

Facility Name & ID Number Norwood Crossing

0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>131</u>	Skilled (SNF)	<u>131</u>	<u>47,815</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>130</u>	Sheltered Care (SC)	<u>130</u>	<u>47,450</u>	5
6		ICF/DD 16 or Less			6
7	<u>261</u>	TOTALS	<u>261</u>	<u>95,265</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,212</u>	<u>17,187</u>	<u>11,968</u>	<u>38,367</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>2,519</u>	<u>15,861</u>		<u>18,380</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,731</u>	<u>33,048</u>	<u>11,968</u>	<u>56,747</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.57%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/24/1896

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 131 and days of care provided 11,968

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/13/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	880,792	114,556	53,436	1,048,784		1,048,784		1,048,784		1
2	Food Purchase		444,276		444,276	(35,040)	409,236	(4,843)	404,393		2
3	Housekeeping	277,149	2		277,151		277,151		277,151		3
4	Laundry	142,138	14,381		156,519		156,519		156,519		4
5	Heat and Other Utilities			404,218	404,218		404,218	(898)	403,320		5
6	Maintenance	192,760	30,985	610,347	834,092		834,092	49,892	883,984		6
7	Other (specify):*										7
8	TOTAL General Services	1,492,839	604,200	1,068,001	3,165,040	(35,040)	3,130,000	44,151	3,174,151		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	4,304,831	260,507	28,013	4,593,351		4,593,351		4,593,351		10
10a	Therapy										10a
11	Activities	300,109	65,989	2,384	368,482		368,482	(205)	368,277		11
12	Social Services	198,942	1,984	2,860	203,786		203,786		203,786		12
13	CNA Training										13
14	Program Transportation	25,088		9,389	34,477		34,477	(34,477)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,828,970	328,480	60,646	5,218,096		5,218,096	(34,682)	5,183,414		16
	C. General Administration										
17	Administrative	108,015		446	108,461		108,461		108,461		17
18	Directors Fees										18
19	Professional Services			77,658	77,658		77,658		77,658		19
20	Dues, Fees, Subscriptions & Promotions			40,341	40,341		40,341	(9,856)	30,485		20
21	Clerical & General Office Expenses	190,683	32,134	238,086	460,903		460,903	(59,561)	401,342		21
22	Employee Benefits & Payroll Taxes			1,405,577	1,405,577	35,040	1,440,617		1,440,617		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,292	21,292		21,292	(2,310)	18,982		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			267,531	267,531		267,531		267,531		26
27	Other (specify):*										27
28	TOTAL General Administration	298,698	32,134	2,050,931	2,381,763	35,040	2,416,803	(71,727)	2,345,076		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,620,507	964,814	3,179,578	10,764,899		10,764,899	(62,258)	10,702,641		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,009,394	1,009,394		1,009,394	(407,089)	602,305			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,875,546	1,875,546		1,875,546	(760,488)	1,115,058			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			128,006	128,006		128,006		128,006			36
37	TOTAL Ownership			3,012,946	3,012,946		3,012,946	(1,167,577)	1,845,369			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		709,189	1,034,988	1,744,177		1,744,177		1,744,177			39
40	Barber and Beauty Shops	60,541	1,354		61,895		61,895		61,895			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*	344,568	36,314	207,587	588,469		588,469	(588,469)				43
44	TOTAL Special Cost Centers	405,109	746,857	1,314,298	2,466,264		2,466,264	(588,469)	1,877,795			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,025,616	1,711,671	7,506,822	16,244,109		16,244,109	(1,818,304)	14,425,805			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,843)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(407,089)	30		9
10	Interest and Other Investment Income	(41,993)	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	(6,783)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,357,596)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,818,304)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,818,304)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Norwood CrossingID# 0012237Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Income	\$ (26,165)	14	1
2	Transportation Charity Rendered	(623)	14	2
3	Flowers Expense	(5,473)	21	3
4	Telephone Billing	(18,837)	21	4
5	Misc. Income	(1,319)	21	5
6	Utilities/Exp. - Other Properties	(898)	05	6
7	Marketing Contract Expense	(16,882)	43	7
8	Marketing Supplies & Expenses	(946)	43	8
9	Brochures/Materials	(19,085)	43	9
10	Premiums/Give Aways	(6,694)	43	10
11	NPH News	(3,022)	43	11
12	Marketing Postage	(6,567)	43	12
13	Mktg Advertising	(6,391)	43	13
14	Electronic Marketing	(634)	43	14
15	Mktg Mtg & Conf	(45)	43	15
16	Strength Training Income	(205)	11	16
17	Late Fee	(470)	21	17
18	Additional R&M	49,892	06	18
19	Marketing Salaries	(80,012)	43	19
20	Out of State Seminars	(2,310)	24	20
21	Transpot Escort Income	(7,689)	14	21
22	Interest Expense - Assited Living Building	(718,495)	32	22
23	HRA Rebate	(3,073)	20	23
24	Assisted Living Manager	(33,462)	21	24
25				25
26				26
27	Independent Living			27
28		(448,191)	43	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	(1,357,596)		49

Norwood Crossing

ID# 0012237
 Report Period Beginning: 01/01/09
 Ending: 12/31/09

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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(4,843)											(4,843)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(898)											(898)	5
6	Maintenance	49,892											49,892	6
7	Other (specify):*													7
8	TOTAL General Services	44,151											44,151	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(205)											(205)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(34,477)											(34,477)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(34,682)											(34,682)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services													19
20	Fees, Subscriptions & Promotions	(9,856)											(9,856)	20
21	Clerical & General Office Expenses	(59,561)											(59,561)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,310)											(2,310)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(71,727)											(71,727)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,258)											(62,258)	29

STATE OF ILLINOIS

Facility Name & ID Number Norwood Crossing# 0012237

Report Period Beginning:

01/01/09

Ending:

Summary B

12/31/09

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(407,089)											(407,089)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(760,488)											(760,488)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(1,167,577)											(1,167,577)	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):*	(588,469)											(588,469)	43
44	TOTAL Special Cost Centers	(588,469)											(588,469)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,818,304)											(1,818,304)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/09 Ending: 12/31/09

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										
										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	US Bancorp	X	Purchase of Telephone System	\$4,205.00	1/1/04	\$ 239,309	\$	4/30/09	0.0600	\$ 30	1								
2	Charter One	X	Construction of AL Building	Varies	9/30/09	20,000,000	19,928,794	9/30/10	0.0735	718,495	2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Rate Swap Obligation	X								1,157,021	6								
7											7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related			\$4,205.00		\$ 20,239,309	\$ 19,928,794			\$ 1,875,546	9								
B. Non-Facility Related*																			
10	Interest Income	X								(41,993)	10								
11	AL Bldg. Int Exp									(718,495)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$	\$			\$ (760,488)	14								
15	TOTALS (line 9+line14)					\$ 20,239,309	\$ 19,928,794			\$ 1,115,058	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	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										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related										20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>135,036</u>	<u>1896</u>	<u>\$ 20,781</u>	<u>1</u>
2	<u>Facility</u>		<u>2001 - 2004</u>	<u>2,115,355</u>	<u>2</u>
3	TOTALS	135,036		\$ 2,136,136	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	261	1909	1909	\$ 189,756	\$		\$	\$	\$	4
5		1924	1924	88,144						5
6		1951	1951	64,220						6
7		1960	1960	294,792						7
8		1977	1977	3,847,050			76,941	76,941	2,462,112	8
Improvement Type**										
9	Various		1961	23,225		20	465	465	22,902	9
10	Various		1977	22,408		20			22,408	10
11	Various		1981	43,739		20			43,739	11
12	Various		1982	84,988		20			84,988	12
13	Various		1983	18,359		20			18,359	13
14	Various		1984	62,349		20			62,349	14
15	Various		1985	90,235		20			90,235	15
16	Various		1986	1,587,965		20	53,850	53,850	1,245,118	16
17	Various		1987	127,214		20			127,214	17
18	Various		1988	126,029		20			126,029	18
19	Various		1989	68,666		20	5,739	5,739	130,886	19
20	Various		1990	2,331,319		20	77,774	77,774	1,517,378	20
21	Various		1991	39,209		20			39,209	21
22	Various		1992	82,730		20			82,730	22
23	Various		1993	19,043		20			19,043	23
24	Various		1994	180,520		20			181,618	24
25	Various		1995	418,096		20	15,685	15,685	219,612	25
26	Various		1996	38,300		20	1,922	1,922	28,780	26
27	Various		1997	142,961		20	7,197	7,197	90,241	27
28	Various		1998	246,420		20	12,322	12,322	142,837	28
29	Various		1999	3,034,228		20	40,225	40,225	451,808	29
30	Various		2000	145,548		20	7,133	7,133	74,218	30
31	Various		2001	109,327		20	5,466	5,466	49,196	31
32	Various		2002	112,225		20	5,611	5,611	44,899	32
33	Various		2003	288,274		20	14,413	14,413	100,893	33
34	Various		2004	115,925		20	5,796	5,796	34,777	34
35	Various		2005	52,331		20	2,617	2,617	13,083	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								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			1,009,394		(1,009,394)		69
70	TOTAL (lines 4 thru 69)	\$ 14,095,594	\$ 1,009,394		\$ 333,157	\$ (676,237)	\$ 7,526,661	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,095,594	\$ 1,009,394		\$ 333,157	\$ (676,237)	\$ 7,526,661	1
2	Locks For Doors	2006	140		20	7	7	28	2
3	Sprinkler System	2006	1,006		20	50	50	201	3
4	Page System	2006	4,300		20	215	215	860	4
5	Fire Alarm System Enhancements	2006	3,710		20	186	186	742	5
6	Alarm & Detection Repairs	2006	1,397		20	70	70	279	6
7	Carpet - Rooms 243 & 344	2006	801		20	40	40	160	7
8	Carpet Room 209	2006	415		20	21	21	83	8
9	Carpet Room 128	2006	482		20	24	24	96	9
10	Carpet Rm 246	2006	666		20	33	33	133	10
11	Carpet Rm 153 & 155	2006	1,102		20	55	55	220	11
12	Carpet Rm 203	2006	894		20	45	45	179	12
13	Window Fashion	2006	496		20	25	25	99	13
14	Drapery	2006	709		20	35	35	142	14
15	Mini Blinds	2006	1,580		20	79	79	316	15
16	Carpet - Physical Therapy Room	2006	1,832		20	92	92	366	16
17	Carpet Rm 346	2006	1,920		20	96	96	384	17
18	Carpet Rm 206	2006	324		20	16	16	65	18
19	Blinds, Paint	2006	2,305		20	115	115	461	19
20	3Rd Floor Sink	2006	2,157		20	108	108	431	20
21	Locks	2006	147		20	7	7	29	21
22	Carpeting - Rms 248/249	2006	2,235		20	112	112	447	22
23	Interior Door For 1St Flr Conference Area	2006	639		20	32	32	128	23
24	Carpeting - Rms 148/252/349	2006	3,353		20	168	168	671	24
25	Rm 246 Renovation	2006	848		20	42	42	170	25
26	Carpet - Rm 233	2006	465		20	23	23	93	26
27	Fire Code Corrections - Solarium Doors, Mechanical Closets	2006	5,358		20	268	268	1,072	27
28	Room 265 Convert To Private	2006	3,510		20	176	176	702	28
29	Room 278 Convert To Private	2006	2,011		20	101	101	402	29
30	Room 480 Convert To Private	2006	832		20	42	42	166	30
31	Room 463 Convert To Private	2006	2,143		20	107	107	429	31
32	Room 279 Convert To Private	2006	737		20	37	37	147	32
33	Conversion To Private Rms (265,278,480,463,279)	2006	1,224		20	61	61	245	33
34	TOTAL (lines 1 thru 33)		\$ 14,145,332	\$ 1,009,394		\$ 335,643	\$ (673,751)	\$ 7,536,609	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,145,332	\$ 1,009,394		\$ 335,643	\$ (673,751)	\$ 7,536,609	1
2	Alarm Panel - 3Rd Flr Stairwell	2006	1,693		20	85	85	339	2
3	Replacement Of Pump	2007	3,662		20	183	183	549	3
4	Compressor In The Carrier Chiller	2007	12,979		20	649	649	1,947	4
5	Hot Water Heater Pump	2007	1,057		20	53	53	159	5
6	New Compressor For Trane Chiller (Hvac)	2007	8,800		20	440	440	1,320	6
7	Power New Walk-In Freezer And Cooler	2007	2,970		20	149	149	446	7
8	Door Protector Edge	2007	2,495		20	125	125	374	8
9	Sterling Cond Pump	2007	1,532		20	77	77	230	9
10	Carpet 1St & 2Nd Floor	2007	4,000		20	200	200	600	10
11	Carepet- Room 146 +Closet	2007	527		20	26	26	79	11
12	Carpet- 1St And 2Nd Floor	2007	5,442		20	272	272	816	12
13	Carpet Room 345	2007	527		20	26	26	79	13
14	6 Duplex Outlets With Amp Volt Circuits	2007	1,620		20	81	81	243	14
15	Mulligan Lobby Entrance	2007	1,900		20	95	95	285	15
16	48" High Glavanized Chainlink Fence	2007	987		20	49	49	148	16
17	Elevator Repairs	2007	3,432		20	172	172	515	17
18	Carbon-Monoxide System & Alarm	2008	4,065		20	203	203	407	18
19	Trane A/C	2008	3,242		20	162	162	324	19
20	Kewanee Boiler	2008	6,732		20	337	337	673	20
21	16X16 White Steel Access Panel	2008	1,269		20	63	63	127	21
22	Fire Alarm & Material - Nursing Bldg Elevator	2008	17,649		20	882	882	1,765	22
23	Replace Valve In Nursing Chiller	2008	2,733		20	137	137	273	23
24	16X16 White Steel Access Panel	2008	725		20	36	36	73	24
25	16X16 White Steel Access Panel	2008	363		20	18	18	36	25
26	Elevator Racall System	2008	5,496		20	275	275	550	26
27	Carpet Room	2008	1,003		20	50	50	100	27
28	Brain Fitness Lab	2008	357		20	18	18	36	28
29	Brain Fitness Lab	2008	508		20	25	25	51	29
30	Carpet Room 306 & Closet	2008	1,146		20	57	57	115	30
31	Sprinklers For Nursing Bldg	2008	73,278		20	3,664	3,664	7,328	31
32	Carpet Room 203,253 & 340	2008	2,032		20	102	102	203	32
33	Floor Patch To Install Carpet	2008	510		20	26	26	51	33
34	TOTAL (lines 1 thru 33)		\$ 14,320,064	\$ 1,009,394		\$ 344,380	\$ (665,014)	\$ 7,556,848	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 14,320,064	\$ 1,009,394		\$ 344,380	\$ (665,014)	\$ 7,556,848	1
2	Carpet Assistant Director'S Office	2008	406		20	20	20	41	2
3	Replace Outdoor Sign	2008	884		20	44	44	88	3
4	Carpet (Link)	2008	1,930		20	97	97	193	4
5	Alarm Bell Silence Switches - Front Desk	2008	699		20	35	35	70	5
6	50% Deposit On Work For Life Safety Issues	2008	26,720		20	1,336	1,336	2,672	6
7	1St Floor Bathroom	2008	3,373		20	169	169	337	7
8	Water Heaters Repair	2008	2,918		20	146	146	292	8
9	Replaced Sprinkler Valve	2008	2,733		20	137	137	273	9
10	Legal Fees For 2004 Land Purchase	2009	7,064		20	353	353	353	10
11	Fence For Avondale & Niagra	2009	5,501		20	275	275	275	11
12	Roof	2009	10,550		20	528	528	528	12
13	Garage	2009	4,450		20	223	223	223	13
14	Fire Alarm,Redo Fire Doors	2009	4,172		20	209	209	209	14
15	Roof	2009	8,400		20	420	420	420	15
16	Control Boards For Trane Chiller Service Hvac System	2009	5,986		20	299	299	299	16
17	New Fire Service Unit & Fixtures	2009	26,720		20	1,336	1,336	1,336	17
18	Freezer/Refrigeration Unit	2009	13,752		20	688	688	688	18
19	Chill Water Pump & Valve Replacement	2009	4,630		20	232	232	232	19
20	Phone System	2009	19,501		20	975	975	975	20
21	Main Entrance Doors	2009	14,500		20	725	725	725	21
22	1a Replacement Ptac	2009	2,920		20	146	146	146	22
23	Installation Of Digital Cable	2009	25,885		20	2,588	2,588	2,588	23
24	Carpet	2009	7,574		20	379	379	379	24
25	Commercial New Awning	2009	2,550		20	128	128	128	25
26	Awning	2009	2,550		20	128	128	128	26
27	Gift Shop & Hallway Floor	2009	2,864		20	143	143	143	27
28	Paving Of Parking Lot	2009	39,000		20	1,950	1,950	1,950	28
29	Building Tie -In Exits	2009	3,978		20	199	199	199	29
30	Roof	2009	12,000		20	600	600	600	30
31	Stand Alone Access Control System & Loading Dock	2009	2,942		20	147	147	147	31
32	Carpet In Link & Lobby	2009	14,792		20	740	740	740	32
33	Bushes	2009	5,670		20	284	284	284	33
34	TOTAL (lines 1 thru 33)		\$ 14,607,677	\$ 1,009,394		\$ 360,055	\$ (649,339)	\$ 7,574,506	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 14,607,677	\$ 1,009,394		\$ 360,055	\$ (649,339)	\$ 7,574,506	1
2	Roof	2009	12,000		20	600	600	600	2
3	Carpet	2009	10,427		20	521	521	521	3
4	Northcott Porch - Screens, Windows, Flooring, Electrical	2009	28,237		20	1,412	1,412	1,412	4
5	Nursing Lobby - Drywall, Carpet, Electrical, Alarm Systems	2009	27,722		20	1,386	1,386	1,386	5
6	Paint 1st Floor Northcott	2009	3,850		20	193	193	193	6
7	New Fire Alarm Nursing Building	2009	23,699		20	1,185	1,185	1,185	7
8	Norwegian Heritage Room-Sound/Video, Flooring, Drywall, Paint	2009	228,058		20	11,403	11,403	11,403	8
9	Parking Lot Paving	2009	19,500		20	975	975	975	9
10	Elevator Sprinkler System	2009	1,071		20	54	54	54	10
11	1st Bell & Gossett End-Suction Pump	2009	1,400		20	70	70	70	11
12	Assisted Living Area Used By Nursing Home	2009	2,235,429		20	111,771	111,771	111,771	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)		\$ 17,199,070	\$ 1,009,394		\$ 489,624	\$ (519,770)	\$ 7,704,075	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company Information							
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Related Party Information		\$	\$		\$	\$	\$
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 703,556	\$	\$ 93,888	\$ 93,888	10	\$ 554,030	71
72	Current Year Purchases	118,360		11,535	11,535	10	11,535	72
73	Fully Depreciated Assets	2,464,737				10	2,464,737	73
74								74
75	TOTALS	\$ 3,286,653	\$	\$ 105,423	\$ 105,423		\$ 3,030,302	75

D. Vehicle Depreciation (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	VAR	\$ 86,711	\$	\$	\$	5	\$ 86,711	76
77		Town & Country Van	2008	14,118		2,824	2,824	5	5,647	77
78		Grand Caravan	2008	16,118		3,224	3,224	5	6,447	78
79		Bus - New Paint & NC Logo	2009	6,052		1,210	1,210	5	1,210	79
80	TOTALS			\$ 122,999	\$	\$ 7,258	\$ 7,258		\$ 100,016	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 22,744,859	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,009,394	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 602,305	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (407,089)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,834,393	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	See Attached 2001 - 2004	\$ 4,546,869	\$	\$	86
87	Assisted Living Area-Non-Care - 2009	20,174,077			87
88					88
89					89
90					90
91	TOTALS	\$ 24,720,946	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: _____*

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

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

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs				\$	440,275	\$				\$	440,275	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					88,866						88,866	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs					496,997						496,997	4	
5	Physician Care		visits												5	
6	Dental Care	39 - 03	visits					8,850						8,850	6	
7	Work Related Program		hrs												7	
8	Habilitation		hrs												8	
9	Pharmacy		# of prescripts												9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify): <u>See Supplemental</u>									709,189				709,189	13	
14	TOTAL				\$			\$	1,034,988	\$	709,189		\$	1,744,177	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing# 0012237Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 841,235	\$	1
2	Cash-Patient Deposits	1,130,564		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	870,067		3
4	Supply Inventory (priced at)	34,055		4
5	Short-Term Investments			5
6	Prepaid Insurance	74,531		6
7	Other Prepaid Expenses	31,732		7
8	Accounts Receivable (owners or related parties)	797,518		8
9	Other(specify): <u>See Attached Schedule</u>	3,453		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,783,155	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,431,069		13
14	Buildings, at Historical Cost	29,712,988		14
15	Leasehold Improvements, at Historical Cost	5,977,087		15
16	Equipment, at Historical Cost	4,709,048		16
17	Accumulated Depreciation (book methods)	(12,319,961)		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): <u>See Attached Schedule</u>	164,580		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 32,674,811	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 36,457,966	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,279,840	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,500		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	471,757		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,728		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	21,808		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	3,532,702		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,322,335	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	19,928,794		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	12,415,070		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 32,343,864	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 37,666,199	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,208,233)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 36,457,966	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,117,605	1
2	Restatements (describe):		2
3	Adjusting Journal Entry	(18,227)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,099,378	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,307,611)	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)	\$ (2,307,611)	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)	\$ (1,208,233)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing# 0012237Report Period Beginning: 01/01/09Ending: 12/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,188,135	1
2	Discounts and Allowances for all Levels	(1,641,472)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,546,663	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,763,297	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,763,297	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	57,976	13
14	Non-Patient Meals	4,843	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	674,761	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,759	20
21	Other Medical Services	616,219	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,371,558	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	41,993	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,993	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	212,987	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 212,987	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,936,498	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,165,040	31
32	Health Care	5,218,096	32
33	General Administration	2,381,763	33
B. Capital Expense			
34	Ownership	3,012,946	34
C. Ancillary Expense			
35	Special Cost Centers	2,394,541	35
36	Provider Participation Fee	71,723	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,244,109	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,307,611)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,307,611)	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,796	2,057	\$ 98,243	\$ 47.76	1
2	Assistant Director of Nursing	3,725	4,028	147,349	36.58	2
3	Registered Nurses	38,697	42,354	1,210,481	28.58	3
4	Licensed Practical Nurses	26,751	27,112	720,906	26.59	4
5	CNAs & Orderlies	134,073	146,647	2,127,852	14.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,695	21,360	300,109	14.05	10
11	Social Service Workers	8,271	9,849	198,942	20.20	11
12	Dietician	14,142	16,471	358,080	21.74	12
13	Food Service Supervisor					13
14	Head Cook	11,319	12,227	171,671	14.04	14
15	Cook Helpers/Assistants	32,025	36,041	351,041	9.74	15
16	Dishwashers					16
17	Maintenance Workers	8,942	10,055	192,760	19.17	17
18	Housekeepers	24,907	27,413	277,149	10.11	18
19	Laundry	11,183	12,863	142,138	11.05	19
20	Administrator	1,845	1,988	94,904	47.74	20
21	Assistant Administrator					21
22	Other Administrative	225	225	13,111	58.27	22
23	Office Manager					23
24	Clerical	9,700	10,523	190,683	18.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	22,000	22,942	430,197	18.75	33
34	TOTAL (lines 1 - 33)	369,297	404,156	\$ 7,025,616 *	\$ 17.38	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 53,436	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	99	4,443	10-03	37
38	Nurse Consultant	Monthly	7,208	10-03	38
39	Pharmacist Consultant	Monthly	16,362	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	49	2,384	11-03	44
45	Social Service Consultant	44	2,860	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	191	\$ 104,693		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Silvia Morici	Administrator	0	\$ 94,904	Workers' Compensation Insurance	\$ 179,963	IDPH License Fee	\$	
Michael Toohey	CEO	0	13,111	Unemployment Compensation Insurance	51,202	Advertising: Employee Recruitment	20,790	
				FICA Taxes	495,936	Health Care Worker Background Check	3,756	
				Employee Health Insurance	598,195	(Indicate # of checks performed <u>133</u>)		
				Employee Meals	35,040	Patient Background Checks	80	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,000	
				Pension Expense	80,857	IL Allocation	6,980	
				Employee Physicals	16,846		(3,041)	
				Employee Assistance Program	3,864			
				Employee Gifts	34,129			
				IL Allocation	(55,415)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,015	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,440,617		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Board Development - Meeting Expenses			\$ 446				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 446				Seminar Expense	18,982
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting		\$ 37,050					
MacCabe & McGuire	Legal		3,857					
Answers on Demand	Computer Services		15,072					
Network Support	Computer Services		17,710					
Internet/Web Page Support	Computer Services		1,964					
Encompass	MDS Software		3,510					
IL Allocation			(1,505)					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 77,658				TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 18,982	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Norwood Crossing# 0012237Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$5,403
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yeas
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. \$ 32,775 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 No 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. \$ 71,723
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? Yes 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. \$ 35,040 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,843
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.