

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK

0049999 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	115	Skilled (SNF)	115	41,975	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,396	693	6,521	11,610	8
9	SNF/PED					9
10	ICF	17,582	2,772	2,516	22,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,978	3,465	9,037	34,480	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.14%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 5,920

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 WOODSTOCK** # **0049999** Report Period Beginning: **01/01/2013** Ending: **12/31/2013**

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	239,907	30,837	6,413	277,157		277,157	277,157			1
2	Food Purchase		196,764		196,764		196,764	196,764			2
3	Housekeeping	111,483	36,514		147,997		147,997	147,997			3
4	Laundry	54,804	3,825	4,465	63,094		63,094	63,094			4
5	Heat and Other Utilities			75,834	75,834		75,834	75,834			5
6	Maintenance	51,119		99,395	150,514		150,514	150,514			6
7	Other (specify):*										7
8	TOTAL General Services	457,313	267,940	186,107	911,360		911,360	911,360			8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000	14,000			9
10	Nursing and Medical Records	1,898,788	321,858	41,265	2,261,911		2,261,911	2,261,911			10
10a	Therapy			541,038	541,038		541,038	541,038			10a
11	Activities	54,954	6,711	1,952	63,617		63,617	63,617			11
12	Social Services	39,070		1,830	40,900		40,900	40,900			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,992,812	328,569	600,085	2,921,466		2,921,466	2,921,466			16
	C. General Administration										
17	Administrative	116,320		348,887	465,207		465,207	(236,796)	228,411		17
18	Directors Fees										18
19	Professional Services			63,147	63,147		63,147	39,518	102,665		19
20	Dues, Fees, Subscriptions & Promotions			138,547	138,547		138,547	(72,436)	66,111		20
21	Clerical & General Office Expenses	199,359	17,484	96,336	313,179		313,179	98,498	411,677		21
22	Employee Benefits & Payroll Taxes			526,980	526,980		526,980		526,980		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,555	5,555		5,555	10,461	16,016		24
25	Other Admin. Staff Transportation			17,077	17,077		17,077	10,325	27,402		25
26	Insurance-Prop.Liab.Malpractice			166,295	166,295		166,295	7,210	173,505		26
27	Other (specify):*							11,011	11,011		27
28	TOTAL General Administration	315,679	17,484	1,362,824	1,695,987		1,695,987	(132,209)	1,563,778		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,765,804	613,993	2,149,016	5,528,813		5,528,813	(132,209)	5,396,604		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 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	
	D. Ownership											
30	Depreciation			48,652	48,652		48,652	171,618	220,270			30
31	Amortization of Pre-Op. & Org.							11,300	11,300			31
32	Interest			47,197	47,197		47,197	150,276	197,473			32
33	Real Estate Taxes			2,218	2,218		2,218	63,517	65,735			33
34	Rent-Facility & Grounds			344,960	344,960		344,960	(337,440)	7,520			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP INSURANCE							3,989	3,989			36
37	TOTAL Ownership			443,027	443,027		443,027	63,260	506,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			221,041	221,041		221,041		221,041			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,282	234,282		234,282		234,282			42
43	Other (specify):* Bad Debt			61,574	61,574		61,574	(61,574)				43
44	TOTAL Special Cost Centers			516,897	516,897		516,897	(61,574)	455,323			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,765,804	613,993	3,108,940	6,488,737		6,488,737	(130,523)	6,358,214			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	12,099	30		9
10	Interest and Other Investment Income	(480)	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	(5,171)	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	(61,574)	43		24
25	Fund Raising, Advertising and Promotional	(83,919)	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)	\$ (139,045)		\$	30

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	2	
		Amount	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)	8,522		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,522		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (130,523)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 CROSSROADS CARE CTR WOODSTOCK

ID# 0049999

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES

Amount

1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK# 0049999

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(236,796)	0	0	0	0	0	0	0	0	(236,796)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,535	30,983	0	0	0	0	0	0	0	0	39,518	19
20	Fees, Subscriptions & Promotions	(83,919)	0	11,483	0	0	0	0	0	0	0	0	(72,436)	20
21	Clerical & General Office Expenses	(5,171)	0	103,669	0	0	0	0	0	0	0	0	98,498	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	10,461	0	0	0	0	0	0	0	0	10,461	24
25	Other Admin. Staff Transportation	0	0	10,325	0	0	0	0	0	0	0	0	10,325	25
26	Insurance-Prop.Liab.Malpractice	0	7,210	0	0	0	0	0	0	0	0	0	7,210	26
27	Other (specify):*	0	0	11,011	0	0	0	0	0	0	0	0	11,011	27
28	TOTAL General Administration	(89,090)	15,745	(58,864)	0	(132,209)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(89,090)	15,745	(58,864)	0	(132,209)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK# 0049999

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	12,099	137,917	21,602	0	0	0	0	0	0	0	0	171,618	30
31	Amortization of Pre-Op. & Org.	0	11,300	0	0	0	0	0	0	0	0	0	11,300	31
32	Interest	(480)	150,756	0	0	0	0	0	0	0	0	0	150,276	32
33	Real Estate Taxes	0	63,517	0	0	0	0	0	0	0	0	0	63,517	33
34	Rent-Facility & Grounds	0	(344,960)	7,520	0	0	0	0	0	0	0	0	(337,440)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	3,989	0	0	0	0	0	0	0	0	0	3,989	36
37	TOTAL Ownership	11,619	22,519	29,122	0	63,260	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):*	(61,574)	0	0	0	0	0	0	0	0	0	0	(61,574)	43
44	TOTAL Special Cost Centers	(61,574)	0	0	0	0	0	0	0	0	0	0	(61,574)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(139,045)	38,264	(29,742)	0	0	0	0	0	0	0	0	(130,523)	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	AA HEALTHCARE	SKOKIE	MANAGEMENT
JOSPEH BRANDMAN	25			CCCW REALTY	WOODSTOCK	BLDG RENTAL

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	\$ 344,960	CCCW REALTY	100.00%	\$	\$ (344,960)	1
2	V	33 REAL ESTATE TAX		CCCW REALTY		63,517	63,517	2
3	V	32 INTEREST		CCCW REALTY		150,756	150,756	3
4	V	30 DEPRECIATION		CCCW REALTY		137,917	137,917	4
5	V	31 AMORTIZATION		CCCW REALTY		11,300	11,300	5
6	V	36 MIP INSURANCE		CCCW REALTY		3,989	3,989	6
7	V	26 INSURANCE		CCCW REALTY		7,210	7,210	7
8	V	19 PROF FEES		CCCW REALTY		8,535	8,535	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 344,960			\$ 383,224	\$ * 38,264	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	\$ 175,000	AA Healthcare Management	100.00%	\$	\$ (175,000)
16	V	17 Management Fees	173,887	AA Healthcare Management			(173,887)
17	V	34 Rent		AA Healthcare Management		7,520	7,520
18	V	19 Professional Fees		AA Healthcare Management		30,983	30,983
19	V	20 Fees, Subscriptions		AA Healthcare Management		11,483	11,483
20	V	21 Clerical Salaries		AA Healthcare Management		89,147	89,147
21	V	21 Office Expenses		AA Healthcare Management		14,522	14,522
22	V	24 Travel & Seminars		AA Healthcare Management		10,461	10,461
23	V	25 Transportation		AA Healthcare Management		10,325	10,325
24	V	27 Employee Benefits		AA Healthcare Management		11,011	11,011
25	V	30 Depreciation		AA Healthcare Management		21,602	21,602
26	V	17 Owners Compensation		AA Healthcare Management		112,091	112,091
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 348,887			\$ 319,145	\$ * (29,742)

* 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 WOODSTOCK # 0049999 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	OWNER	Administrative	75.00	106,242	10	20.00	Mgt Fees	\$ 112,091	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 112,091		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 WOODSTOCK # 0049999 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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

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

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

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	17	Owners compensation	Number of Beds	224	\$ 218,333		115	\$ 112,091	1
2	34	Rent	Number of Beds	224	14,647		115	7,520	2
3	19	Professional fees	Number of Beds	224	60,350		115	30,983	3
4	20	Fees, Subscriptions	Number of Beds	224	22,366		115	11,483	4
5	21	Clerical Salaries	Number of Beds	224	173,642	173,642	115	89,147	5
6	21	Office Expenses	Number of Beds	224	28,286		115	14,522	6
7	24	Travel & Seminars	Number of Beds	224	20,377		115	10,461	7
8	25	Transportation	Number of Beds	224	20,111		115	10,325	8
9	27	Employee Benefits	Number of Beds	224	21,448		115	11,011	9
10	30	Depreciation	Number of Beds	224	42,076		115	21,602	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				\$ 621,636	\$ 173,642		\$ 319,145	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	Name of Lender	2		3	4	5	6		8	9	10						
		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	HEARTLAND BANK		X	MORTGAGE	\$29,361.00	01/30/13	\$ 4,513,800	\$ 4,427,307	08/01/2041	2.8600	\$ 150,756	1					
2	Ext Terms America		X	ENERGY EFF LIGHT FIX	\$318.00		7,034	5,855			327	2					
3												3					
4												4					
5												5					
Working Capital																	
6	PRIVATE BANK		X	WORKING CAPITAL				772,975			25,371	6					
7	HOUSING & HEALTHCARE		X	WORKING CAPITAL				28,060			4,314	7					
8	PHARMERICA		X	PHARMACY							17,185	8					
9	TOTAL Facility Related				\$29,679.00		\$ 4,520,834	\$ 5,234,197			\$ 197,953	9					
B. Non-Facility Related*																	
10	INTEREST INCOME										(480)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			(480)	14					
15	TOTALS (line 9+line14)						\$ 4,520,834	\$ 5,234,197			\$ 197,473	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 3,989 Line # 36

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

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CROSSROADS CARE 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-05-254-015</u>	<u>Nursing Home</u>	\$ <u>63,516.80</u>	\$ <u>63,516.80</u>
2. <u>13-05-254-011</u>	<u>Nursing Home</u>	\$ <u>2,217.68</u>	\$ <u>2,217.68</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>65,734.48</u></u>	\$ <u><u>65,734.48</u></u>

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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: 169,499 2. Number of Years Over Which it is Being Amortized: 15
 3. Current Period Amortization: 11,300 4. Dates Incurred: 01/31/13

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>FACILITY</u>	<u>179,865</u>	<u>2013</u>	<u>\$ 450,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>179,865</u>		<u>\$ 450,000</u>	<u>3</u>

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	\$ 131,793	27.5	\$ 131,793	\$	\$ 131,793	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	LANDSCAPING		2008	9,250	925	10	925		5,010	9
10	LANDSCAPING		2008	3,145	315	10	315		1,678	10
11	WINDOW TINTING		2009	2,597	519	5	519		2,510	11
12	Dialysis plumbing		2009	46,831	1,171	40	1,171		5,366	12
13	REPLACEMENT PART-GENERATOR		2009	3,247	325	10	325		1,489	13
14	A/C UNIT		2009	4,880	488	10	488		2,196	14
15	WATER HEATER		2009	13,687	1,369	10	1,369		6,159	15
16	REMODELING		2009	2,506	63	40	63		282	16
17	DIALYSIS STATION & ELEC		2009	2,394	60	40	60		264	17
18	DIALYSIS ROOM COSTS		2009	290	7	39	7		32	18
19	PLUMBING		2009	2,516	84	30	84		343	19
20	SIGNAGE		2009	6,254	625	10	625		2,762	20
21	REMODELING- FLOORING		2009	99,038	9,904	10	9,904		43,742	21
22	DRAPERIES & CUBICLE CURTAINS		2009	22,171	4,434	5	4,434		19,584	22
23	NURSES STATION		2009	26,145	1,743	15	1,743		7,698	23
24	WALLCOVERING		2009	64,464	12,893	5	12,893		56,944	24
25	HANDRAILS & BUMPER GUARDS		2009	32,751	2,183	15	2,183		9,643	25
26	RECESSED CANNED LIGHTING		2009	37,123	1,237	30	1,237		5,465	26
27	SHOWER/GUEST BATHROOM REMODELING		2009	39,205	1,005	39	1,005		4,021	27
28	LIGHTING		2009	427	43	10	43		175	28
29	PARKING LOT LIGHTS		2009	570	29	20	29		115	29
30	RESIDENT ROOMS- NEW LIGHTING		2009	1,930	49	39	49		202	30
31	DOORS		2010	4,957	330	15	330		1,184	31
32	HANDICAP RAMP		2010	4,926	328	15	328		1,176	32
33	RETUBING BOILER		2010	5,122	341	15	341		1,081	33
34	REMODELING PHASE 2-SHOWER ROOMS-CONTRACT		2010	31,892	818	39	818		3,203	34
35	SKYLIGHT		2011	825	21	39	21		63	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK

0049999

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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	\$	\$ 178	37
38	WATER HEATER GAS CONTROL	2011	1,074	107	10	107		277	38
39	VALVE REPLACEMENT	2011	2,295	230	10	230		574	39
40	REPAIR HOT WATER LINE IN FLOOR	2011	1,532	153	10	153		383	40
41	BRONZE BODY PUMP	2011	867	87	10	87		210	41
42	ROOM 301 & 303 REMODELING-CONTRACT	2011	5,366	134	40	134		313	42
43	HALL OF 300 WING- PLUMBING- JENSENS PLUMBING	2011	763	19	40	19		44	43
44	REPAIR LEAK UNDER FLOOR	2011	3,187	80	40	80		180	44
45	ROOM 301 & 303 REMODELING- MATERIAL- MENARDS	2011	1,127	113	10	113		254	45
46	NEW OVERLOAD CONTRACTOR	2011	944	94	10	94		196	46
47	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	20,920	536	39	536		1,117	47
48	SHED REMODEL- CONTRACT- BOB'S REMODELING	2011	3,518	176	20	176		367	48
49	CONCRETE PATIOS- CONTRACT- BOB'S REMODELING	2011	10,300	515	20	515		1,073	49
50	PATIENT ROOM REMODELING-CONTRACT BOB'S	2011	21,290	546	39	546		1,365	50
51	BOILER REPAIR	2011	2,568	257	10	257		664	51
52	1/2 " COPPER LINE	2012	788	20	40	20		38	52
53	3 SOLID WOOD DOORS	2012	1,255	125	10	125		230	53
54	BATHROOM VANITY TOE KICKS	2012	565	57	10	57		99	54
55	HOT WATER HEATER COUPLING	2012	1,605	161	10	161		268	55
56	LIGHTING FIXTURES	2012	318	32	10	32		53	56
57	KITCHEN EXHAUST	2012	18,800	470	40	470		783	57
58	DINING ROOM AC UNIT	2012	7,587	759	10	759		1,265	58
59	ROOF REPAIRS	2012	1,825	46	40	46		73	59
60	ENERGY EFFICIENT LIGHTING	2012	7,034	176	40	176		279	60
61	PANIC BAR	2012	596	60	10	60		75	61
62	AUTO OPERATING DOOR SYSTEM	2012	8,225	548	15	548		1,051	62
63	BOILER VALVE	2012	594	30	20	30		57	63
64	DOORS	2013	3,336	60	27.5	60		60	64
65	SURVEY AND ARCHITECT OF PARKING LOT	2013	1,175	43	27.5	43		43	65
66	ENERGY EFFICIENT LIGHTING	2013	6,851	125	27.5	125		125	66
67	WIRING & INSTALLATION OF COMPUTER NETWORK	2013	6,266	114	27.5	114		114	67
68	REPLACE BOILER	2013	11,072	201	27.5	201		201	68
69	GENERATOR	2013	78,644	715	27.5	715		715	69
70	TOTAL (lines 4 thru 69)		\$ 4,483,942	\$ 179,952		\$ 179,952	\$	\$ 326,904	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,483,942	\$ 179,952		\$ 179,952	\$	\$ 326,904	1
2	TIE IN WATER	2013	5,538	101	27.5	101		101	2
3	REMODEL THERAPY ROOM	2013	3,010	55	27.5	55		55	3
4	KITCHEN EXHAUST	2013	13,022	237	27.5	237		237	4
5	SPRINKLERS	2013	89,134	5,178	27.5	1,621	(3,557)	1,621	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	TOTAL (lines 1 thru 33)		\$ 4,594,646	\$ 185,523		\$ 181,966	\$ (3,557)	\$ 328,918	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	\$ 329,379	\$	\$ 32,938	\$ 32,938	10	\$ 138,062	71
72	Current Year Purchases	65,189	1,046	1,046		10	1,046	72
73	Fully Depreciated Assets							73
74	ALLOC FROM AA HC MGT		21,602	4,320	(17,282)			74
75	TOTALS	\$ 394,568	\$ 22,648	\$ 38,304	\$ 15,656		\$ 139,108	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,439,214	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 208,171	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 220,270	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,099	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 468,026	85

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

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

G. Construction-in-Progress

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

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

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

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 76,475 Description: Med Equipment 76475

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK # 0049999 Report Period Beginning: 01/01/2013 Ending: 12/31/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 228,292	\$		\$ 228,292	1
2	Licensed Speech and Language Development Therapist		hrs			70,187			70,187	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			242,559			242,559	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				133,411		133,411	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Dialysis</u>						87,630		87,630	12
13	Other (specify):									13
14	TOTAL			\$		\$ 541,038	\$ 221,041		\$ 762,079	14

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

Facility Name & ID Number **CROSSROADS CARE CTR WOODSTOCK**# **0049999**Report Period Beginning: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(last day of reporting year)

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	\$ 67,518	\$ 73,558	1
2	Cash-Patient Deposits	7,921	7,921	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,267,228	2,267,228	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,712	26,712	6
7	Other Prepaid Expenses	99,523	99,523	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow, Reserves		141,484	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,468,902	\$ 2,616,426	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	752,972	928,701	15
16	Equipment, at Historical Cost	392,104	392,104	16
17	Accumulated Depreciation (book methods)	(304,551)	(579,992)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		169,499	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,300)	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)	\$ 840,525	\$ 5,130,912	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,309,427	\$ 7,747,338	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,856,122	\$ 1,856,122	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,283	18,283	28
29	Short-Term Notes Payable	801,047	801,047	29
30	Accrued Salaries Payable	123,733	123,733	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,867	20,867	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,328	25,390	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Others	751,428	841,123	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,574,808	\$ 3,686,565	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,842	4,433,149	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)	\$ 5,842	\$ 4,433,149	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,580,650	\$ 8,119,714	46
47	TOTAL EQUITY(page 18, line 24)	\$ (271,223)	\$ (372,376)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,309,427	\$ 7,747,338	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (788,308)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (788,308)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	517,085	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	()	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)	\$ 517,085	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)	\$ (271,223)	24 *

* This must agree with page 17, line 47.

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	\$ 6,974,222	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,974,222	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***	480	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 480	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	31,120	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,120	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,005,822	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	911,360	31
32	Health Care	2,921,466	32
33	General Administration	1,695,987	33
B. Capital Expense			
34	Ownership	443,027	34
C. Ancillary Expense			
35	Special Cost Centers	282,615	35
36	Provider Participation Fee	234,282	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,488,737	40
41	Income before Income Taxes (line 30 minus line 40)**	517,085	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 517,085	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,625,271	44
45	Private Pay - Net Inpatient Revenue	732,772	45
46	Medicare - Net Inpatient Revenue	3,040,799	46
47	Other-(specify) Hospice, Insurance, Managed Care, B Income	575,380	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,974,222	49

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

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

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

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

Facility Name & ID Number **CROSSROADS CARE CTR WOODSTOCK**

0049999

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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	3,703	3,766	\$ 121,107	\$ 32.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,550	20,001	525,397	26.27	3
4	Licensed Practical Nurses	14,465	15,463	403,009	26.06	4
5	CNAs & Orderlies	67,800	70,456	822,650	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,086	4,292	54,954	12.80	10
11	Social Service Workers	2,082	2,280	39,070	17.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,893	23,221	239,907	10.33	15
16	Dishwashers					16
17	Maintenance Workers	2,420	2,456	51,119	20.81	17
18	Housekeepers	13,173	13,641	111,483	8.17	18
19	Laundry	5,646	6,074	54,804	9.02	19
20	Administrator	2,096	2,160	116,320	53.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,223	13,181	199,359	15.12	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	1,211	1,489	26,625	17.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,348	178,480	\$ 2,765,804 *	\$ 15.50	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	128	\$ 6,413	1-3	35
36	Medical Director		14,000	9-3	36
37	Medical Records Consultant	96	4,608	10-3	37
38	Nurse Consultant		28,216	10-3	38
39	Pharmacist Consultant		8,441	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,952	11-3	44
45	Social Service Consultant	30	1,830	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	\$ 65,460		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LYNETTE RUGG	ADMINISTRATOR		\$ 116,320	Workers' Compensation Insurance	\$ 59,999	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	133,182	Advertising: Employee Recruitment	39,208	
				FICA Taxes	211,584	Health Care Worker Background Check		
				Employee Health Insurance	122,215	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	200 2,000	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on long term care	11,195	
						Advertising	83,919	
						Alloc from AA hlth mgmt	11,483	
						Misc Licenses	235	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 116,320			Less: Public Relations Expense	()	
						Non-allowable advertising	(83,919)	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 66,111	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
HOME OFFICE			\$ 175,000					
MANAGEMENT FEES			173,887					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 348,887					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
BKD	ACCOUNTING		\$ 21,673				Out-of-State Travel	\$
MENDEL S. SCHNEIDER	ACCOUNTING		7,000					
REHAB MANAGEMENT	REIMBURSEMENT CONSULTING		24,000				In-State Travel	
KENETH HENRY	LEGAL		2,590					
MEYER MAGENCE	LEGAL		313				Seminar Expense	5,555
FRANKS GERKIN MCKENNA	LEGAL		1,072				Allocated from AA hlth Mgmt	10,461
TALX	UC CONSULTING		394					
ORCHESTRALL	REIMBURSEMENT CONSULTING		6,105				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,147	TOTAL				
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 16,016

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number CROSSROADS CARE CTR WOODSTOCK

0049999

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. ILL COUNCIL 11,195
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,000 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 234,282
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NP For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.