		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

I. IDPH License ID Number: 0012237

Facility Name: Norwood Crossing

Address: 6016 North Nina Avenue (Number) Chicago (City) 60631 (Zip Code)

County: Cook

Telephone Number: (773) 631-4856 **Fax #** (773) 631-4850

HFS ID Number:

Date of Initial License for Current Owners: 04/24/1896

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,746	12,930	10,106	40,782	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		10,326	9,584	19,910	12
13	DD 16 OR LESS					13
14	TOTALS	17,746	23,256	19,690	60,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.71%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/2/1896

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 10,106

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	892,829	215,752	41,788	1,150,369		1,150,369		1,150,369			1
2	Food Purchase		611,062		611,062	(45,406)	565,656	(16,518)	549,138			2
3	Housekeeping	462,522	39,359	403	502,284		502,284		502,284			3
4	Laundry		42,328	280	42,608		42,608		42,608			4
5	Heat and Other Utilities			335,374	335,374		335,374	(3,470)	331,904			5
6	Maintenance	314,240	24,802	226,340	565,382		565,382	34,497	599,879			6
7	Other (specify):*											7
8	TOTAL General Services	1,669,591	933,303	604,185	3,207,079	(45,406)	3,161,673	14,509	3,176,182			8
	B. Health Care and Programs											
9	Medical Director			40,003	40,003		40,003		40,003			9
10	Nursing and Medical Records	5,344,599	372,430	21,903	5,738,932		5,738,932	(602)	5,738,330			10
10a	Therapy											10a
11	Activities	215,711	132,717	4,867	353,295		353,295		353,295			11
12	Social Services	413,167	2,243	3,360	418,770		418,770		418,770			12
13	CNA Training											13
14	Program Transportation	47,264		17,544	64,808		64,808	(62,529)	2,279			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,020,741	507,390	87,677	6,615,808		6,615,808	(63,131)	6,552,677			16
	C. General Administration											
17	Administrative	188,391		907,402	1,095,793		1,095,793		1,095,793			17
18	Directors Fees											18
19	Professional Services			225,641	225,641		225,641	(9,891)	215,750			19
20	Dues, Fees, Subscriptions & Promotions			25,066	25,066		25,066	(3,374)	21,692			20
21	Clerical & General Office Expenses	199,669	66,088	156,698	422,455		422,455	(230,170)	192,285			21
22	Employee Benefits & Payroll Taxes			1,984,719	1,984,719	45,406	2,030,125		2,030,125			22
23	Inservice Training & Education											23
24	Travel and Seminar			38,486	38,486		38,486	(200)	38,286			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			325,542	325,542		325,542		325,542			26
27	Other (specify):*											27
28	TOTAL General Administration	388,060	66,088	3,663,554	4,117,702	45,406	4,163,108	(243,635)	3,919,473			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,078,392	1,506,781	4,355,416	13,940,589		13,940,589	(292,257)	13,648,332			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norwood Crossing #0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,798,369	1,798,369		1,798,369	(975,665)	822,704			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			545,283	545,283		545,283	(465,545)	79,738			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,755	9,755		9,755		9,755			35
36	Other (specify):*			153,084	153,084		153,084	(46,266)	106,818			36
37	**TOTAL Ownership**			2,506,491	2,506,491		2,506,491	(1,487,476)	1,019,015			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		426,472	1,218,328	1,644,800		1,644,800		1,644,800			39
40	Barber and Beauty Shops	66,447	1,868		68,315		68,315		68,315			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,981	257,981		257,981		257,981			42
43	Other (specify):*	1,890,531	10,756	1,186,552	3,087,839		3,087,839	(3,087,839)				43
44	**TOTAL Special Cost Centers**	1,956,978	439,096	2,662,861	5,058,935		5,058,935	(3,087,839)	1,971,096			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,035,370	1,945,877	9,524,768	21,506,015		21,506,015	(4,867,572)	16,638,443			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: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,518)	02		4
5	Telephone, TV & Radio in Resident Rooms	(23,672)	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	(975,665)	30		9
10	Interest and Other Investment Income	(4,027)	32		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	(3,847,690)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,867,572)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,867,572)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Norwood Crossing

ID# 0012237

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Income	$ (50,247)	14	1
2	Transport Escort Income	(12,282)	14	2
3	Flowers Expense	(5,779)	21	3
4	Regulatory Fee	(6,206)	21	4
5	Misc. Income	(2,680)	21	5
6	Utilities/Exp. - Other Properties	(3,470)	05	6
7	Marketing & Advertising Expense	(144,056)	43	7
8	Trips & Outings	(166)	43	8
9	Senior Center for City of Chicago	(93,740)	43	9
10	Late Fees	(17,229)	21	10
11	Gain/Loss on Asset Disposal	(24,939)	36	11
12	Year End Inter Co Transfers	(174,604)	21	12
13	Medical Records Income	(602)	10	13
14	Interest Expense - Assisted Living Building	(461,518)	32	14
15	PAC Dues	(3,374)	20	15
16	Marketing Seminar	(200)	24	16
17	Non-Allowable Legal	(9,891)	19	17
18	Marketing Salaries	(104,366)	43	18
19	Additional R&M	41,055	06	19
20	Capitalized R&M	(6,558)	06	20
21				21
22	Amortization	(21,327)	36	22
23	Assisted Living Salaries	(1,786,165)	43	23
24	Assisted Living Other	(959,347)	43	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,847,690)		49

Norwood Crossing

ID# 0012237

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norwood Crossing # 0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(16,518)											(16,518)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,470)											(3,470)	5
6	Maintenance	34,497											34,497	6
7	Other (specify):*													7
8	**TOTAL General Services**	14,509											14,509	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(602)											(602)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(62,529)											(62,529)	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(63,131)											(63,131)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(9,891)											(9,891)	19
20	Fees, Subscriptions & Promotions	(3,374)											(3,374)	20
21	Clerical & General Office Expenses	(230,170)											(230,170)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(200)											(200)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(243,635)											(243,635)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(292,257)											(292,257)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norwood Crossing **#** 0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(975,665)											(975,665)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(465,545)											(465,545)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(46,266)											(46,266)	36
37	**TOTAL Ownership**	(1,487,476)											(1,487,476)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,087,839)											(3,087,839)	43
44	**TOTAL Special Cost Centers**	(3,087,839)											(3,087,839)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,867,572)											(4,867,572)	45

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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
See Attached List of Board of Directors						

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	Total			$			$	$ *	14

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 907,402	Norwood Management Company		$ 907,402	$	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	Total			$ 907,402			$ 907,402	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Computer Services	$ 126,572	Parasol Alliance		$ 126,572	$	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	Total			$ 126,572			$ 126,572	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 935,845	Symbria, Inc		$ 935,845	$	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	Total			$ 935,845			$ 935,845	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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	Total			$			$	$ *	39

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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					Norwood Mangement Co	Chicago, IL	Management Co	1
2					Symbria, Inc	Warenville, IL	Therapy Company	2
3					Parasol Alliance	Chicago, IL	IT Support	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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: 01/01/17 Ending: 12/31/17

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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Norwood Management Company
Street Address: 6016 Norht Nina Avenue
City / State / Zip Code: Chicago, Il 60631
Phone Number: (
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Mangement Fees				$	$		$ 907,402	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					$	$		$ 907,402	25

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Parasol Allance
Street Address: 5620 N. Kedvale Ave
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773)219-2220
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Computer Services	Direct			$	$		$ 126,572	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					$	$		$ 126,572	25

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Symbria, Inc.
Street Address: 28100 Torch Parkway, Suite 600
City / State / Zip Code: Warrenville, IL 60555
Phone Number: (630)413-5832
Fax Number: (630)413-5801

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct			$	$		$ 935,845	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					$	$		$ 935,845	25

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lancaster Pollard/HUD		X	Construction of AL Building	$91,022.67	41102	$ 21,056,300	$ 18,359,020	7/2042	2.9800	$ 461,518	1
2	Lancaster Pollard/HUD		X	Expansion of SNF Dining Room	$11,165.71	42215	1,998,400	1,896,588	8/2042	4.4200	75,156	2
3												3
4												4
5												5
	Working Capital											
6	US Bank		X	Line of Credit	Int Only			500,000			8,609	6
7												7
8												8
9	TOTAL Facility Related				$102,188.38		$ 23,054,700	$ 20,755,608			$ 545,283	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,027)	10
11	AL Bldg. Int Exp		X								(461,518)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (465,545)	14
15	TOTALS (line 9+line14)						$ 23,054,700	$ 20,755,608			$ 79,738	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 106,818 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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

Facility Does Not Pay Real Estate Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2016 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	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	3,077,640	8
	Improvement Type**										
9	Various			1961	2,214		20			2,214	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			1984	55,806		20			55,806	13
14	Various			1985	2,531		20			33,294	14
15	Various			1986	1,532,833		20			1,532,833	15
16	Various			1987	106,916		20	1,358	1,358	90,626	16
17	Various			1988	15,515		20			15,515	17
18	Various			1989	108,918		20	3,534	3,534	66,512	18
19	Various			1990	2,301,596		20	77,774	77,774	2,109,847	19
20	Various			1991	10,636		20			10,636	20
21	Various			1992	37,016		20			37,016	21
22	Various			1993	1,100		20			1,100	22
23	Various			1994	35,404		20	55	55	34,745	23
24	Various			1995	367,498		20	15,685	15,685	337,212	24
25	Various			1996	32,783		20	172	172	34,331	25
26	Various			1997	124,571		20	3,238	3,238	126,096	26
27	Various			1998	224,763		20	11,526	11,526	224,773	27
28	Various			1999	2,953,811		20	38,490	38,490	732,125	28
29	Various			2000	93,561		20	3,443	3,443	96,415	29
30	Various			2001	106,994		20	5,466	5,466	92,927	30
31	Various			2002	59,708		20	5,611	5,611	65,990	31
32	Various			2003	51,421		20	13,223	13,223	203,937	32
33	Various			2004	82,869		20	4,241	4,241	58,617	33
34	Various			2005	26,114		20	1,676	1,676	18,554	34
35	Various			2006	12,485		20	826	826	7,125	35
36	Various			2007	23,043		20	1,651	1,651	8,715	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2008	$ 145,697	$	20	$ 7,285	$ 7,285	$ 72,849	37
38	Various	2009	403,231		20	22,075	22,075	188,149	38
39	Various	2010	172,980		20	12,948	12,948	26,434	39
40	Various	2011	318,625		20	19,647	19,647	121,308	40
41	Various	2012	619,381		20	53,534	53,534	321,203	41
42	Various	2013	587,393		20	31,171	31,171	155,857	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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			1,798,369			(1,798,369)		69
70	TOTAL (lines 4 thru 69)		$ 15,165,751	$ 1,798,369		$ 411,568	$ (1,386,801)	$ 10,024,777	70

**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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,165,751	$ 1,798,369		$ 411,568	$ (1,386,801)	$ 10,024,777	1
2	Snf Bldg-Boiler Room Double Door -Furnished & Installed Door,	2014	4,331		20	217	217	866	2
3	Snf - Ceiling Tiles	2014	3,981		20	199	199	796	3
4	Flooring Sc Rooms-149-,255,146 & 351,345,230,206	2014	3,551		20	666	666	2,665	4
5	2Nd & 3Rd Floor Nina Porch Ceiling	2014	2,650		20	133	133	530	5
6	Patching & Painting Due To Alarmn System Work	2014	5,493		20	275	275	1,099	6
7	Nina & Northcott Roof & Gutters	2014	5,050		20	253	253	1,010	7
8	Emergency Electrical Wiring	2014	3,340		20	167	167	668	8
9	Fire Alarm Panel Programming (Allocated)	2014	9,643		20	482	482	1,929	9
10	Admin Office-Demolish & Install New Drywall,Ceiling,Tiles	2014	4,540		20	227	227	908	10
11	22 Ptac Units	2014	33,730		20	1,687	1,687	6,746	11
12	Parking Lot Reconfigure - Rear Entrance (Allocated)	2014	3,300		20	165	165	660	12
13	Nina Elevador Upgrade	2014	99,612		20	4,981	4,981	19,922	13
14	Re Seal Kitchen Walls	2014	9,110		20	456	456	1,822	14
15	Snf Bldg - Move 28 Smoke Detectors Away From Air Vents	2014	8,250		20	413	413	1,650	15
16	Business Office - New Flooring, Ceiling Tiles And Lights,	2014			20				16
17	Remove & Replace Wall , Repair Drywall & Paint	2014	10,903		20	545	545	2,181	17
18	Concrete Replacement (Hud Site Visit) /Nina Courtyard /Sidewall	2014	13,650		20	683	683	2,730	18
19	Replace Contactors In Dumb Waiter	2014	2,740		20	137	137	548	19
20	Penthouse Heat Exchager	2014	86,124		20	4,306	4,306	17,225	20
21	Railling And Enclosure For Penthouse Stairs	2014	10,439		20	522	522	2,088	21
22	Patient Stations	2014	2,602		20	130	130	520	22
23	Painting Of Common Areas And Resident Rooms	2014	5,348		20	267	267	1,070	23
24	Flooring Sc Rooms-149-,255,146 & 351,345,230,206	2014	(3,551)		20				24
25	Dishwashing Room Floor	2015	4,600		20	460	460	1,380	25
26	Nursing Kidec	2015	42,165		20	4,217	4,217	12,650	26
27	Dish Room Hood - Pipe Replacement	2015	2,945		20	147	147	442	27
28	Snf Elevator Door Circuits	2015	5,305		20	265	265	796	28
29	Avenue Round 46& Gallon/ Mulligan Courtyard & Entrance.1/2	2015	2,862		20	143	143	429	29
30	Mulligan Courtyard Retaining Wall	2015	10,420		20	521	521	1,563	30
31	General Landscaping 2015 , Parking Lot, Front And Rear Entran	2015	10,035		20	502	502	1,505	31
32	Brandt Lobby Door	2015	2,745		20	137	137	412	32
33	2015 Dinning Room Expansion	2015	2,175,350		20	109,010	109,010	327,029	33
34	TOTAL (lines 1 thru 33)		$ 17,747,014	$ 1,798,369		$ 543,878	$ (1,254,491)	$ 10,438,615	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 17,747,014	$ 1,798,369		$ 543,878	$ (1,254,491)	$ 10,438,615	1
2	Landscaping 2015 Dr Expansion	2015	9,546		20	477	477	1,432	2
3	Security Cameras 2015 Dr Expansion	2015	5,019		20	251	251	753	3
4	Paint, Drywall Repairs 2015 Dr Expansion	2015	22,065		20	1,198	1,198	3,593	4
5	Flooring 2015 Dr Expansion	2015	76,319		20	3,975	3,975	11,926	5
6	Window Treatments 2015 Dr Expansion	2015	5,650		20	283	283	848	6
7	Penthouse Boiler Upgrade	2015	13,591		20	680	680	2,039	7
8	Penthouse Chiller Air Handler Coil	2015	6,891		20	345	345	1,034	8
9	Filters Housing For 3 Chillers	2015	9,444		20	472	472	1,417	9
10	Northcott Chiller	2015	4,088		20	204	204	613	10
11	Flooring Main Lobby	2015	7,163		20	358	358	1,074	11
12	Flooring Mulling Lobby	2015	7,163		20	358	358	1,074	12
13	Flooring Bandt Lobby	2015	7,163		20	358	358	1,074	13
14	Floor & Installation Admission Office	2015	4,954		20	248	248	743	14
15	Wander Guard System-Nursing	2015	95,641		20	4,782	4,782	14,346	15
16	Snf Roof	2015	31,950		20	1,598	1,598	4,793	16
17	Cameras Parking Lot Front	2015	8,357		20	418	418	1,254	17
18	Steam Coil Penthouse Heat Exchanger	2015	4,990		20	250	250	749	18
19	Sealcoating	2015	6,000		20	300	300	900	19
20	Transfer Swich Generator Notrhcott	2015	2,950		20	148	148	443	20
21	Lighting Retrofit	2015	21,465		20	1,073	1,073	3,220	21
22	Nurse Call System - Nursing	2015	14,047		20	702	702	2,107	22
23	Condensate Link In Link	2015	13,159		20	658	658	1,974	23
24	Nursing Offfices Hvac	2015	4,680		20	234	234	702	24
25	Hvac Loop /Northcott	2015	19,760		20	988	988	2,964	25
26	Le Office Windows	2015	4,950		20	248	248	743	26
27	Rear Entrance Awnings	2015	3,000		20	150	150	450	27
28	Siding - House	2015	8,040		20	402	402	1,206	28
29	Nursing Hvac Loop	2015	9,304		20	465	465	1,396	29
30	Replace Steam Valves	2015	2,778		20	139	139	417	30
31	Rapair Dry System	2015	3,504		20	175	175	526	31
32	Painting Of Common Areas And Resident Rooms	2015	4,367		20	218	218	655	32
33	Lobby Bathrooms - Tile, Fixtures & Reinforced Grab Bars	2016	13,317		20	666	666	1,332	33
34	TOTAL (lines 1 thru 33)		$ 18,198,330	$ 1,798,369		$ 566,698	$ (1,231,671)	$ 10,506,408	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 18,198,330	$ 1,798,369		$ 566,698	$ (1,231,671)	$ 10,506,408	1
2	Wireless Cabling Upgrade	2016	19,475		20	1,948	1,948	3,895	2
3	Network And Wifi Upgrade	2016	129,495		20	12,950	12,950	25,899	3
4	Telephone System , Cisco Conectors	2016	140,499		20	7,025	7,025	14,050	4
5	Fiber Run From Server Room To All Closets	2016	27,516		20	1,376	1,376	2,752	5
6	Nursing Boiler Ignition	2016	4,420		20	221	221	442	6
7	Steam Line Repalcement (Hall To Hr)	2016	6,280		20	314	314	628	7
8	Retubed The #1 And #2 Kewanee Boilers - Nursing Penthouse	2016	23,204		20	1,160	1,160	2,320	8
9	Shelt.Care Renovat.-Resident Rooms,Hvac System,Tub Room…	2016	814,446		20	40,722	40,722	81,445	9
10	Jed Rod Courtyard Drain	2016	2,555		20	128	128	256	10
11	Painting Of Common Areas And Resident Rooms	2016	3,146		20	157	157	315	11
12	Stain Doors And Hand Rails - Sheltered Care Area	2017	8,750		20	438	438	438	12
13	Nina Hot Water System	2017	3,971		20	199	199	199	13
14	Sheltered Care Halls Ceiling	2017	27,225		20	1,361	1,361	1,361	14
15	Sheltered Care Signage	2017	12,436		20	622	622	622	15
16	Sheltered Care Halls Paint And Touch Up	2017	5,983		20	299	299	299	16
17	Sheltered Care Halls Baseboard	2017	11,705		20	585	585	585	17
18	Pluming Pipe Replacement	2017	5,600		20	280	280	280	18
19	Solarium Windows	2017	39,686		20	1,984	1,984	1,984	19
20	Solarium Shades	2017	6,750		20	338	338	338	20
21	3Rd Floor Northcott Tub Room - Sc Renovation - New Flooring	2017			20				21
22	Tiling, Lights, Cabinets & Countertop,Custom Shower Door	2017	28,602		20	1,430	1,430	1,430	22
23	Sc Common Areas-Resident Dining Areas & Elevator Lobbies:	2017			20				23
24	Flooring,Lighting,Tiles,Food Prep Area, Cabinets, Countertops	2017	114,272		20	5,714	5,714	5,714	24
25	Tub - 1St Floor	2017	13,262		20	663	663	663	25
26	Booster Heater For Dw In Kitchen	2017	2,958		20	148	148	148	26
27	Tub 2Nd Floor Nursing	2017	13,253		20	663	663	663	27
28	Sheltered Care Halls Flooring	2017	74,902		20	3,745	3,745	3,745	28
29	Nhr Flooring	2017	12,528		20	626	626	626	29
30	Lines From Compressor To Valves And Pneumatic Compressor -N	2017	13,669		20	683	683	683	30
31	Replace 3 Way Chilled Water Valve And Actuator Insulate	2017	3,285		20	164	164	164	31
32	Boiler Nc Building	2017	3,670		20	184	184	184	32
33	Sc Chiller Water Pump	2017	3,861		20	193	193	193	33
34	TOTAL (lines 1 thru 33)		$ 19,775,734	$ 1,798,369		$ 653,017	$ (1,145,352)	$ 10,658,727	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 19,775,734	$ 1,798,369		$ 653,017	$ (1,145,352)	$ 10,658,727	1
2	Link Air Handler Coils	2017	5,990		20	300	300	300	2
3	Insulate Ac 3 Gate	2017	2,880		20	144	144	144	3
4	Nursing Penthouse-Rebuilt Rooftop Hvac Unit For Snf Building	2017	4,518		20	226	226	226	4
5	1St Floor Northcoott Tub Room - New Flooring, Tiling, Lights,	2017			20				5
6	Cabinets & Countertop, Shower Area	2017	34,587		20	1,729	1,729	1,729	6
7	Northcott Bldg Windows In Resident Rooms	2017	39,000		20	1,950	1,950	1,950	7
8	Rileys Plumming Replacement	2017	5,190		20	260	260	260	8
9	Landscaping Improvements	2017	4,300		20	215	215	215	9
10	Nursing Generator Tank	2017	5,449		20	272	272	272	10
11	Wanderguard Upgrade	2017	52,478		20	2,624	2,624	2,624	11
12	Wander Guard Upgrade	2017	8,655		20	433	433	433	12
13	Shelt.Care Renovat.-Resident Rooms,Hvac System,Tub Room…	2017	421,534		20	21,077	21,077	21,077	13
14	Painting Common Areas And Resident Rooms	2017	6,558		20	328	328	328	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)		$ 20,366,872	$ 1,798,369		$ 682,574	$ (1,115,795)	$ 10,688,284	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: 01/01/17 Ending: 12/31/17

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	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
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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	TOTAL (lines 1 thru 33)		$	$		$	$	$	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: 01/01/17 Ending: 12/31/17

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		$	$		$	$	$	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$	$		$	$	$	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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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)		$	$		$	$	$	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: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 442,527	$	$ 101,200	$ 101,200	10	$ 878,211	71
72	Current Year Purchases	144,853		14,485	14,485	10	14,485	72
73	Fully Depreciated Assets	2,673,563				10	2,673,563	73
74								74
75	TOTALS	$ 3,260,943	$	$ 115,685	$ 115,685		$ 3,566,259	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	1900	$ 119,411	$	$ 1,842	$ 1,842	5	$ 117,569	76
77		2015 WC Van / Ford E350 Van T	2015	66,570		13,314	13,314	5	39,942	77
78		2016 Ford Super Duty White	2016	46,449		9,290	9,290	5	18,580	78
79										79
80	TOTALS			$ 232,430	$	$ 24,446	$ 24,446		$ 176,091	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)	$ 25,998,718	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,798,369	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 822,704	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (975,665)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,430,634	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	Non-Care Assets 2001 - 2014	$ 27,061,877	$	$	86
87	Non-Care Assets - 2015	20,317			87
88	2016 Non-Care Assets - 2016	19,172			88
89	2017 Non-Care Assets - 2017	123,150			89
90					90
91	TOTALS	$ 27,224,516	$	$	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: 01/01/17 Ending: 12/31/17

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	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 9,755 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Norwood Crossing

STATE OF ILLINOIS
0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 458,016	$		$ 458,016	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			94,984			94,984	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			571,727			571,727	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			2,074			2,074	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				305,253		305,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					91,527	121,219		212,746	13
14	TOTAL			$		$ 1,218,328	$ 426,472		$ 1,644,800	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.

STATE OF ILLINOIS

Facility Name & ID Number Norwood Crossing **#** 0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,960	$	1
2	Cash-Patient Deposits	1,174,061		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,688,095		3
4	Supply Inventory (priced at)	53,470		4
5	Short-Term Investments			5
6	Prepaid Insurance	229,396		6
7	Other Prepaid Expenses	201,948		7
8	Accounts Receivable (owners or related parties)	1,464,809		8
9	Other(specify): See Attached Schedule	853,709		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,771,448	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,433,406		13
14	Buildings, at Historical Cost	34,357,230		14
15	Leasehold Improvements, at Historical Cost	7,047,253		15
16	Equipment, at Historical Cost	5,242,227		16
17	Accumulated Depreciation (book methods)	(21,718,719)		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): See Attached Schedule	2,277,764		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 31,639,161	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 38,410,609	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,039,489	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,163,952		28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	619,132		30
31	Accrued Taxes Payable (excluding real estate taxes)	134,622		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	44,976		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,103,641		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,605,812	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	20,255,608		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	12,939,508		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,195,116	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 37,800,928	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 609,681	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 38,410,609	$	48

***(See instructions.)**

Facility Name & ID Number Norwood Crossing **#** 0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,358,336	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,358,338	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(748,657)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (748,657)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 609,681	24 *

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 24,081,142	1
2	Discounts and Allowances for all Levels	(7,500,958)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,580,184	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,800,131	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,800,131	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	48,945	13
14	Non-Patient Meals	16,518	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	388,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,798	20
21	Other Medical Services	754,927	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,226,762	23
	D. Non-Operating Revenue		
24	Contributions	23,954	24
25	Interest and Other Investment Income***	4,027	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,981	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	122,300	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 122,300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 20,757,358	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,207,079	31
32	Health Care	6,615,808	32
33	General Administration	4,117,702	33
	B. Capital Expense		
34	Ownership	2,506,491	34
	C. Ancillary Expense		
35	Special Cost Centers	4,800,954	35
36	Provider Participation Fee	257,981	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,506,015	40
41	**Income before Income Taxes (line 30 minus line 40)****	(748,657)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (748,657)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,390,925	44
45	Private Pay - Net Inpatient Revenue	6,254,811	45
46	Medicare - Net Inpatient Revenue	2,378,675	46
47	Other-(specify) Assisted Living	4,741,223	47
48	Other-(specify) Charity	(185,450)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,580,184	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: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,235	2,559	$ 145,800	$ 56.97	1
2	Assistant Director of Nursing	3,130	3,385	147,139	43.47	2
3	Registered Nurses	45,749	50,072	1,717,964	34.31	3
4	Licensed Practical Nurses	29,887	30,288	957,100	31.60	4
5	CNAs & Orderlies	127,417	150,132	2,376,596	15.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,609	14,836	215,711	14.54	10
11	Social Service Workers	11,289	12,467	413,167	33.14	11
12	Dietician	7,601	8,771	271,103	30.91	12
13	Food Service Supervisor					13
14	Head Cook	17,211	18,853	279,782	14.84	14
15	Cook Helpers/Assistants	27,245	29,427	341,944	11.62	15
16	Dishwashers					16
17	Maintenance Workers	13,216	15,007	314,240	20.94	17
18	Housekeepers	47,094	35,200	462,522	13.14	18
19	Laundry					19
20	Administrator	2,336	2,607	188,391	72.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,250	11,211	199,669	17.81	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)	93,440	98,429	2,004,242	20.36	33
34	TOTAL (lines 1 - 33)	451,708	483,244	$ 10,035,370 *	$ 20.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Weekly	$ 41,788	01-03	35
36	Medical Director	Weekly	40,003	09-03	36
37	Medical Records Consultant	87	4,350	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per occup bed	17,553	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	95	4,867	11-03	44
45	Social Service Consultant	48	3,360	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	230	$ 111,921		49

C. CONTRACT NURSES

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Silvia Morici	CEO	0	$ 224,699
Catherine Kottl	Administrator	0	109,032
Jacinta McGee	Administrator	0	99,911
AL Allocations			(245,251)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 188,391

B. Administrative - Other

Description	Amount
Norwood Management Company - Management Fees	$ 907,402
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 907,402

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 61,902
See Attached	Legal	24,696
John Sterling Associates	OIG Exclusion Screening	2,800
Ability Network	MDS Review	1,771
Unempl. Tax Control Assoc	Unemployment Consult	8,360
Answers on Demand	Computer Services	23,194
Parasol Alliance	IT Support	126,572
Point Click Care	EHR & Billing Software	41,099
Careworx	Computer Services	1,176
E Health Data	UB & MDS Review Software	3,588
AL Allocations		(69,517)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 225,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 312,974
Unemployment Compensation Insurance	19,755
FICA Taxes	703,329
Employee Health Insurance	712,419
Employee Meals	45,406
Illinois Municipal Retirement Fund (IMRF)*	
Employee Gifts/Christmas Expense	37,226
401K Match	178,171
Employee Physicals	20,845
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,030,125

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,368
Health Care Worker Background Check	
(Indicate # of checks performed 66)	2,310
Patient Background Checks 218	1,910
Dues & Subscriptions	24,523
AL Allocations	(11,419)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,692

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	38,286
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 38,286

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Norwood Crossing # 0012237 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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. **Leading Age $21,085**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **68,860** 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. $ **257,981**
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. $ **45,406** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **16,518**

(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? **N/A**
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? **In Process**
Firm Name: **Marcum LLP**

(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