOR SYSTEM	2012	8,225	548	15	548		2,695	62
63	BOILER VALVE	2012	594	30	20	30		147	63
64	DOORS	2013	3,336	120	27.5	120		420	64
65	SURVEY AND ARCHITECT OF PARKING LOT	2013	1,175	43	27.5	43		172	65
66	ENERGY EFFICIENT LIGHTING	2013	6,851	250	27.5	250		875	66
67	WIRING & INSTALLATION OF COMPUTER NETWORK	2013	6,266	228	27.5	228		798	67
68	REPLACE BOILER	2013	11,072	402	27.5	402		1,407	68
69	GENERATOR	2013	78,644	3,149	27.5	3,149		10,162	69
70	TOTAL (lines 4 thru 69)		\$ 4,483,942	\$ 153,013		\$ 171,290	\$ 18,277	\$ 875,428	70

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

Facility Name & ID Number CROSSROADS CRE CTR WOODSTOCK

0049999

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,483,942	\$ 153,013		\$ 171,290	\$ 18,277	\$ 875,428	1
2	<u>TIE IN WATER</u>	2013	5,538	202	27.5	202		707	2
3	<u>REMODEL THERAPY ROOM</u>	2013	3,010	110	27.5	110		385	3
4	<u>KITCHEN EXHAUST</u>	2013	13,022	474	27.5	474		1,659	4
5	<u>SPRINKLERS</u>	2013	89,134	3,241	27.5	3,241		11,344	5
6	<u>INSTALLATION OF NEW VINYL FLOOR IN CORRIDOR</u>								6
7	<u>AND RESIDENT BATHROOMS</u>	2014	30,775	1,119	27.5	1,119		2,471	7
8	<u>SPRINKLERS</u>	2014	3,372	123	27.5	123		364	8
9	<u>FLOORING</u>	2014	2,355	86	27.5	86		247	9
10	<u>NEW SIGN</u>	2014	9,280	337	27.5	337		941	10
11	<u>EXIT DOOR SERVICE</u>	2014	572	21	27.5	21		57	11
12	<u>RECIRCULATION PIPE</u>	2014	700	25	27.5	25		68	12
13	<u>COPPER PIPE</u>	2014	2,149	78	27.5	78		211	13
14	<u>A/C CONDENSOR</u>	2014	4,917	179	27.5	179		455	14
15	<u>Generator</u>	2014	2,441	89	27.5	89		178	15
16	<u>Window treatments</u>	2015	7,542	717	15	503	(214)	880	16
17	<u>New Boiler</u>	2015	41,448	3,938	15	2,763	(1,175)	4,835	17
18	<u>Water heater</u>	2015	10,820	1,028	15	721	(307)	1,262	18
19	<u>Call Light</u>	2015	1,253	119	15	84	(35)	147	19
20	<u>Parking Lot</u>	2015	975	93	15	65	(28)	114	20
21	<u>Aquarium Design</u>	2015	17,043	1,619	15	1,136	(483)	1,988	21
22	<u>Roofing</u>	2015	1,095	104	15	73	(31)	128	22
23	<u>New piping</u>	2015	8,752	831	15	583	(248)	1,021	23
24	<u>Replace ball valve</u>	2015	1,414	134	15	94	(40)	165	24
25	<u>Build New Closets in 28 patient rooms</u>	2015	29,855	2,836	15	1,990	(846)	3,483	25
26	<u>Remodel New dining room, Replace windows,</u>	2015	163,500	15,533	15	10,900	(4,633)	19,075	26
27	<u>Update Baseboard heaters in all rooms,Install oak Headboards in allRooms</u>								27
28	<u>New Water Heater</u>	2016	22,511	750	15	750		750	28
29	<u>New entrance and parking Lot , Scrape and Paint Sofits facia,</u>	2016	47,242	1,575	15	1,575		1,575	29
30	<u>and all roof copings all around the facility</u>								30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,004,657	\$ 188,374		\$ 198,611	\$ 10,237	\$ 929,938	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 464,896	\$ 8,279	\$ 46,890	\$ 38,611	10	\$ 276,783	71
72	Current Year Purchases	11,784	6,866	1,178	(5,688)	10	1,178	72
73	Fully Depreciated Assets							73
74	Alloc from AA Mgmt		315	315			598	74
75	TOTALS	\$ 476,680	\$ 15,460	\$ 48,383	\$ 32,923		\$ 278,559	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	5,931,337
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	203,834
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	246,994
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	43,160
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,208,497

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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	Allocated rent				14,295			5
6								6
7	TOTAL				\$ 14,295			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.
9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? ☐ 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 230,969	\$		\$ 230,969	1
2	Licensed Speech and Language Development Therapist		hrs			99,665			99,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			271,062			271,062	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				242,631		242,631	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Dialysis						60,403		60,403	12
13	Other (specify):									13
14	TOTAL			\$		\$ 601,696	\$ 303,034		\$ 904,730	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 18,165	\$ 18,647	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,822,503	2,822,503	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,728	47,728	6
7	Other Prepaid Expenses	14,461	14,461	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related homes	20,343	20,343	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,923,200	\$ 2,923,682	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	1,128,592	1,498,596	15
16	Equipment, at Historical Cost	474,425	474,425	16
17	Accumulated Depreciation (book methods)	(507,750)	(1,241,103)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		221,734	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(175,883)	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)	\$ 1,095,267	\$ 5,009,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,018,467	\$ 7,933,351	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,344,847	\$ 2,376,047	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,115	22,115	28
29	Short-Term Notes Payable	702,083	702,083	29
30	Accrued Salaries Payable	161,487	161,487	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,014	23,014	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,179	13,477	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related Homes		76,392	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,256,725	\$ 3,374,615	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		10,812,082	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)	\$	\$ 10,812,082	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,256,725	\$ 14,186,697	46
47	TOTAL EQUITY(page 18, line 24)	\$ 761,742	\$ (6,253,346)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,018,467	\$ 7,933,351	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 348,435	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 348,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	513,307	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	(100,000)	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)	\$ 413,307	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)	\$ 761,742	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CROSSROADS CRE CTR WOODSTOCK

0049999

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,200,042	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,200,042	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***	3,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,622	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)	\$ 8,203,664	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	843,519	31
32	Health Care	3,162,693	32
33	General Administration	1,914,212	33
	B. Capital Expense		
34	Ownership	975,015	34
	C. Ancillary Expense		
35	Special Cost Centers	559,073	35
36	Provider Participation Fee	235,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,690,357	40
41	Income before Income Taxes (line 30 minus line 40)**	513,307	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 513,307	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,254,193	44
45	Private Pay - Net Inpatient Revenue	846,983	45
46	Medicare - Net Inpatient Revenue	3,065,046	46
47	Other-(specify) <u>Managed Care, Med B</u>	1,033,820	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,200,042	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,048	3,363	\$ 190,303	\$ 56.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,137	17,163	496,122	28.91	3
4	Licensed Practical Nurses	18,164	19,065	495,149	25.97	4
5	CNAs & Orderlies	50,131	52,783	701,969	13.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,144	37,361	17.43	9
10	Activity Assistants	2,668	2,857	28,261	9.89	10
11	Social Service Workers	1,976	2,144	43,226	20.16	11
12	Dietician					12
13	Food Service Supervisor	1,779	1,902	38,399	20.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,556	19,072	176,950	9.28	15
16	Dishwashers					16
17	Maintenance Workers	2,142	2,185	50,919	23.30	17
18	Housekeepers	13,668	14,022	121,646	8.68	18
19	Laundry	3,748	4,016	36,872	9.18	19
20	Administrator	1,608	1,855	100,820	54.35	20
21	Assistant Administrator	1,032	1,032	23,610	22.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,981	10,466	213,582	20.41	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)	146,654	154,069	\$ 2,755,189 *	\$ 17.88	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	105	\$ 4,900	1-3	35
36	Medical Director		50,000	9-3	36
37	Medical Records Consultant	135	4,054	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,036	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	100	5,055	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	847	11-3	44
45	Social Service Consultant	30	1,152	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	394	\$ 75,044		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
LYNETTE RUGG	Administrative		\$ 100,820
Yaakov Brandman	Administrative		23,610
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 124,430
B. Administrative - Other			
Description			Amount
Home Office Expense			\$ 488,460
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 488,460
C. Professional Services			
Vendor/Payee	Type		Amount
Mendel Schneider	Accounting		\$ 13,000
Rehab management Systems	Reimbursement Consulting		24,000
Achieve Accrediation	Accrediation		9,777
Prospect Resources	Utilities Management		600
Align	Executive Search		13,800
Law Office of Daniel Parsons	Legal		8,657
Meyer Magence	Legal		1,063
Mcdermott Will and Emery	Legal		11,087
Woodstock Legal Consultants	Legal		2,485
Franks Gerkin Mckenna	Legal		1,228
Bank Leumi	Legal		2,883
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 88,580
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 72,360
Unemployment Compensation Insurance			87,494
FICA Taxes			204,779
Employee Health Insurance			147,641
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 512,274
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			\$ 1,990
Advertising: Employee Recruitment			18,968
Health Care Worker Background Check (Indicate # of checks performed 150)			1,500
Patient Background Checks 300			3,000
Illinois council on Long Term Care			12,420
The Joint Commission			2,600
Advertising			51,151
Misc License			2,856
Less: Public Relations Expense			(51,151)
Non-allowable advertising			()
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 43,334
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Relias Learning			5,310
Illinois council On long term care allocated from aa healthcare			2,638
			25,426
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 33,374

*** Attach copy of IMRF notifications**

****See instructions.**

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 12420

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(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.

\$ 235,845

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 benefit 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. \$ 0

(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