FOR BHF USE

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0012237

Facility Name: Norwood Crossing

Address: 6016 North Nina Ave (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: Deb Emerson **Telephone Number:** 317-569-6230
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 01/01/20 to 12/31/20 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) Bruce Harris
(Title) Senior Controller

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deb Emerson, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 317-574-9707

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: 01/01/20 Ending: 12/31/20

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	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	130	Sheltered Care (SC)	130	47,580	5
6		ICF/DD 16 or Less			6
7	261	TOTALS	261	95,526	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	15,929	12,866	8,681	37,476	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		10,456	10,871	21,327	12
13	DD 16 OR LESS					13
14	TOTALS	15,929	23,322	19,552	58,803	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.56%

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 8,681

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	862,429	239,063	409,318	1,510,810		1,510,810	(141,053)	1,369,757			1
2	Food Purchase		818,334		818,334	(50,880)	767,454	(179,703)	587,751			2
3	Housekeeping	353,494	75,007		428,501		428,501	(38,665)	389,836			3
4	Laundry		58,985		58,985		58,985	(12,832)	46,153			4
5	Heat and Other Utilities			480,258	480,258		480,258	(268,074)	212,184			5
6	Maintenance	234,452	106,636	553,610	894,698		894,698	(340,349)	554,349			6
7	Other (specify):*											7
8	TOTAL General Services	1,450,375	1,298,025	1,443,186	4,191,586	(50,880)	4,140,706	(980,676)	3,160,030			8
	B. Health Care and Programs											
9	Medical Director			56,058	56,058		56,058		56,058			9
10	Nursing and Medical Records	5,583,540	879,195	20,985	6,483,720		6,483,720		6,483,720			10
10a	Therapy											10a
11	Activities	303,051	7,342	53,945	364,338		364,338	(13,333)	351,005			11
12	Social Services	162,801	455	1,923	165,179		165,179	(517)	164,662			12
13	CNA Training											13
14	Program Transportation			12,453	12,453		12,453	(15,162)	(2,709)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,049,392	886,992	145,364	7,081,748		7,081,748	(29,012)	7,052,736			16
	C. General Administration											
17	Administrative	246,277		1,002,665	1,248,942		1,248,942	(218,126)	1,030,816			17
18	Directors Fees											18
19	Professional Services			305,845	305,845		305,845	(66,535)	239,310			19
20	Dues, Fees, Subscriptions & Promotions			105,859	105,859		105,859	(23,029)	82,830			20
21	Clerical & General Office Expenses	835,166	68,998	731,794	1,635,958		1,635,958	(234,850)	1,401,108			21
22	Employee Benefits & Payroll Taxes			2,123,306	2,123,306	50,880	2,174,186	(552,668)	1,621,518			22
23	Inservice Training & Education					17,507	17,507		17,507			23
24	Travel and Seminar			25,889	25,889	(17,507)	8,382	(1,823)	6,559			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			614,088	614,088		614,088	(133,592)	480,496			26
27	Other (specify):*											27
28	TOTAL General Administration	1,081,443	68,998	4,909,446	6,059,887	50,880	6,110,767	(1,230,623)	4,880,144			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,581,210	2,254,015	6,497,996	17,333,221		17,333,221	(2,240,311)	15,092,910			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: 01/01/20 Ending: 12/31/20

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			1,641,066	1,641,066		1,641,066	(774,540)	866,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			528,122	528,122		528,122	(433,312)	94,810			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Loan Amortization			117,007	117,007		117,007	(19,530)	97,477			36
37	**TOTAL Ownership**			2,286,195	2,286,195		2,286,195	(1,227,382)	1,058,813			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		535,222	1,172,797	1,708,019		1,708,019		1,708,019			39
40	Barber and Beauty Shops	74,346			74,346		74,346		74,346			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			243,970	243,970		243,970		243,970			42
43	Other (specify):* Marketing/AL	3,151,261	5,407	63,243	3,219,911		3,219,911	(3,219,911)				43
44	**TOTAL Special Cost Centers**	3,225,607	540,629	1,480,010	5,246,246		5,246,246	(3,219,911)	2,026,335			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	11,806,817	2,794,644	10,264,201	24,865,662		24,865,662	(6,687,604)	18,178,058			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: 01/01/20 Ending: 12/31/20

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,678)	2		4
5	Telephone, TV & Radio in Resident Rooms	(16,774)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(774,540)	30		9
10	Interest and Other Investment Income	(11,961)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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 See PG5A	(5,882,651)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,687,604)		$	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))**	$ (6,687,604)		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: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Income	$ (12,453)	14	1
2	Flowers Expense	(9,463)	21	2
3	Regulatory Fees	(3,099)	21	3
4	Late Fees	(27,403)	21	4
5	Telephone Billing	(20,676)	21	5
6	Utilities/Exp - Other Properties	(3,733)	5	6
7	Marketing Expense	(68,650)	43	7
8	Loan Fee Amortization	(19,530)	36	8
9	Interest Expense - Assisted Living Building	(421,351)	32	9
10	Marketing Salaries	(110,888)	43	10
11	AL Salaries	(3,040,373)	43	11
12	Non-SNF Dietary Costs	(141,053)	1	12
13	Non-SNF Food Purchases	(178,025)	2	13
14	Non-SNF Housekeeping	(38,665)	3	14
15	Non-SNF Laundry	(12,832)	4	15
16	Non-SNF Utilities	(247,567)	5	16
17	Non-SNF Maintenance	(340,349)	6	17
18	Non-SNF Activities	(13,333)	11	18
19	Non-SNF Social Services	(517)	12	19
20	Non-SNF Transportation	(2,709)	14	20
21	Non-SNF Administrative	(218,126)	17	21
22	Non-SNF Professional Fees	(66,535)	19	22
23	Non-SNF Dues, Fees, Subscriptions, & Promotions	(23,029)	20	23
24	Non-SNF Clerical & Office Expense	(174,209)	21	24
25	Non-SNF Employee Benefits	(552,668)	22	25
26	Non-SNF Travel & Seminar	(1,823)	24	26
27	Non-SNF Insurance	(133,592)	26	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**	(5,882,651)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(141,053)	0	0	0	0	0	0	0	0	0	0	(141,053)	1
2	Food Purchase	(179,703)	0	0	0	0	0	0	0	0	0	0	(179,703)	2
3	Housekeeping	(38,665)	0	0	0	0	0	0	0	0	0	0	(38,665)	3
4	Laundry	(12,832)	0	0	0	0	0	0	0	0	0	0	(12,832)	4
5	Heat and Other Utilities	(268,074)	0	0	0	0	0	0	0	0	0	0	(268,074)	5
6	Maintenance	(340,349)	0	0	0	0	0	0	0	0	0	0	(340,349)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(980,676)	0	0	0	0	0	0	0	0	0	0	(980,676)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,333)	0	0	0	0	0	0	0	0	0	0	(13,333)	11
12	Social Services	(517)	0	0	0	0	0	0	0	0	0	0	(517)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(15,162)	0	0	0	0	0	0	0	0	0	0	(15,162)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(29,012)	0	0	0	0	0	0	0	0	0	0	(29,012)	16
	C. General Administration													
17	Administrative	(218,126)	0	0	0	0	0	0	0	0	0	0	(218,126)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(66,535)	0	0	0	0	0	0	0	0	0	0	(66,535)	19
20	Fees, Subscriptions & Promotions	(23,029)	0	0	0	0	0	0	0	0	0	0	(23,029)	20
21	Clerical & General Office Expenses	(234,850)	0	0	0	0	0	0	0	0	0	0	(234,850)	21
22	Employee Benefits & Payroll Taxes	(552,668)	0	0	0	0	0	0	0	0	0	0	(552,668)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,823)	0	0	0	0	0	0	0	0	0	0	(1,823)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(133,592)	0	0	0	0	0	0	0	0	0	0	(133,592)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,230,623)	0	0	0	0	0	0	0	0	0	0	(1,230,623)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,240,311)	0	0	0	0	0	0	0	0	0	0	(2,240,311)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norwood Crossing **#** 0012237 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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	(774,540)	0	0	0	0	0	0	0	0	0	0	(774,540)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(433,312)	0	0	0	0	0	0	0	0	0	0	(433,312)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(19,530)	0	0	0	0	0	0	0	0	0	0	(19,530)	36
37	**TOTAL Ownership**	(1,227,382)	0	0	0	0	0	0	0	0	0	0	(1,227,382)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,219,911)	0	0	0	0	0	0	0	0	0	0	(3,219,911)	43
44	**TOTAL Special Cost Centers**	(3,219,911)	0	0	0	0	0	0	0	0	0	0	(3,219,911)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,687,604)	0	0	0	0	0	0	0	0	0	0	(6,687,604)	45

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
				Norwood Management	Chicago, IL	Management Co
				Parasol Alliance	Chicago, IL	IT Support
				Anderson Rasor	Chicago, IL	Legal
				Norwood Business Ven	Chicago, IL	Property Rental
				Quales Insurance	Chicago, IL	Insurance

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)	
1	V	17	Management Fees	$ 1,002,665	Norwood Management Company		$ 1,002,665	$	1
2	V	19	Computer Services	115,069	Parasol Alliance		115,069		2
3	V	19	Legal	73,637	Anderson Rasor		73,637		3
4	V	26	Insurance	506,579	Quales Insurance		506,579		4
5	V	5	Space Rental-COVID	40,000	Norwood Business Ventures		40,000		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			$ 1,737,950			$ 1,737,950	$ *	14

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Michele Calbi	BOD						1
2	Susan Kroll	BOD						2
3	Dirk Danker	BOD						3
4	Ingrid Forsberg	BOD						4
5	Ron Norene	BOD						5
6	Maria Gabriela Rodil	BOD						6
7	Mike Shaik	BOD						7
8	Suzanne Venema	BOD						8
9	Michael Toohey	BOD						9
10	Silvia Morici	BOD						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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD/Lument		X	Consturction of AL Building	$82,979.06	7/12/12	$ 21,056,300	$ 16,677,649	8/1/42	2.4800	$ 421,351	1
2	HUD/Lument		X	Expansion of SNF Dining Room	$10,006.44	7/30/15	1,998,400	1,751,253	8/1/42	4.4200	69,725	2
3												3
4												4
5												5
	Working Capital											
6	US Bank		X	Line of Credit	Int Only			735,418			33,991	6
7	Symbria		X								3,055	7
8												8
9	TOTAL Facility Related				$92,985.50		$ 23,054,700	$ 19,164,320			$ 528,122	9
	B. Non-Facility Related*											
10	ALBuilding Interest Expense		X								(421,351)	10
11	Interest Income		X								(11,961)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (433,312)	14
15	TOTALS (line 9+line14)						$ 23,054,700	$ 19,164,320			$ 94,810	15

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

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

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norwood Crossing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012237

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 125,229 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
Assisted Living (55 beds)
Norwood Business Ventures
Norwood Lifecare Foundation

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: 01/01/20 Ending: 12/31/20

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	3,308,463	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			2,531	14
15	Various			1986	1,532,833		20			1,532,833	15
16	Various			1987	106,916		20	1,358	1,358	94,699	16
17	Various			1988	15,515		20			15,515	17
18	Various			1989	108,918		20	3,534	3,534	77,114	18
19	Various			1990	2,301,596		20	36,201	36,201	2,301,596	19
20	Various			1991	10,636		20			10,636	20
21	Various			1992	11,242		20			11,242	21
22	Various			1993	1,100		20			1,100	22
23	Various			1994	35,404		20	55	55	34,910	23
24	Various			1995	367,498		20	15,685	15,685	341,549	24
25	Various			1996	32,783		20	172	172	31,232	25
26	Various			1997	124,571		20	47	47	124,150	26
27	Various			1998	65,763		20	67	67	65,763	27
28	Various			1999	2,942,096		20	38,490	38,490	829,921	28
29	Various			2000	93,561		20	28	28	93,561	29
30	Various			2001	106,994		20	5,466	5,466	106,994	30
31	Various			2002	59,708		20	5,611	5,611	54,103	31
32	Various			2003	51,421		20	13,223	13,223	30,565	32
33	Various			2004	82,869		20	4,241	4,241	70,559	33
34	Various			2005	24,065		20	1,574	1,574	15,720	34
35	Various			2006	12,485		20	826	826	8,358	35
36	Various			2007	23,043		20	1,651	1,651	13,140	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: 01/01/20 Ending: 12/31/20

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	$ 94,703	37
38	Various	2009	403,231		20	22,075	22,075	229,667	38
39	Various	2010	172,980		20	12,948	12,948	62,167	39
40	Various	2011	318,625		20	19,574	19,574	180,030	40
41	Various	2012	619,381		20	53,534	53,534	481,805	41
42	Various	2013	587,393		20	31,171	31,171	249,371	42
43	Various	2014	317,790		20	16,462	16,462	113,913	43
44	Various	2015	2,680,379		20	137,556	137,556	811,287	44
45	Various	2016	1,294,079		20	72,599	72,599	358,018	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,259,462	$		$ 578,374	$ 578,374	$ 11,879,612	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: 01/01/20 Ending: 12/31/20

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		$ 19,259,462	$		$ 578,374	$ 578,374	$ 11,879,612	1
2	Stain doors and hand rails - sheltered care area	2017	8,750		20	438	438	1,751	2
3	Nina Hot Water System	2017	3,971		20	199	199	795	3
4	Sheltered Care Halls - paint and touch up	2017	5,983		20	299	299	1,196	4
5	Sheltered Care Halls Baseboard	2017	9,268		20	463	463	2,097	5
6	Plumbing Pipe replacement	2017	5,600		20	280	280	1,120	6
7	Solarium Windows	2017	39,686		20	1,984	1,984	7,937	7
8	Solarium Shades	2017	6,750		20	338	338	1,351	8
9	3rd Floor Northcott Tub Room - SC Renovation - New Flooring	2017			20				9
10	Tiling, Lights, Cabinets & Countertop, Custom Shower	2017	23,335		20	1,167	1,167	5,194	10
11	SC Common Areas-Resident Dining Areas & Elevator Lobbies	2017			20				11
12	Flooring, Lighting, Tiles, Food Prep, Cabinets, Countertops	2017	105,900		20	5,295	5,295	22,017	12
13	NHR Flooring	2017	12,528		20	626	626	2,505	13
14	Replace 3 Way Chilled Water Valave and Actuator Insulate	2017	3,285		20	164	164	657	14
15	Boiler NC Building	2017	3,670		20	184	184	735	15
16	SC Chiller Water Pump	2017	3,861		20	193	193	772	16
17	Link Air Handler Coils	2017	5,990		20	300	300	1,199	17
18	Insulate AC 3 Gate	2017	2,880		20	144	144	576	18
19	Nursing Penthouse-Rebuilt Rooftop HVAC Unit for SNF	2017	4,518		20	226	226	904	19
20	1st Floor Northcott Tub Room - New Flooring, Tiling, Lights	2017			20				20
21	Cabinets & Countertop, Shower area	2017	29,320		20	1,466	1,466	6,392	21
22	Northcott Bldg Windows in resident rooms	2017	39,000		20	1,950	1,950	7,800	22
23	Rileys Plumbing replacement	2017	5,190		20	260	260	1,039	23
24	Landscaping Improvements	2017	4,300		20	215	215	860	24
25	Nursing Generator Tank	2017	5,449		20	272	272	1,089	25
26	Wanderguard Upgrade	2017	52,478		20	2,624	2,624	10,496	26
27	Wanderguard Upgrade	2017	8,655		20	433	433	1,731	27
28	SC Reno - Resident Rooms, HVAC system, Tub Room	2017	421,534		20	21,077	21,077	84,307	28
29	Painting Common Areas and Resident Rooms	2017	6,558		20	328	328	1,312	29
30	Installed New Compressor/Pipe - Kitchen Cooler	2018	2,954		20	148	148	296	30
31	Repaired Elevator Door Edge SC Common Area	2018	3,397		20	170	170	340	31
32	Installed Kitchen Garbage Disposal	2018	2,921		20	146	146	292	32
33	Riley's Diner Reno - Stainless Steel Counter	2018	17,576		20	879	879	1,758	33
34	TOTAL (lines 1 thru 33)		$ 20,104,769	$		$ 620,642	$ 620,642	$ 12,048,130	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: 01/01/20 Ending: 12/31/20

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		$ 20,104,769	$		$ 620,642	$ 620,642	$ 12,048,130	1
2	Installed Booster Heater	2018	3,750		20	188	188	376	2
3	Mulligan Lobby Reno - Flooring, Electric Work	2018	5,915		20	296	296	592	3
4	Repaired SNF HVAC Unit Valves	2018	6,771		20	339	339	678	4
5	Irrigation System Upgrade	2018	40,800		20	2,040	2,040	4,080	5
6	Penthouse - Replace Compressor and hi pressure control	2018	8,693		20	435	435	870	6
7	Penthouse - Boiler - Install Skimmer Valve	2018	5,205		20	260	260	520	7
8	Sprinkler System Valves	2018	2,650		20	133	133	266	8
9	Penthouse Relay and Tubuing Air Handling Unit Repair	2018	3,040		20	152	152	304	9
10	Penthouse Expansion Tank - North Side	2018	3,153		20	185	185	370	10
11	Hot Water Store Tank Leak Repair	2018	14,414		20	721	721	1,442	11
12	Wellness Center Flooring	2018	9,668		20	483	483	966	12
13	HVAC #4 Repair	2018	5,088		20	254	254	508	13
14	Wellness - Carpet Install	2018	4,490		20	225	225	450	14
15	Roof Soffits - SC Building	2018	26,280		20	1,314	1,314	2,628	15
16	Replace Leaking Tube in Kawanee Boiler	2018	2,505		20	125	125	250	16
17	Repaired Generator - Electrice Work/Amps/Cable - Basement	2018	18,920		20	946	946	1,892	17
18	Repaired Elevator	2018	203,122		20	10,156	10,156	20,312	18
19	Installed Nurse Call System/Elec Work SNF & SC	2018	156,565		20	7,828	7,828	15,656	19
20	Nurse Call System - SNF & SC	2018	54,806		20	2,740	2,740	5,480	20
21	Install New Transformer/Electrical/Lighting-Nurse Call Syst	2018	3,156		20	158	158	316	21
22	SC Common Area - Flooring/Patching/Paint/Railings	2018	4,550		20	228	228	456	22
23	Repair AH in Courtyard - Bad Bearings	2019	2,504		20	125	125	250	23
24	Penthouse Boiler Lear Repair	2019	2,780		20	139	139	278	24
25	Replace Bladder in Expansion Tank for Domestic Water	2019	2,985		20	149	149	298	25
26	North Penthouse Boiler Valve Repair	2019	3,111		20	156	156	312	26
27	South Boiler Room Door Repair	2019	3,397		20	170	170	340	27
28	North Roof Boiler Rm Door Repair	2019	3,397		20	170	170	340	28
29	Air Handler Valve Installation - AC	2019	3,516		20	176	176	352	29
30	Repair Penthouse Boiler Pumps	2019	4,855		20	243	243	486	30
31	Replace Stem Coil in Air Handler #6	2019	7,214		20	361	361	722	31
32	Install cabinets - day rooms 1st, 2nd 3rd floors	2019	8,150		20	408	408	816	32
33	Elevator - coil replacement	2019	8,342		20	417	417	834	33
34	TOTAL (lines 1 thru 33)		$ 20,738,561	$		$ 652,362	$ 652,362	$ 12,111,570	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: 01/01/20 Ending: 12/31/20

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		$ 20,738,561	$		$ 652,362	$ 652,362	$ 12,111,570	1
2	Repair Leaking pipes on boilers in Penthouse	2019	8,503		20	425	425	850	2
3	Replace Chilled Water Coil in AH #6	2019	8,704		20	435	435	870	3
4	Elevator Repair - Fire Service Upgrade	2019	10,891		20	545	545	1,090	4
5	Main Building - Top flat roof limestone wall coping	2019	12,078		20	604	604	1,208	5
6	Plumbing work - 2 Hand Was Sinks	2019	13,400		20	670	670	1,340	6
7	Install Gas Pressure Regulators for 2 PSI Gas	2019	20,670		20	1,034	1,034	2,068	7
8	Main Building (S. Penhouse Area) New Roof Install	2019	42,065		20	2,103	2,103	4,206	8
9	Install New Domestic Water Heater	2019	45,963		20	2,298	2,298	4,596	9
10	Install 130 Windows - Main Building	2019	71,805		20	3,590	3,590	7,180	10
11	Brandt Lobby Elevator Upgrade	2019	154,254		20	7,713	7,713	15,426	11
12	Hot Water Tank, AC, Storage Tank Repairs	2019	3,740		20	187	187	374	12
13	Elevator- Northcott Coil Replaceme	2020	4,572		20	419	419	419	13
14	Pent House Misc Repair	2020	1,044		20	174	174	174	14
15	New Rudd Heater -Main Kitchen Sink	2020	3,800		20	633	633	633	15
16	Penthouse N Chiller - Roof	2020	1,373		20	183	183	183	16
17	Northcoff - Replace coil on chille	2020	9,276		20	618	618	618	17
18	Camera Replacement- MS	2020	2,154		20	126	126	126	18
19	Replace Bearing Assemble & Pumps	2020	3,098		20	155	155	155	19
20	Replace Exhaust Fan -Northcott	2020	2,230		20	186	186	186	20
21	Replace Control Valve for Steam Co	2020	1,270		20	106	106	106	21
22	Replace Steam Valve	2020	1,511		20	126	126	126	22
23	B&G 100 AB Circulator	2020	1,045		20	58	58	58	23
24	Replace1-1/2 PRV & 2-1/2 Globe Vol	2020	2,305		20	77	77	77	24
25	New Jockey Controller(Pump Room)	2020	2,961		20	99	99	99	25
26	Replace antifreeze in 2 systems(Pu	2020	3,850		20	128	128	128	26
27	Replace Gauges- Pump Room	2020	2,200		20	73	73	73	27
28	Room 335- HVC & AC Repair	2020	5,769		20	48	48	48	28
29	Elevator Repair	2020	4,638		20				29
30	Replace 3 Way Valve 1st Norcott bu	2020	1,040		20				30
31	Install Valve on hot water-Pent Ho	2020	3,250		20				31
32	New Carpet Installation	2020	2,120		20				32
33	Voltage Project-flooring/audio/vid	2020	858		20				33
34	TOTAL (lines 1 thru 33)		$ 21,190,996	$		$ 675,175	$ 675,175	$ 12,153,987	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: 01/01/20 Ending: 12/31/20

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		$ 21,190,996	$		$ 675,175	$ 675,175	$ 12,153,987	1
2									2
3									3
4									4
5	Financial Statement Depreciation			1,641,066			(1,641,066)		5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 21,190,996	$ 1,641,066		$ 675,175	$ (965,891)	$ 12,153,987	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: 01/01/20 Ending: 12/31/20

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	$ 1,410,316	$	$ 156,541	$ 156,541	10	$ 862,682	71
72	Current Year Purchases	133,976		15,903	15,903	10	15,903	72
73	Fully Depreciated Assets	2,131,485					2,131,485	73
74								74
75	TOTALS	$ 3,675,777	$	$ 172,444	$ 172,444		$ 3,010,070	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 Listing		Various	$ 304,871	$	$ 18,907	$ 18,907	5	$ 241,047	76
77										77
78										78
79										79
80	TOTALS			$ 304,871	$	$ 18,907	$ 18,907		$ 241,047	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)	$ 27,310,117	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,641,066	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 866,526	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (774,540)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,405,104	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 (AL)	$ 27,298,763	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 27,298,763	$	$	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: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 106,096 Description: See Attached
(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: 01/01/20 Ending: 12/31/20

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 401,255	$		$ 401,255	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			142,857			142,857	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			418,162			418,162	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				298,059		298,059	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound, Lab, Xray, Etc	39-2					237,163		237,163	12
13	Other (specify): DME, Lab, Xray, Othe	39-3				210,523			210,523	13
14	TOTAL			$		$ 1,172,797	$ 535,222		$ 1,708,019	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:** 01/01/20 **Ending:** 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/20 **(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	$ 2,939,003	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,759,608)	2,017,161		3
4	Supply Inventory (priced at)	61,064		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,494		6
7	Other Prepaid Expenses	131,292		7
8	Accounts Receivable (owners or related parties)	(7,633,759)		8
9	Other(specify): See Attached Schedule	1,050,413		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,399,332)	$	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	35,300,881		14
15	Leasehold Improvements, at Historical Cost	7,166,814		15
16	Equipment, at Historical Cost	5,166,457		16
17	Accumulated Depreciation (book methods)	(26,600,971)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,466,587	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,067,255	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 875,754	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	925,740		28
29	Short-Term Notes Payable	1,376,586		29
30	Accrued Salaries Payable	826,089		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,803		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	40,940		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Revenue	1,798,468		36
37	See Attached Schedule	2,400,101		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,272,481	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	17,322,479		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 17,322,479	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 25,594,960	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,527,705)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,067,255	$	48

***(See instructions.)**

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (527,914)	1
2	Restatements (describe):		2
3	Intercompany Transfers	(438,262)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (966,176)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(561,524)	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) Rounding	(5)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (561,529)	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)**	$ (1,527,705)	24 *

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 24,121,471	1
2	Discounts and Allowances for all Levels	(7,104,396)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,017,075	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,096,279	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,096,279	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	10,673	13
14	Non-Patient Meals	1,678	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	350,963	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,875	20
21	Other Medical Services	955,630	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,338,819	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,961	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,961	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule	221,795	28
28a	COVID-19 PHE Funding	3,618,209	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,840,004	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 24,304,138	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,191,586	31
32	Health Care	7,081,748	32
33	General Administration	6,059,887	33
	B. Capital Expense		
34	Ownership	2,286,195	34
	C. Ancillary Expense		
35	Special Cost Centers	5,002,276	35
36	Provider Participation Fee	243,970	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 24,865,662	40
41	**Income before Income Taxes (line 30 minus line 40)****	(561,524)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (561,524)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,402,494	44
45	Private Pay - Net Inpatient Revenue	6,243,636	45
46	Medicare - Net Inpatient Revenue	2,980,292	46
47	Other-(specify) Assisted Living	4,569,735	47
48	Other-(specify) Charity	(179,082)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,017,075	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: 01/01/20 Ending: 12/31/20

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	1,950	1,950	$ 98,354	$ 50.44	1
2	Assistant Director of Nursing	3,434	3,434	140,952	41.05	2
3	Registered Nurses	92,430	92,430	3,389,914	36.68	3
4	Licensed Practical Nurses	7,711	7,711	274,225	35.56	4
5	CNAs & Orderlies	165,896	165,896	3,232,486	19.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,025	2,025	46,273	22.85	9
10	Activity Assistants	20,932	20,932	341,035	16.29	10
11	Social Service Workers	8,447	8,447	208,065	24.63	11
12	Dietician					12
13	Food Service Supervisor	1,950	1,950	67,204	34.46	13
14	Head Cook	25,748	25,748	445,573	17.31	14
15	Cook Helpers/Assistants	46,861	46,861	689,257	14.71	15
16	Dishwashers					16
17	Maintenance Workers	19,826	19,826	483,892	24.41	17
18	Housekeepers	41,436	41,436	729,588	17.61	18
19	Laundry	1,980	1,980	28,077	14.18	19
20	Administrator	5,460	5,460	246,277	45.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,784	22,784	1,039,291	45.61	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) Other	8,080	8,080	346,354	42.87	33
34	TOTAL (lines 1 - 33)	476,950	476,950	$ 11,806,817 *	$ 24.75	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	Monthly	$ 50,277	01-3	35
36	Medical Director	Weekly	56,058	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Per Occ Bed	20,075	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,452	11-3	44
45	Social Service Consultant	21	1,120	12-3	45
46	Other(specify)	1	150	43-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	51	$ 129,132		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: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jon Ragsdale	Administrator	0	$ 123,006
Jacinta McGee	Administrator	0	123,271
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 246,277

B. Administrative - Other

Description	Amount
Norwood Management Fees	$ 1,002,665
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,002,665

C. Professional Services

Vendor/Payee	Type	Amount
CLA	Accounting	$ 3,937
Anderson Rasor	Legal	73,637
Ira N. Helfgot	Legal	624
Pathway Health	Consulting	39,588
John Sterling	Compliance Screening	1,900
O'Hagen Meyer LLC	Legal	5,064
Parasol Alliance	IT Support	115,069
PamSki Solutions	Consulting	775
Marcum LLP	Accounting	65,251
Less AL/Mktg Allocation		(66,535)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 239,310

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,028
Unemployment Compensation Insurance	35,514
FICA Taxes	862,046
Employee Health Insurance	781,357
Employee Meals	50,880
Illinois Municipal Retirement Fund (IMRF)*	
Employee Gifts/Christmas Exp	14,061
401K Match	230,372
Employee Physicals	19,981
Tuition Reimbursement	2,925
Uniforms	3,022
Less AL/Mktg Allocation	(552,668)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,621,518

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	62,287
Health Care Worker Background Check	
(Indicate # of checks performed 44)	5,235
Patient Background Checks 193	1,930
Dues & Subscriptions	36,407
Less AL/Mktg Allocation	(23,029)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,830

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,382
Less AL/Mktg Allocation	(1,823)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,559

**See instructions.

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LeadingAge - $22,331**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **97,967** 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. $ **243,970**
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. $ **50,880** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,678**

(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**
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? **Yes**
Firm Name: **CLA - CliftonLarsonAllen LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.