

		FOR BHF USE					

LL1

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2020)

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 Care Ctr Woodstek

Address: 309 McHenry Avenue Woodstock 60098

County: McHenry

Telephone Number: 815-338-1700 Fax # 815-338-1765

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

x PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: David Shamsi Telephone Number: 847-983-4860

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 01/01/2020 to 12/31/2020 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) 4/28/2021

(Type or Print Name) Aaron Topper

(Title) CEO

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Crossroads Care Ctr Woodstck

0049999 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,868</u>	<u>1,532</u>	<u>23,336</u>	<u>30,736</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,868</u>	<u>1,532</u>	<u>23,336</u>	<u>30,736</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.02%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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 6,002

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.

Facility Name & ID Number Crossroads Care Ctr Woodstck # 0049999 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	306,019	41,132	24,307	371,458		371,458		371,458			1
2	Food Purchase		173,767		173,767		173,767		173,767			2
3	Housekeeping	122,210	24,750	4,678	151,638		151,638		151,638			3
4	Laundry	16,732	2,626		19,358		19,358		19,358			4
5	Heat and Other Utilities			95,315	95,315		95,315		95,315			5
6	Maintenance	84,101	53,072	79,513	216,686		216,686		216,686			6
7	Other (specify):*											7
8	TOTAL General Services	529,062	295,347	203,813	1,028,222		1,028,222		1,028,222			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,924,750	184,687	781,870	2,891,307		2,891,307		2,891,307			10
10a	Therapy			606,874	606,874		606,874		606,874			10a
11	Activities	51,344	4,545	1,901	57,790		57,790		57,790			11
12	Social Services	57,644			57,644		57,644		57,644			12
13	CNA Training											13
14	Program Transportation			3,166	3,166		3,166		3,166			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,033,738	189,232	1,411,811	3,634,781		3,634,781		3,634,781			16
	C. General Administration											
17	Administrative	131,808	3,055	453,504	588,367		588,367	(24,254)	564,113			17
18	Directors Fees											18
19	Professional Services			80,288	80,288		80,288		80,288			19
20	Dues, Fees, Subscriptions & Promotions			19,904	19,904		19,904	(13,644)	6,260			20
21	Clerical & General Office Expenses	272,336		415,393	687,729		687,729		687,729			21
22	Employee Benefits & Payroll Taxes			511,297	511,297		511,297		511,297			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,238	8,238		8,238		8,238			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			323,174	323,174		323,174		323,174			26
27	Other (specify):*											27
28	TOTAL General Administration	404,144	3,055	1,811,798	2,218,997		2,218,997	(37,898)	2,181,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,966,944	487,634	3,427,422	6,882,000		6,882,000	(37,898)	6,844,102			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			108,472	108,472		108,472	140,664	249,136			30
31	Amortization of Pre-Op. & Org.			22,381	22,381		22,381	3,482	25,863			31
32	Interest			12,008	12,008		12,008	487,776	499,784			32
33	Real Estate Taxes			105,024	105,024		105,024	66,878	171,902			33
34	Rent-Facility & Grounds			744,893	744,893		744,893	(744,893)				34
35	Rent-Equipment & Vehicles			2,521	2,521		2,521		2,521			35
36	Other (specify):*											36
37	TOTAL Ownership			995,299	995,299		995,299	(46,093)	949,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,536	171,536		171,536		171,536			42
43	Other (specify):* Bad Debt			213,830	213,830		213,830		213,830			43
44	TOTAL Special Cost Centers			385,366	385,366		385,366		385,366			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,966,944	487,634	4,808,087	8,262,665		8,262,665	(83,991)	8,178,674			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	(20,719)	30		9
10	Interest and Other Investment Income				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	(873)	32		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	(1,554)	17		18
19	Entertainment				19
20	Contributions	(22,700)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(213,830)			24
25	Fund Raising, Advertising and Promotional	(13,644)	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)	\$ (273,320)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (273,320)		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

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
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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: 01/01/2020 Ending: 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(24,254)	0	0	0	0	0	0	0	0	0	0	(24,254)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,644)	0	0	0	0	0	0	0	0	0	0	(13,644)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,898)	0	0	0	0	0	0	0	0	0	0	(37,898)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(37,898)	0	0	0	0	0	0	0	0	0	0	(37,898)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Crossroads Care Ctr Woodstck # 0049999 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(20,719)	161,383	0	0	0	0	0	0	0	0	0	140,664	30
31	Amortization of Pre-Op. & Org.	0	3,482	0	0	0	0	0	0	0	0	0	3,482	31
32	Interest	(873)	488,649	0	0	0	0	0	0	0	0	0	487,776	32
33	Real Estate Taxes	0	66,878	0	0	0	0	0	0	0	0	0	66,878	33
34	Rent-Facility & Grounds	0	(744,893)	0	0	0	0	0	0	0	0	0	(744,893)	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	(21,592)	(24,501)	0	0	0	0	0	0	0	0	0	(46,093)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(59,490)	(24,501)	0	0	0	0	0	0	0	0	0	(83,991)	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			

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	\$ 744,893	CCCW Realty	100.00%	\$	(744,893)	1
2	V	33	Real Estate Tax		CCCW Realty	100.00%	66,878	66,878	2
3	V	32	Interest		CCCW Realty	100.00%	488,649	488,649	3
4	V	30	Depreciation		CCCW Realty	100.00%	161,383	161,383	4
5	V	31	Amortization		CCCW Realty	100.00%	3,482	3,482	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 744,893			\$ 720,392	\$ * (24,501)	14

* 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 Care Ctr Woodstk # 0049999 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	932,289	20	40.00	Mngmnt Fee	\$ 416,289	17-3	1
2	Joseph Brandman	Manager	Management	25.00	88,766	20	40.00	Mngmnt Fee	33,296	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	\$ 449,585		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: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____
Fax Number (_____)

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank Leumi		x	Mortgage	\$60,919.00	10/1/20	\$ 10,319,652	\$ 9,807,800	9/30/21	5.5000	\$ 138,000	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$60,919.00		\$ 10,319,652	\$ 9,807,800			\$ 138,000	9	
	B. Non-Facility Related*												
10	Interest Income										(873)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (873)	14	
15	TOTALS (line 9+line14)						\$ 10,319,652	\$ 9,807,800			\$ 137,127	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

				Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2019 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.)	\$			66,654		2
3. Under or (over) accrual (line 2 minus line 1).	\$			66,654		3
4. Real Estate Tax accrual used for 2020 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.	\$			66,654		7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015		74,076		8
		2016		65,778		9
		2017		65,836		10
		2018		66,663		11
		2019		66,654		12

	FOR BHF USE ONLY		
13 FROM R. E. TAX STATEMENT FOR 2019	\$		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.

2019 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 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 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 13-05-254-015	Facility	\$ 64,212.00	\$ 64,212.00
2. 13-05-254-011	Facility	\$ 2,442.00	\$ 2,442.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 66,654.00	\$ 66,654.00

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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: 14,921

4. Dates Incurred: 3/17/15

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 Care Ctr Woodstck

0049999

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Landscaping		2008		9,250	925	10		(925)	9,250
10	Landscaping		2008		3,145	315	10		(315)	3,145
11	Window Tinting		2009		2,597		5			2,597
12	Dialysis Plumbing		2009		46,831	809	40	1,171	362	13,563
13	Replacement Part Generator		2009		3,247		10			3,247
14	A/C Unit		2009		4,880		10			4,880
15	Water Heater		2009		13,687		10			13,687
16	Remodeling		2009		2,506		40	63	63	723
17	Dialysis Station & Elec		2009		2,394	87	40	60	(27)	684
18	Dialysis Room Costs		2009		290	11	39	7	(4)	81
19	Plumbing		2009		2,516	91	39	65	(26)	912
20	Signage		2009		6,254		10			6,254
21	Remodeling Flooring		2009		99,038		10			99,038
22	Draperies & Cubicle Curtains		2009		22,171		5			22,171
23	Nurse Station		2009		26,145		15	1,743	1,743	19,899
24	Wallcovering		2009		64,464		5			64,464
25	Handrails & Bumper Guards		2009		32,751		15	2,183	2,183	24,924
26	Recessed Canned Lighting		2009		37,123	1,350	30	1,237	(113)	14,124
27	Shower/Guest Bathroom Remodeling		2009		39,205	1,426	39	1,005	(421)	11,056
28	Lighting		2009		427		10			427
29	Parking Lot Lights		2009		570	57	20	29	(28)	318
30	Resident Rooms New Lighting		2009		1,930		39	49	49	545
31	Doors		2010		4,957	180	15	330	150	3,494
32	Handicap Ramp		2010		4,926	179	15	328	149	3,472
33	Retubing Boiler		2010		5,122		15	341	341	3,468
34	Remodeling Phase 2-Shower Rooms-Contract		2010		31,892	1,160	39	818	(342)	8,929
35	Skylight		2011		825	30	39	21	(9)	210
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:

01/01/2020

Ending:

12/31/2020

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	\$	\$ 605	37
38	Water Heater Gas Control	2011	1,074	107	10	107		1,026	38
39	Valve Replacement	2011	2,295	230	10	230		2,184	39
40	Repair Hot Water Line in Floor	2011	1,532	153	10	153		1,454	40
41	Bonze Body Pump	2011	867	87	10	87		819	41
42	Room 301 & 303 Remodeling Contract	2011	5,366	134	40	134		1,251	42
43	Hall of 300 Wing-Plumbing	2011	763	19	40	19		177	43
44	Repair Leak Under Floor	2011	3,187	80	40	80		740	44
45	Room 301 & 303 Remodeling Material	2011	1,127	113	10	113		1,045	45
46	New Overload Contractor	2011	944	94	10	94		854	46
47	Shed Remodel Contract	2011	20,920	536	39	536		4,869	47
48	Shed Remodel Contract	2011	3,518	1,055	20	176	(879)	1,599	48
49	Concrete Patios	2011	10,300	515	20	515		4,678	49
50	Patient Room Remodeling	2011	21,290	2,129	39	546	(1,583)	5,187	50
51	Boiler Repair	2011	2,568	257	10	257		2,463	51
52	1/2" Copper Line	2012	788	20	40	20		178	52
53	3 Solid Wood Doors	2012	1,255	125	10	126	1	1,106	53
54	Bathroom Vanity Toe Kicks	2012	565	57	10	57		498	54
55	Hot Water Heater Coupling	2012	1,605	161	10	161		1,395	55
56	Lighting Fixtures	2012	318	32	10	32		277	56
57	Kitchen Exhaust	2012	18,800	470	40	470		4,073	57
58	Dining Room A/C unit	2012	7,587	759	10	759		6,578	58
59	Roof Repairs	2012	1,825	46	40	46		395	59
60	Energy Efficient Lighting	2012	7,034	176	40	176		1,511	60
61	Panic Bar	2012	596	60	10	60		495	61
62	Auto Operating Door System	2012	8,225	548	15	548		4,887	62
63	Boiler Valve	2012	594	30	20	30		267	63
64	Doors	2013	3,336	120	27.5	121	1	901	64
65	Survey and Architect of Parking Lot	2013	1,175	43	27.5	43		344	65
66	Energy Efficient Lighting	2013	6,851	250	27.5	249	(1)	1,874	66
67	Wiring & Installation of Computer Network	2013	6,266	228	27.5	228		1,710	67
68	Replace Boiler	2013	11,072	402	27.5	403	1	2,841	68
69	Generator	2013	78,644	3,149	27.5	2,860	(289)	22,469	69
70	TOTAL (lines 4 thru 69)		\$ 4,483,942	\$ 156,390		\$ 156,471	\$ 81	\$ 416,312	70

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

Facility Name & ID Number Crossroads Care Ctr Woodstock

0049999

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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	\$ 156,390		\$ 156,471	\$ 81	\$ 416,312	1
2	<u>Tie in Water</u>	2013	5,538	202	27.5	201	(1)	1,514	2
3	<u>Remodel Therapy Room</u>	2013	3,010	110	27.5	109	(1)	824	3
4	<u>Kitchen Exhausts</u>	2013	13,022	474	27.5	474		3,555	4
5	<u>Sprinklers</u>	2013	89,134	3,241	27.5	3,241		24,308	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		6,947	7
8	<u>Sprinklers</u>	2014	3,372	123	27.5	123		856	8
9	<u>Flooring</u>	2014	2,355	86	27.5	86		591	9
10	<u>New Sign</u>	2014	9,280	337	27.5	337		2,289	10
11	<u>Exit Door Service</u>	2014	572	21	27.5	21		141	11
12	<u>Recirculation Pipe</u>	2014	700	25	27.5	25		168	12
13	<u>Copper Pipe</u>	2014	2,149	78	27.5	78		523	13
14	<u>A/C Condensor</u>	2014	4,917	179	27.5	179		1,171	14
15	<u>Generator</u>	2014	2,441	89	27.5	89		534	15
16	<u>Window Treatments</u>	2015	7,542	754	15	503	(251)	2,892	16
17	<u>New Boiler</u>	2015	41,448	4,145	15	2,763	(1,382)	15,887	17
18	<u>Water Heater</u>	2015	10,820	1,082	15	721	(361)	4,146	18
19	<u>Call Light</u>	2015	1,253	125	15	84	(41)	483	19
20	<u>Parking Lot</u>	2015	975	97	15	65	(32)	374	20
21	<u>Aquarium Design</u>	2015	17,043	1,704	15	1,136	(568)	6,532	21
22	<u>Roofing</u>	2015	1,095	109	15	73	(36)	420	22
23	<u>New piping</u>	2015	8,752	875	15	583	(292)	3,353	23
24	<u>Replace Ball Valve</u>	2015	1,414	141	15	94	(47)	541	24
25	<u>Build New Closets in 28 Patient Rooms</u>	2015	29,855	2,985	15	1,990	(995)	11,443	25
26	<u>Remodel New Dining Room Replace Windows</u>	2015	100,890	15,533	15	6,726	(8,807)	45,979	26
27	<u>Update Baseboard Heaters in All Rooms, Install Oak Headboards</u>								27
28	<u>New Water Heater</u>	2016	22,511	1,501	15	1,501		6,754	28
29	<u>New Entrance and Parking Lot, Scrape and Paint Sofits Facia</u>	2016	47,242	3,149	15	3,149		14,171	29
30	<u>And All Roof Copings</u>								30
31	<u>Fire rating work Laundry Boiler Rooms</u>	2017	84,985	5,666	15	5,666		22,664	31
32	<u>Replace Rear Door, Install Security Cameras</u>								32
33	<u>Construct Employee Breakroom, Remodel Guest Bathroom, Install Water Shutoff</u>								33
34	TOTAL (lines 1 thru 33)		\$ 5,027,032	\$ 200,340		\$ 187,607	\$ (12,733)	\$ 595,372	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:

01/01/2020 Ending: 12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,027,032	\$ 200,340		\$ 187,607	\$ (12,733)	\$ 595,372	1
2	repair Kitchen floor, Entry Patio, Bathroom Remodeling								2
3	Resurface Parking Lot	2018	9,855	985	15	657	(328)	2,197	3
4	Repair Water System Valves	2018	9,754	975	15	650	(325)	1,955	4
5	New Kitchen Breakers	2018	2,933	293	15	196	(97)	501	5
6	Repair West Exit Door	2018	3,710	371	15	247	(124)	540	6
7	New Patio and Shelter	2018	41,980	4,197	15	2,799	(1,398)	6,123	7
8	Installed 2 New Boiler Circulator Pumps	2019	17,555	2,633	15	1,755	(878)	1,974	8
9	Install Magic force Operator on Patio Door, Paint Kitchen	2019	3,343	501	15	223	(278)	348	9
10	Dug Down 3 Feet by Cooler in Kitchen, Tunneled Under Cooler, R	2019	3,215		15	214	214	415	10
11	Heat Pump Installation	2020	117,271		15	1,955	1,955	1,955	11
12	HVAC Replacements	2020	68,000		15	1,511	1,511	1,511	12
13	Lease repair	2020	3,186		5	212	212	212	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,307,834	\$ 210,295		\$ 198,026	\$ (12,269)	\$ 613,103	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	\$508,877	\$13,115	\$50,888	\$37,773	10	\$218,067	71
72	Current Year Purchases	17,791	222	222		5	222	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$526,668	\$13,337	\$51,110	\$37,773		\$218,289	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)			\$	6,284,502
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	223,632
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	249,136
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	25,504
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	831,392

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								5
6								6
7	TOTAL				\$			7

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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	\$ 671,636	\$ 840,298	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,244,850	2,244,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,744	103,744	6
7	Other Prepaid Expenses	11,981	11,981	7
8	Accounts Receivable (owners or related parties)	26,178	26,178	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,058,389	\$ 3,227,051	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	1,425,998	1,620,273	15
16	Equipment, at Historical Cost	235,031	410,760	16
17	Accumulated Depreciation (book methods)	(948,520)	(2,178,723)	17
18	Deferred Charges	89,524	311,258	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,381)	(212,192)	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)	\$ 779,652	\$ 4,183,276	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,838,041	\$ 7,410,327	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,366,476	\$ 1,366,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,987	26,987	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,858	110,858	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,474	69,474	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,200	39,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,612,995	\$ 1,612,995	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	611,635	611,635	39
40	Mortgage Payable		9,807,800	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related Parties	698,446	954,064	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,310,081	\$ 11,373,499	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,923,076	\$ 12,986,494	46
47	TOTAL EQUITY(page 18, line 24)	\$ 914,965	\$ (5,576,167)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,838,041	\$ 7,410,327	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 257,403	1
2	Restatements (describe):		2
3	account reconciliations	(808,222)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (550,819)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,525,510	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	(59,726)	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)	\$ 1,465,784	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)	\$ 914,965	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Crossroads Care Ctr Woodstck

0049999

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,787,301	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,787,301	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***	874	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 874	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)	\$ 9,788,175	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,028,222	31
32	Health Care	3,634,781	32
33	General Administration	2,258,635	33
	B. Capital Expense		
34	Ownership	955,661	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	171,536	36
	D. Other Expenses (specify):		
37	Bad Debt	213,830	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,262,665	40
41	Income before Income Taxes (line 30 minus line 40)**	1,525,510	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,525,510	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,230,312	44
45	Private Pay - Net Inpatient Revenue	596,555	45
46	Medicare - Net Inpatient Revenue	4,047,193	46
47	Other-(specify) Cares Act	913,241	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,787,301	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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	1,939	2,051	\$ 138,115	\$ 67.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,697	11,078	400,555	36.16	3
4	Licensed Practical Nurses	17,518	18,632	597,564	32.07	4
5	CNAs & Orderlies	34,961	36,925	788,516	21.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,003	2,115	39,453	18.65	9
10	Activity Assistants	1,231	1,231	11,891	9.66	10
11	Social Service Workers	1,976	2,176	57,644	26.49	11
12	Dietician	13,307	13,675	185,080	13.53	12
13	Food Service Supervisor					13
14	Head Cook	9,357	9,443	120,939	12.81	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,259	3,355	84,101	25.07	17
18	Housekeepers	11,276	11,554	122,210	10.58	18
19	Laundry	1,676	1,676	16,732	9.98	19
20	Administrator	2,066	2,074	136,307	65.72	20
21	Assistant Administrator	2,064	2,064	89,289	43.26	21
22	Other Administrative	7,248	7,358	127,363	17.31	22
23	Office Manager	2,063	2,099	51,185	24.39	23
24	Clerical					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)	122,641	127,506	\$ 2,966,944 *	\$ 23.27	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	384	\$ 19,584	line 1, col 3	35
36	Medical Director		18,000	line 9, col 3	36
37	Medical Records Consultant	345	13,837	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,612	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,462	line 11, col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Reimbursement		24,000	line 10, col 3	47
48					48
49	TOTAL (lines 35 - 48)	729	\$ 80,495		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 26,668	line 10, col 3	50
51	Licensed Practical Nurses		27,687	line 10, col 3	51
52	Certified Nurse Assistants/Aides		269,919	line 10, col 3	52
53	TOTAL (lines 50 - 52)		\$ 324,274		53

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI/IL Counsil LT Care, \$16,635</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>15</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>40,000</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>171,536</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> 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? <u>50</u>
d. Have vehicle usage logs been maintained? <u>N/A</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|---|