

		FOR BHF USE					

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

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.

<p><b>I. IDPH License ID Number:</b> <u>0012237</u></p> <p><b>Facility Name:</b> <u>Norwood Crossing</u></p> <p><b>Address:</b> <u>6016 North Nina Ave</u> <u>Chicago</u> <u>60631</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 631-4856</u> <b>Fax #</b> <u>(773) 631-4850</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/24/1896</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> Limited Liability Co. _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. _____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																								
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Facility Name & ID Number Norwood Crossing

# 0012237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 N/A

	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	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	130	Sheltered Care (SC)	130	47,450	5
6		ICF/DD 16 or Less			6
7	261	TOTALS	261	95,265	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	14,440	15,719	13,429	43,588	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	11,677	13,052	120	24,849	12
13	DD 16 OR LESS					13
14	TOTALS	26,117	28,771	13,549	68,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.84%

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 4/24/1896

J. Was the facility purchased or leased after January 1, 1978? YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year? YES  NO  If YES, enter number of beds certified 131 and days of care provided 13,333

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

**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
	<b>A. General Services</b>										
1	Dietary	719,809	156,017		875,826		875,826		875,826		1
2	Food Purchase		642,437		642,437	(42,632)	599,805	(20,070)	579,735		2
3	Housekeeping	414,089	40,143	64	454,296		454,296		454,296		3
4	Laundry	51,498	36,290		87,788		87,788		87,788		4
5	Heat and Other Utilities			312,047	312,047		312,047	(2,996)	309,051		5
6	Maintenance	266,408	45,847	217,607	529,862		529,862	31,864	561,726		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,451,804	920,734	529,718	2,902,256	(42,632)	2,859,624	8,798	2,868,422		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	4,919,598	388,475	15,807	5,323,880		5,323,880		5,323,880		10
10a	Therapy										10a
11	Activities	238,069	121,880	2,832	362,781		362,781	(275)	362,506		11
12	Social Services	289,155	4,402	3,080	296,637		296,637		296,637		12
13	CNA Training										13
14	Program Transportation	51,398		26,913	78,311		78,311	(65,880)	12,431		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	5,498,220	514,757	66,632	6,079,609		6,079,609	(66,155)	6,013,454		16
	<b>C. General Administration</b>										
17	Administrative	178,511			178,511		178,511		178,511		17
18	Directors Fees										18
19	Professional Services			132,909	132,909		132,909	(21,662)	111,247		19
20	Dues, Fees, Subscriptions & Promotions			31,764	31,764		31,764	(4,842)	26,922		20
21	Clerical & General Office Expenses	141,674	58,857	981,465	1,181,996		1,181,996	(91,900)	1,090,096		21
22	Employee Benefits & Payroll Taxes			1,770,967	1,770,967	42,632	1,813,599		1,813,599		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,447	24,447		24,447	(375)	24,072		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			228,159	228,159		228,159		228,159		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	320,185	58,857	3,169,711	3,548,753	42,632	3,591,385	(118,779)	3,472,606		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	7,270,209	1,494,348	3,766,061	12,530,618		12,530,618	(176,136)	12,354,482		29

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

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

Facility Name &amp; ID Number

Norwood Crossing

#0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	
	<b>D. Ownership</b>											
30	Depreciation			1,420,332	1,420,332		1,420,332	(831,633)	588,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			499,667	499,667		499,667	(499,667)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			119,804	119,804		119,804	(19,071)	100,733			36
37	<b>TOTAL Ownership</b>			2,039,803	2,039,803		2,039,803	(1,350,371)	689,432			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		645,750	1,568,490	2,214,240		2,214,240		2,214,240			39
40	Barber and Beauty Shops	67,198	869		68,067		68,067		68,067			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			256,232	256,232		256,232		256,232			42
43	Other (specify):*	1,583,261	15,339	841,323	2,439,923		2,439,923	(2,439,923)				43
44	<b>TOTAL Special Cost Centers</b>	1,650,459	661,958	2,666,045	4,978,462		4,978,462	(2,439,923)	2,538,539			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,920,668	2,156,306	8,471,909	19,548,883		19,548,883	(3,966,430)	15,582,453			45

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

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning: 01/01/14

Ending: 12/31/14

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,070)	02		4
5	Telephone, TV & Radio in Resident Rooms	(25,360)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(831,633)	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		02		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				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				24
25	Fund Raising, Advertising and Promotional				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	(3,089,367)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (3,966,430)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (3,966,430)</b>		<b>37</b>

\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>						
48		49		50		51
						52

## Norwood Crossing

ID#	0012237
Report Period Beginning:	01/01/14
Ending:	12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Income	\$ (50,507)	14	1
2	Transport Escort Income	(15,373)	14	2
3	Flowers Expense	(3,367)	21	3
4	Regulatory Fee	(36,330)	21	4
5	Misc. Income	(13,683)	21	5
6	Utilities/Exp. - Other Properties	(2,996)	05	6
7	Marketing & Advertising Expense	(112,284)	43	7
8	Strength Training Income	(275)	11	8
9	Late Fee	(13,160)	21	9
10	Gain/Loss on Sale of Security	(243)	36	10
11	Gain/Loss on Asset Disposal	(2,909)	36	11
12	Interest Expense - Assisted Living Building	(499,667)	32	12
13	Annual Report	(1,170)	20	13
14	LSN Association Pac Dues	(3,672)	20	14
15	Non-Allowable Seminars	(375)	24	15
16	Non-Allowable Legal	(21,662)	19	16
17	Marketing Salaries	(136,980)	43	17
18				18
19	Amortization	(15,919)	36	19
20	Assisted Living Salaries	(1,446,281)	43	20
21	Assisted Living Other	(744,378)	43	21
22				22
23	Additional R&M	39,814	06	23
24	Capitalized R&M	(7,950)	06	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	<b>Total</b>		(3,089,367)	49

Norwood Crossing

ID# 0012237

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32



82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

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													1
2	Food Purchase	(20,070)											(20,070)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,996)											(2,996)	5
6	Maintenance	31,864											31,864	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>8,798</b>											<b>8,798</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(275)											(275)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(65,880)											(65,880)	14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(66,155)</b>											<b>(66,155)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(21,662)											(21,662)	19
20	Fees, Subscriptions & Promotions	(4,842)											(4,842)	20
21	Clerical & General Office Expenses	(91,900)											(91,900)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(375)											(375)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(118,779)</b>											<b>(118,779)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(176,136)</b>											<b>(176,136)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14 Ending:

12/31/14

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	(831,633)											(831,633)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(499,667)											(499,667)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(19,071)											(19,071)	36
37	<b>TOTAL Ownership</b>	<b>(1,350,371)</b>											<b>(1,350,371)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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													42
43	Other (specify):*	(2,439,923)											(2,439,923)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,439,923)</b>											<b>(2,439,923)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(3,966,430)</b>											<b>(3,966,430)</b>	<b>45</b>

**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
<a href="#">See Attached List of Board of Directors</a>						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								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	<b>Total</b>			\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

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 Norwood Crossing # 0012237 Report Period Beginning: 01/01/14 Ending: 12/31/14

## 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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts									11
12	anticipated to be considered allowable by the IL. Dept. of HFS.									12
13								TOTAL	\$	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 Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25



Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending: 12/31/14

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Lancaster Pollard/HUD		X	Construction of AL Building	\$91,235.22	7/12/12	\$ 21,056,300	\$ 19,919,957	7/2042	2.8900	\$ 499,667	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$91,235.22		\$ 21,056,300	\$ 19,919,957			\$ 499,667	9						
<b>B. Non-Facility Related*</b>																		
10	AL Bldg. Int Exp										(499,667)	10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(499,667)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 21,056,300	\$ 19,919,957			\$	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 100,733 Line # 36

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

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

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>															
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>															

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 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.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<b>FOR BHF USE ONLY</b>			
	2010 _____	9				
	2011 _____	10				
	2012 _____	11				
	2013 _____	12				
<b>Facility Does Not Pay Real Estate Taxes</b>			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norwood Crossing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
2.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
3.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
4.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
5.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
6.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
7.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
8.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
9.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
10.	<hr style="border-top: 1px solid black;"/>	<hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>	\$ <hr style="border-top: 1px solid black;"/>
		<b>TOTALS</b>	\$ <hr style="border-top: 3px double black;"/>	\$ <hr style="border-top: 3px double black;"/>

**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                 NO

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

C. **Tax Bills**

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

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





4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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             NO

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Norwood Crossing

# 0012237 Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 120,294 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 4

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).

Senior Network - Home Health Services  
Our Savior Lutheran Church  
Assisted Living

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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility	135,036	1896	\$ 20,781	1
2	Facility		2001-2004	2,117,692	2
3	TOTALS	135,036		\$ 2,138,473	3

**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	261	1909	1909	\$ 189,756	\$		\$	\$	\$	4
5		1924	1924	88,144						5
6		1951	1951	64,220						6
7		1960	1960	294,792						7
8		1977	1977	3,847,050			76,941	76,941	2,846,817	8
<b>Improvement Type**</b>										
9	Various		1961	23,225		20			23,225	9
10	Various		1977	22,408		20			22,408	10
11	Various		1981	6,841		20			6,841	11
12	Various		1982	35,128		20			35,128	12
13	Various		1983	12,709		20			12,709	13
14	Various		1984	55,806		20			55,806	14
15	Various		1985	33,294		20			33,294	15
16	Various		1986	1,534,833		20	53,850	53,850	1,461,236	16
17	Various		1987	106,916		20	1,358	1,358	86,554	17
18	Various		1988	15,515		20			15,515	18
19	Various		1989	133,867		20	3,534	3,534	80,859	19
20	Various		1990	2,330,763		20	77,774	77,774	1,905,692	20
21	Various		1991	39,209		20			39,209	21
22	Various		1992	82,154		20			82,154	22
23	Various		1993	19,043		20			19,043	23
24	Various		1994	35,404		20	55	55	34,581	24
25	Various		1995	375,378		20	15,685	15,685	298,037	25
26	Various		1996	39,775		20	2,094	2,094	39,251	26
27	Various		1997	139,091		20	7,061	7,061	123,256	27
28	Various		1998	224,763		20	11,526	11,526	190,195	28
29	Various		1999	2,960,943		20	38,490	38,490	623,787	29
30	Various		2000	111,011		20	5,893	5,893	102,684	30
31	Various		2001	106,994		20	5,466	5,466	76,528	31
32	Various		2002	86,585		20	5,611	5,611	72,954	32
33	Various		2003	264,995		20	13,294	13,294	165,126	33
34	Various		2004	84,815		20	4,241	4,241	47,060	34
35	Various		2005	32,032		20	1,676	1,676	16,764	35
36	Various		2006	16,069		20	826	826	7,430	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

**XI. OWNERSHIP COSTS (continued)**

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2007	\$ 33,012	\$	20	\$ 1,651	\$ 1,651	\$ 13,205	37
38	Various	2008	147,627		20	7,381	7,381	51,670	38
39	Various	2009	458,868		20	22,943	22,943	140,819	39
40	Various	2010	268,557		20	13,428	13,428	67,139	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F &amp; 12G)</u>								
68	<u>Related Party Allocations (Pages 12H &amp; 12I)</u>								
69	<u>Financial Statement Depreciation</u>								
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 14,321,592	\$ 1,420,332		\$ 370,778	\$ (1,049,554)	\$ 8,796,976	70

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

Facility Name &amp; ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 14,321,592	\$ 1,420,332		\$ 370,778	\$ (1,049,554)	\$ 8,796,976	1
2	Porch - Metal Rails, Stairs Painted	2011	3,800		20	190	190	760	2
3	Lobby Carpet	2011	3,497		20	175	175	699	3
4	3 Ptac Units For Nursing Bldg	2011	4,350		20	218	218	870	4
5	Elevator Door Operator	2011	6,339		20	317	317	1,268	5
6	Elevator Solid State Starter	2011	4,325		20	216	216	865	6
7	Chilled Water Coil - Lobby Unit	2011	5,225		20	261	261	1,045	7
8	Compressor	2011	13,540		20	677	677	2,708	8
9	Replacement Ptac - Nursing Building	2011	8,520		20	426	426	1,704	9
10	Condense Receiver Assembly	2011	6,950		20	348	348	1,390	10
11	Elevator Upgrade Required By City	2011	3,020		20	151	151	604	11
12	Windows In Chapel	2011	4,350		20	218	218	870	12
13	Wellness Center - Construction/Demolition (154,077)	2011	129,038		20	6,452	6,452	25,808	13
14	Wellness Center - Plumbing (12,642)	2011	10,588		20	632	632	2,528	14
15	Wellness Center - Alarms / Sprinklers (18,571)	2011	15,553		20	929	929	3,714	15
16	Wellness Center - Electrical / Lights (24,892)	2011	20,847		20	1,245	1,245	4,978	16
17	Wellness Center - Flooring (40,936)	2011	34,284		20	2,047	2,047	8,187	17
18	Wellness Center - Cabinets / Countertops (28,948)	2011	24,244		20	1,447	1,447	5,790	18
19	Attic Remodel - Carpenter & Electrical	2011	7,083		20	354	354	1,417	19
20	Attic Remodel For Storage	2011	3,214		20	161	161	643	20
21	Sprinkler Heads For Elevators & Electrical Room	2011	4,580		20	229	229	916	21
22	Chapel Conversion To Hr - Construction	2011	25,631		20	1,282	1,282	5,126	22
23	Chapel Conversion - Flooring & Cabinetry	2011	3,140		20	157	157	628	23
24	Flooring	2011	10,992		20	550	550	2,198	24
25	Solarium Cabinets & Countertop	2011	5,731		20	287	287	1,146	25
26	Chiller Repair	2011	7,827		20	391	391	1,565	26
27	Elevator Repairs	2011	10,971		20	549	549	2,194	27
28	Notifer Fire Alarm System Project	2012	138,837		20	6,942	6,942	20,826	28
29	Nina Porch & Stairs Railing	2012	4,917		20	246	246	737	29
30	Installation Of P-Trap And Riser Insulation For 160 Bathrooms A	2012	5,640		20	282	282	846	30
31	Handicap Switch Near Entrance (Inner Door)	2012	5,356		20	268	268	803	31
32	Nursing Building -07 Fire System Dampers	2012	5,600		20	280	280	840	32
33	Nursing Building Generator Replace Board	2012	5,100		20	510	510	1,530	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 14,864,682	\$ 1,420,332		\$ 399,211	\$ (1,021,121)	\$ 8,902,181	34

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

Facility Name &amp; ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 14,864,682	\$ 1,420,332		\$ 399,211	\$ (1,021,121)	\$ 8,902,181	1
2	Northcott Freight Elevator	2012	6,340		20	317	317	951	2
3	Chiller Northcott	2012	47,105		20	2,355	2,355	7,066	3
4	Nurses Building Stairs North And South	2012	10,300		20	1,030	1,030	3,090	4
5	Dietary Office	2012	6,508		20	651	651	1,952	5
6	Snf Renovation - Electrical, Floors, Alarms, Sprinklers, Wall Cove	2012	397,585		20	39,758	39,758	119,275	6
7	Nina Porches- Flooring And Door 2012	2012	4,259		20	426	426	1,278	7
8	Automatic Door Closers	2012	2,926		20	146	146	439	8
9	New Steam Traps For Boiler	2012	3,220		20	161	161	483	9
10	Condensate Receiver	2012	3,231		20	162	162	485	10
11	Kitchen Ceiling, Supplies, Sam'S Wages	2013	7,151		20	358	358	715	11
12	Nina/Northcott Repairs - Painting, Soffit And Gutters (13,170)	2013	8,692		20	435	435	869	12
13	Stucco Repairs	2013	2,650		20	133	133	265	13
14	Backsplash In Fyer Area	2013	2,650		20	133	133	265	14
15	Upgrade Sprinkler System In Kitchen	2013	3,117		20	156	156	312	15
16	Water Sealing/Soffit Repair, Inner Courtyard, Sam'S Wage	2013	11,503		20	575	575	1,150	16
17	Fire Doors Closers Nina Building	2013	10,217		20	511	511	1,022	17
18	Kitchen Floor	2013	3,000		20	150	150	300	18
19	Pepper House Roof	2013	3,729		20	186	186	373	19
20	Sprinkers Upgrade	2013	187,445		20	9,372	9,372	18,745	20
21	Elevator Furnish And Install New Gall Car Door, Operator & Doo	2013	15,856		20	793	793	1,586	21
22	1 Tub Snf 2Nd Floor Bathroom	2013	12,529		20	626	626	1,253	22
23	1 Tub- 4Th Floor	2013	13,025		20	651	651	1,302	23
24	1 Tub-4Th Floor	2013	13,025		20	651	651	1,302	24
25	Fire Alarm System Sheltered Care	2013	188,160		20	9,408	9,408	18,816	25
26	Replace Chiller Pump- Snf- By Admissions	2013	3,725		20	186	186	373	26
27	Furnish And Install Side Stream Filter For Chiller	2013	4,670		20	234	234	467	27
28	Penthouse Chiller	2013	4,670		20	234	234	467	28
29	25 Ptacs Units	2013	36,000		20	3,600	3,600	7,200	29
30	Boilers- Low Water Cut Off	2013	2,857		20	143	143	286	30
31	Return Pumps- Maint Shop	2013	6,430		20	322	322	643	31
32	Outdoor Signs- Main Entrance, Parking Lot Entrance, Digital Mar	2013	59,143		20	2,957	2,957	5,914	32
33	Asphalt Overlay- Parking Lot	2013	11,450		20	573	573	1,145	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,957,849	\$ 1,420,332		\$ 476,602	\$ (943,730)	\$ 9,101,970	34

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

Facility Name &amp; ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 15,957,849	\$ 1,420,332		\$ 476,602	\$ (943,730)	\$ 9,101,970	1
2	Wall Fans Sc Halls	2013	2,679		20	134	134	268	2
3	Cooler Repair	2013	3,055		20	153	153	306	3
4	Chiller Repair	2013	8,065		20	403	403	807	4
5	Bolier Repairs	2013	2,771		20	139	139	277	5
6	Hvac Repair	2013	3,027		20	151	151	303	6
7	Pm And Hvac Repairs	2013	2,572		20	129	129	257	7
8	Painting Of Common Areas And Various Residents Rooms	2013	3,596		20	180	180	360	8
9	Snf Bldg-Boiler Room Double Door -Furnished & Installed Door, I	2014	4,331		20	217	217	217	9
10	Snf - Ceiling Tiles	2014	3,981		20	199	199	199	10
11	Flooring Sc Rooms-149-,255,146 & 351,345,230,206	2014	13,324		20	666	666	666	11
12	2Nd & 3Rd Floor Nina Porch Ceiling	2014	2,650		20	133	133	133	12
13	Patching & Painting Due To Alarmn System Work	2014	5,493		20	275	275	275	13
14	Nina & Northcott Roof & Gutters	2014	5,050		20	253	253	253	14
15	Emergency Electrical Wiring	2014	3,340		20	167	167	167	15
16	Fire Alarm Panel Programming (Allocated)	2014	9,643		20	482	482	482	16
17	Admin Office-Demolish & Install New Drywall,Ceiling,Tiles	2014	4,540		20	227	227	227	17
18	22 Ptac Units	2014	33,730		20	1,687	1,687	1,687	18
19	Parking Lot Reconfigure - Rear Entrance (Allocated)	2014	3,300		20	165	165	165	19
20	Nina Elevador Upgrade	2014	99,612		20	4,981	4,981	4,981	20
21	Re Seal Kitchen Walls	2014	9,110		20	456	456	456	21
22	Snf Bldg - Move 28 Smoke Detectors Away From Air Vents	2014	8,250		20	413	413	413	22
23	Business Office - New Flooring, Ceiling Tiles And Lights,	2014			20				23
24	Remove & Replace Wall , Repair Drywall & Paint	2014	10,903		20	545	545	545	24
25	Concrete Replacement (Hud Site Visit) /Nina Courtyard /Sidewalk	2014	13,650		20	683	683	683	25
26	Replace Contactors In Dumb Waiter	2014	2,740		20	137	137	137	26
27	Penthouse Heat Exchager	2014	86,124		20	4,306	4,306	4,306	27
28	Railling And Enclosure For Penthouse Stairs	2014	10,439		20	522	522	522	28
29	Patient Stations	2014	2,602		20	130	130	130	29
30	Painting Of Common Areas And Resident Rooms	2014	5,348		20	267	267	267	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,321,775	\$ 1,420,332		\$ 494,799	\$ (925,533)	\$ 9,121,454	34

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

Facility Name & ID Number **Norwood Crossing**

# **0012237**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$ 16,321,775	\$ 1,420,332		\$ 494,799	\$ (925,533)	\$ 9,121,454	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	TOTAL (lines 1 thru 33)	\$ 16,321,775	\$ 1,420,332		\$ 494,799	\$ (925,533)	\$ 9,121,454	34

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



Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	<b>Totals from Page 12E, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number **Norwood Crossing**

# **0012237**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1		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	<b>Totals from Page 12F, Carried Forward</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

\*\*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	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number **Norwood Crossing**

# **0012237**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**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	<b>Totals from Page 12H, Carried Forward</b>		\$	\$		\$	\$	\$	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
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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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	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	\$ 260,647	\$	\$ 88,048	\$ 88,048	10	\$ 616,211	71
72	Current Year Purchases	58,522		5,852	5,852	10	5,852	72
73	Fully Depreciated Assets	2,783,691				10	2,783,691	73
74								74
75	TOTALS	\$ 3,102,860	\$	\$ 93,900	\$ 93,900		\$ 3,405,755	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		See Attached	various	\$ 83,123	\$	\$	\$	5	\$ 75,755	76
77		Town & Country Van	2008	14,118				5	14,118	77
78		Grand Caravan	2008	16,118				5	16,118	78
79		Bus - New Paint & NC Logo	2009	6,052				5	6,052	79
80	TOTALS			\$ 119,411	\$	\$	\$		\$ 112,043	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)	\$ 21,682,519	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,420,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 588,699	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (831,633)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,639,252	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	See Attached 2001 - 2009	\$ 26,855,322	\$	\$	86
87	Assisted Living - 2010	6,853			87
88	Wellness Center - AL - 2011	74,742			88
89	AL Roof Replacement - 2012	36,000			89
90	Non-Care Assets - 2013, 2014	91,475			90
91	TOTALS	\$ 27,064,392	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 Norwood Crossing # 0012237 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	690,992	\$		\$	690,992	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				105,932				105,932	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				770,083				770,083	4
5	Physician Care		visits									5
6	Dental Care	39 - 03	visits				1,483				1,483	6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>							645,750			645,750	13
14	TOTAL			\$		\$	1,568,490	\$	645,750	\$	2,214,240	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 Norwood Crossing# 0012237Report Period Beginning: 01/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,212,276	\$	1
2	Cash-Patient Deposits	1,385,043		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,699,948		3
4	Supply Inventory (priced at )	47,851		4
5	Short-Term Investments			5
6	Prepaid Insurance	186,519		6
7	Other Prepaid Expenses	154,909		7
8	Accounts Receivable (owners or related parties)	871,284		8
9	Other(specify):	443,684		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 7,001,514	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,433,406		13
14	Buildings, at Historical Cost	29,842,531		14
15	Leasehold Improvements, at Historical Cost	8,014,488		15
16	Equipment, at Historical Cost	4,764,583		16
17	Accumulated Depreciation (book methods)	(17,894,519)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	438,168		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 29,598,657	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 36,600,171	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 426,545	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,384,358		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	690,405		30
31	Accrued Taxes Payable (excluding real estate taxes)	99,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	36,167		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	1,027,066		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,664,447	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	19,919,957		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule	11,948,449		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 31,868,406	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 35,532,853	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,067,318	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 36,600,171	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (462,085)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	(3)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (462,088)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,529,406	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,529,406	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,067,318	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 23,173,138	1
2	Discounts and Allowances for all Levels	(7,345,386)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 15,827,752</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,761,716	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 3,761,716</b>	8
<b>C. Other Operating Revenue</b>			
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	57,488	13
14	Non-Patient Meals	20,070	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	503,271	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	23,644	20
21	Other Medical Services	746,050	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,350,523</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	138,298	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 138,298</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 21,078,289</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,902,256	31
32	Health Care	6,079,609	32
33	General Administration	3,548,753	33
<b>B. Capital Expense</b>			
34	Ownership	2,039,803	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,722,230	35
36	Provider Participation Fee	256,232	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 19,548,883</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,529,406</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,529,406</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,666,565	44
45	Private Pay - Net Inpatient Revenue	6,473,600	45
46	Medicare - Net Inpatient Revenue	2,717,269	46
47	Other-(specify) <u>Assisted Living</u>	4,093,815	47
48	Other-(specify) <u>Charity</u>	(123,497)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 15,827,752</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Norwood Crossing

# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	1,860	2,129	\$ 112,195	\$ 52.70	1
2	Assistant Director of Nursing	3,927	4,246	171,420	40.37	2
3	Registered Nurses	45,254	49,530	1,575,345	31.81	3
4	Licensed Practical Nurses	31,945	32,375	950,205	29.35	4
5	CNAs & Orderlies	136,541	149,782	2,110,433	14.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	15,595	17,075	238,069	13.94	10
11	Social Service Workers	10,431	11,445	289,155	25.27	11
12	Dietician	6,746	7,545	194,673	25.80	12
13	Food Service Supervisor					13
14	Head Cook	15,258	16,408	232,334	14.16	14
15	Cook Helpers/Assistants	27,486	29,398	292,802	9.96	15
16	Dishwashers					16
17	Maintenance Workers	11,290	12,432	266,408	21.43	17
18	Housekeepers	36,322	40,242	414,089	10.29	18
19	Laundry	4,137	4,742	51,498	10.86	19
20	Administrator	2,949	3,343	178,511	53.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,923	5,559	141,674	25.48	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) <u>See Supplemental</u>	78,022	85,359	1,701,857	19.94	33
34	TOTAL (lines 1 - 33)	432,684	471,609	\$ 8,920,668 *	\$ 18.92	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	\$		35
36	Medical Director	Monthly 18,000	09-03	36
37	Medical Records Consultant	89	10-03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	per occup bed 11,808	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	57	11-03	44
45	Social Service Consultant	44	12-03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	190 \$ 39,719		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

Facility Name & ID Number Norwood Crossing

# 0012237

Report Period Beginning: 01/01/14

Ending: 12/31/14

**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	
Silvia Morici	CEO	0	\$ 165,289	Workers' Compensation Insurance	\$ 241,315	IDPH License Fee	\$	
Catherine Kottl	Administrator	0	70,202	Unemployment Compensation Insurance	79,937	Advertising: Employee Recruitment	22,436	
Jessica Bartel	Administrator	0	63,798	FICA Taxes	571,055	Health Care Worker Background Check		
				Employee Health Insurance	690,783	(Indicate # of checks performed <u>171</u> )	2,555	
AL Allocations			(120,778)	Employee Meals	42,632	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,586	
				Employee Gifts/Christmas Expense	36,801	AL Allocations	(12,655)	
				401K Match	121,637			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 178,511	Employee Physicals	27,156			
(List each licensed administrator separately.)				Employee Assistance Program	2,283			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,813,599	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,922	
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
						\$	Out-of-State Travel	\$
C. Professional Services								
Vendor/Payee	Type		Amount				In-State Travel	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 54,539					
See Attached	Legal		28,460				Seminar Expense	24,072
Answers on Demand	Computer Services		16,916					
Provinet Solutions	Computer Services		44,884				Entertainment Expense	( )
Westcom Solutions	Computer Services		36,279				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 24,072
AL Allocations			(48,169)	TOTAL		\$		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 132,909					
(For legal fee disclosure, see page 39 of instructions)								

\* 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	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
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12												
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14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Norwood Crossing# 0012237

Report Period Beginning:

01/01/14

Ending:

12/31/14**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. LSN \$10,200, Leading Age \$3200
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 79,272 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 256,232  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes 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. \$ 42,632 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 20,070
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? Yes  
Firm Name: Frost, Ruttenberg & Rothblatt
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.