

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

<p>I. IDPH License ID Number: <u>0012237</u></p> <p>Facility Name: <u>Norwood Crossing</u></p> <p>Address: <u>6016 North Nina Ave</u> <u>Chicago</u> <u>60631</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 631-4856</u> Fax # <u>(773) 631-4850</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/24/1896</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/15</u> to <u>12/31/15</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																							
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Facility Name & ID Number Norwood Crossing

0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>17,951</u>	<u>15,198</u>	<u>13,799</u>	<u>46,948</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC	<u>14,312</u>	<u>12,419</u>	<u>9</u>	<u>26,740</u>	12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>32,263</u>	<u>27,617</u>	<u>13,808</u>	<u>73,688</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.35%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 131 and days of care provided 13,705

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	782,845	169,188	12,179	964,212		964,212		964,212		1
2	Food Purchase		622,283		622,283	(38,544)	583,739	(23,730)	560,009		2
3	Housekeeping	468,520	46,736	190	515,446		515,446		515,446		3
4	Laundry		37,259		37,259		37,259		37,259		4
5	Heat and Other Utilities			348,382	348,382		348,382	(3,369)	345,013		5
6	Maintenance	306,450	37,329	251,983	595,762		595,762	47,442	643,204		6
7	Other (specify):*										7
8	TOTAL General Services	1,557,815	912,795	612,734	3,083,344	(38,544)	3,044,800	20,343	3,065,143		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	5,195,757	406,732	15,338	5,617,827		5,617,827		5,617,827		10
10a	Therapy										10a
11	Activities	269,361	133,601	2,448	405,410		405,410	(100)	405,310		11
12	Social Services	333,574	3,217	3,010	339,801		339,801		339,801		12
13	CNA Training										13
14	Program Transportation	50,361		20,889	71,250		71,250	(53,697)	17,553		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,849,053	543,550	59,685	6,452,288		6,452,288	(53,797)	6,398,491		16
	C. General Administration										
17	Administrative	189,255			189,255		189,255		189,255		17
18	Directors Fees										18
19	Professional Services			193,580	193,580		193,580	(23,331)	170,249		19
20	Dues, Fees, Subscriptions & Promotions			50,714	50,714		50,714	(7,158)	43,556		20
21	Clerical & General Office Expenses	128,816	80,027	1,125,694	1,334,537		1,334,537	(231,134)	1,103,403		21
22	Employee Benefits & Payroll Taxes			1,917,209	1,917,209	38,544	1,955,753		1,955,753		22
23	Inservice Training & Education										23
24	Travel and Seminar			46,388	46,388		46,388	(26)	46,362		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			244,782	244,782		244,782		244,782		26
27	Other (specify):*										27
28	TOTAL General Administration	318,071	80,027	3,578,367	3,976,465	38,544	4,015,009	(261,650)	3,753,359		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,724,939	1,536,372	4,250,786	13,512,097		13,512,097	(295,105)	13,216,992		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:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,508,708	1,508,708		1,508,708	(757,263)	751,445			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			519,968	519,968		519,968	(487,956)	32,012			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,757	18,757		18,757		18,757			35
36	Other (specify):*			134,665	134,665		134,665	(28,205)	106,460			36
37	TOTAL Ownership			2,182,098	2,182,098		2,182,098	(1,273,424)	908,674			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		650,330	1,558,779	2,209,109		2,209,109		2,209,109			39
40	Barber and Beauty Shops	71,533	1,198		72,731		72,731		72,731			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			252,167	252,167		252,167		252,167			42
43	Other (specify):*	1,685,723	21,647	1,033,911	2,741,281		2,741,281	(2,741,281)	(0)			43
44	TOTAL Special Cost Centers	1,757,256	673,175	2,844,857	5,275,288		5,275,288	(2,741,281)	2,534,007			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,482,195	2,209,547	9,277,741	20,969,483		20,969,483	(4,309,810)	16,659,673			45

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

Norwood CrossingID# 0012237Report Period Beginning: 01/01/15Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Income	\$ (42,547)	14	1
2	Transport Escort Income	(11,151)	14	2
3	Flowers Expense	(4,010)	21	3
4	Regulatory Fee	(684)	21	4
5	Misc. Income	(6,298)	21	5
6	Utilities/Exp. - Other Properties	(3,369)	05	6
7	Marketing & Advertising Expense	(121,362)	43	7
8	Strength Training Income	(100)	11	8
9	Late Fee	(485)	21	9
10	Gain/Loss on Asset Disposal	(10,001)	36	10
11	Year End Inter Co Transfers	(194,939)	21	11
12	Non-Allowable Seminars	(26)	24	12
13	Non-Allowable Legal	(23,331)	19	13
14	Senior Center for City of Chicago	(89,414)	43	14
15	Marketing Salaries	(123,875)	43	15
16	Capitalized R&M	(10,649)	06	16
17	Additional R&M	58,091	06	17
18	Interest Expense - Assisted Living Building	(487,224)	32	18
19	Annual Report	(760)	20	19
20	PAC Dues	(5,938)	20	20
21				21
22	Amortization	(18,204)	36	22
23	Assisted Living Salaries	(1,561,848)	43	23
24	Assisted Living Other	(844,782)	43	24
25				25
26	Chamber of Commerce	(460)	20	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,503,366)		49

Norwood Crossing

Report Period Beginning: ID# 0012237
 Ending: 01/01/15
 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(23,730)											(23,730)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,369)											(3,369)	5
6	Maintenance	47,442											47,442	6
7	Other (specify):*													7
8	TOTAL General Services	20,343											20,343	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(100)											(100)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(53,697)											(53,697)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(53,797)											(53,797)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(23,331)											(23,331)	19
20	Fees, Subscriptions & Promotions	(7,158)											(7,158)	20
21	Clerical & General Office Expenses	(231,134)											(231,134)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(26)											(26)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(261,650)											(261,650)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(295,105)											(295,105)	29

STATE OF ILLINOIS

Facility Name & ID Number Norwood Crossing# 0012237

Report Period Beginning:

01/01/15

Ending:

Summary B

12/31/15

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	(757,263)											(757,263)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(487,956)											(487,956)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(28,205)											(28,205)	36
37	TOTAL Ownership	(1,273,424)											(1,273,424)	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):*	(2,741,281)											(2,741,281)	43
44	TOTAL Special Cost Centers	(2,741,281)											(2,741,281)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(4,309,810)											(4,309,810)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	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:

01/01/15

Ending:

12/31/15

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing

0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Norwood Crossing # 0012237 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number

Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Lancaster Pollard/HUD		X	Construction of AL Building	\$91,022.67	7/12/2012	\$ 21,056,300	\$ 19,412,480	7/2042	2.9800	\$ 487,224	1							
2	Lancaster Pollard/HUD		X	Expansion of SNF Dining Room	\$11,165.71	7/30/2015	1,998,400	1,984,418	8/2042	4.4200	32,744	2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$102,188.38		\$ 23,054,700	\$ 21,396,898			\$ 519,968	9							
B. Non-Facility Related*																			
10	Interest Income		X								(732)	10							
11	AL Bldg. Int Exp										(487,224)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (487,956)	14							
15	TOTALS (line 9+line14)						\$ 23,054,700	\$ 21,396,898			\$ 32,012	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 106,463 Line # 36

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

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

Facility Name & ID Number

Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 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 2015 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:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
Facility Does Not Pay Real Estate Taxes				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norwood Crossing COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0012237

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

01/01/15

Ending:

12/31/15

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:

A. Land.

	1	2	3	4	
	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>2,117,692</u>	<u>2</u>
3	TOTALS	135,036		\$ 2,138,473	3

Facility Name & ID Number Norwood Crossing

0012237

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	261	1909	1909	\$ 189,756	\$		\$	\$	\$	4
5		1924	1924	88,144						5
6		1951	1951	64,220						6
7		1960	1960	294,792						7
8		1977	1977	3,847,050			76,941	76,941	2,923,758	8
Improvement Type**										
9	Various		1961	23,225		20			23,225	9
10	Various		1977	22,408		20			22,408	10
11	Various		1981	6,841		20			6,841	11
12	Various		1982	35,128		20			35,128	12
13	Various		1983	12,709		20			12,709	13
14	Various		1984	55,806		20			55,806	14
15	Various		1985	2,531		20			33,294	15
16	Various		1986	1,534,833		20	53,850	53,850	1,515,086	16
17	Various		1987	106,916		20	1,358	1,358	87,911	17
18	Various		1988	15,515		20			15,515	18
19	Various		1989	133,867		20	3,534	3,534	84,393	19
20	Various		1990	2,330,763		20	77,774	77,774	1,983,466	20
21	Various		1991	39,209		20			39,209	21
22	Various		1992	82,154		20			82,154	22
23	Various		1993	19,043		20			19,043	23
24	Various		1994	35,404		20	55	55	34,635	24
25	Various		1995	375,378		20	15,685	15,685	313,722	25
26	Various		1996	39,775		20	1,727	1,727	40,979	26
27	Various		1997	139,091		20	7,061	7,061	130,317	27
28	Various		1998	224,763		20	11,526	11,526	201,721	28
29	Various		1999	2,960,943		20	38,490	38,490	662,277	29
30	Various		2000	111,011		20	4,295	4,295	106,979	30
31	Various		2001	106,994		20	5,466	5,466	81,994	31
32	Various		2002	83,505		20	5,611	5,611	78,565	32
33	Various		2003	263,566		20	13,223	13,223	177,491	33
34	Various		2004	84,815		20	4,241	4,241	51,301	34
35	Various		2005	32,032		20	1,676	1,676	18,441	35
36	Various		2006	16,069		20	826	826	8,256	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2007	\$ 33,012	\$	20	\$ 1,651	\$ 1,651	\$ 14,855	37
38	Various	2008	145,697		20	7,285	7,285	58,279	38
39	Various	2009	437,910		20	22,075	22,075	157,555	39
40	Various	2010	253,241		20	12,948	12,948	77,688	40
41	Various	2011	335,348		20	19,731	19,731	98,654	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F & 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H & 12I)</u>								68
69	<u>Financial Statement Depreciation</u>			1,508,708			(1,508,708)		69
70	TOTAL (lines 4 thru 69)		\$ 14,583,463	\$ 1,508,708		\$ 387,027	\$ (1,121,680)	\$ 9,253,656	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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,583,463	\$ 1,508,708		\$ 387,027	\$ (1,121,680)	\$ 9,253,656	1
2	Notifer Fire Alarm System Project	2012	138,837		20	6,942	6,942	27,767	2
3	Nina Porch & Stairs Railing	2012	4,917		20	246	246	983	3
4	Installation Of P-Trap And Riser Insulation For 160 Bathrooms A	2012	5,640		20	282	282	1,128	4
5	Handicap Switch Near Entrance (Inner Door)	2012	5,356		20	268	268	1,071	5
6	Nursing Building -07 Fire System Dampers	2012	5,600		20	280	280	1,120	6
7	Nursing Building Generator Replace Board	2012	5,100		20	510	510	2,040	7
8	Northcott Freight Elevator	2012	6,340		20	317	317	1,268	8
9	Chiller Northcott	2012	47,105		20	2,355	2,355	9,421	9
10	Nurses Building Stairs North And South	2012	10,300		20	1,030	1,030	4,120	10
11	Dietary Office	2012	6,508		20	651	651	2,603	11
12	Snf Renovation - Electrical, Floors, Alarms, Sprinklers, Wall Cove	2012	370,041		20	39,758	39,758	159,034	12
13	Nina Porches- Flooring And Door 2012	2012	4,259		20	426	426	1,704	13
14	Automatic Door Closers	2012	2,926		20	146	146	585	14
15	New Steam Traps For Boiler	2012	3,220		20	161	161	644	15
16	Condensate Receiver	2012	3,231		20	162	162	646	16
17	Kitchen Ceiling, Supplies, Sam'S Wages	2013	7,151		20	358	358	1,073	17
18	Nina/Northcott Repairs - Painting, Soffit And Gutters (13,170)	2013	8,692		20	435	435	1,304	18
19	Stucco Repairs	2013	2,650		20	133	133	398	19
20	Backsplash In Fyer Area	2013	2,650		20	133	133	398	20
21	Upgrade Sprinkler System In Kitchen	2013	3,117		20	156	156	467	21
22	Water Sealing/Soffit Repair, Inner Courtyard, Sam'S Wage	2013	11,503		20	575	575	1,725	22
23	Fire Doors Closers Nina Building	2013	10,217		20	511	511	1,533	23
24	Kitchen Floor	2013	3,000		20	150	150	450	24
25	Pepper House Roof	2013	3,729		20	186	186	559	25
26	Sprinklers Upgrade	2013	187,445		20	9,372	9,372	28,117	26
27	Elevator Furnish And Install New Gall Car Door, Operator & Doc	2013	15,856		20	793	793	2,378	27
28	Fire Alarm System Sheltered Care	2013	188,123		20	9,408	9,408	28,224	28
29	Replace Chiller Pump- Snf- By Admissions	2013	3,725		20	186	186	559	29
30	Furnish And Install Side Stream Filter For Chiller	2013	4,670		20	234	234	701	30
31	Penthouse Chiller	2013	4,670		20	234	234	701	31
32	25 Ptacs Units	2013	36,000		20	3,600	3,600	10,800	32
33	Boilers- Low Water Cut Off	2013	2,857		20	143	143	429	33
34	TOTAL (lines 1 thru 33)		\$ 15,698,898	\$ 1,508,708		\$ 467,166	\$ (1,041,542)	\$ 9,547,605	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:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 15,698,898	\$ 1,508,708		\$ 467,166	\$ (1,041,542)	\$ 9,547,605	1
2	Return Pumps- Maint Shop	2013	6,430		20	322	322	965	2
3	Outdoor Signs- Main Entrance, Parking Lot Entrance, Digital Ma	2013	59,143		20	2,957	2,957	8,871	3
4	Wall Fans Sc Halls	2013	2,679		20	134	134	402	4
5	Cooler Repair	2013	3,055		20	153	153	458	5
6	Chiller Repair	2013	8,065		20	403	403	1,210	6
7	Boiler Repairs	2013	2,771		20	139	139	416	7
8	Hvac Repair	2013	3,027		20	151	151	454	8
9	Pm And Hvac Repairs	2013	2,572		20	129	129	386	9
10	Painting Of Common Areas And Various Residents Rooms	2013	3,596		20	180	180	539	10
11	Snf Bldg-Boiler Room Double Door -Furnished & Installed Door,	2014	4,331		20	217	217	433	11
12	Snf - Ceiling Tiles	2014	3,981		20	199	199	398	12
13	Flooring Sc Rooms-149-,255,146 & 351,345,230,206	2014	13,324		20	666	666	1,332	13
14	2Nd & 3Rd Floor Nina Porch Ceiling	2014	2,650		20	133	133	265	14
15	Patching & Painting Due To Alarmn System Work	2014	5,493		20	275	275	549	15
16	Nina & Northcott Roof & Gutters	2014	5,050		20	253	253	505	16
17	Emergency Electrical Wiring	2014	3,340		20	167	167	334	17
18	Fire Alarm Panel Programming (Allocated)	2014	9,643		20	482	482	964	18
19	Admin Office-Demolish & Install New Drywall,Ceiling,Tiles	2014	4,540		20	227	227	454	19
20	22 Ptac Units	2014	33,730		20	1,687	1,687	3,373	20
21	Parking Lot Reconfigure - Rear Entrance (Allocated)	2014	3,300		20	165	165	330	21
22	Nina Elevator Upgrade	2014	99,612		20	4,981	4,981	9,961	22
23	Re Seal Kitchen Walls	2014	9,110		20	456	456	911	23
24	Snf Bldg - Move 28 Smoke Detectors Away From Air Vents	2014	8,250		20	413	413	825	24
25	Business Office - New Flooring, Ceiling Tiles And Lights,	2014			20				25
26	Remove & Replace Wall , Repair Drywall & Paint	2014	10,903		20	545	545	1,090	26
27	Concrete Replacement (Hud Site Visit) /Nina Courtyard /Sidewall	2014	13,650		20	683	683	1,365	27
28	Replace Contactors In Dumb Waiter	2014	2,740		20	137	137	274	28
29	Penthouse Heat Exchager	2014	86,124		20	4,306	4,306	8,612	29
30	Railling And Enclosure For Penthouse Stairs	2014	10,439		20	522	522	1,044	30
31	Patient Stations	2014	2,602		20	130	130	260	31
32	Painting Of Common Areas And Resident Rooms	2014	5,348		20	267	267	535	32
33	Dishwashing Room Floor	2015	4,600		20	460	460	460	33
34	TOTAL (lines 1 thru 33)		\$ 16,132,997	\$ 1,508,708		\$ 489,101	\$ (1,019,607)	\$ 9,595,581	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:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 16,132,997	\$ 1,508,708		\$ 489,101	\$ (1,019,607)	\$ 9,595,581	1
2	Nursing Kidec	2015	42,165		20	4,217	4,217	4,217	2
3	Dish Room Hood - Pipe Replacement	2015	2,945		20	147	147	147	3
4	Snf Elevator Door Circuits	2015	5,305		20	265	265	265	4
5	Avenue Round 46& Gallon/ Mulligan Courtyard & Entrance.1/2	2015	2,862		20	143	143	143	5
6	Mulligan Courtyard Retaining Wall	2015	10,420		20	521	521	521	6
7	General Landscaping 2015 , Parking Lot, Front And Rear Entran	2015	10,035		20	502	502	502	7
8	Nina/Northcott Residents Rooms Floor	2015	9,726		20	486	486	486	8
9	Brandt Lobby Door	2015	2,745		20	137	137	137	9
10	2015 Dinning Room Expansion	2015	2,180,196		20	109,010	109,010	109,010	10
11	Landscaping 2015 Dr Expansion	2015	9,546		20	477	477	477	11
12	Security Cameras 2015 Dr Expansion	2015	5,019		20	251	251	251	12
13	Paint, Drywall Repairs 2015 Dr Expansion	2015	23,952		20	1,198	1,198	1,198	13
14	Flooring 2015 Dr Expansion	2015	79,509		20	3,975	3,975	3,975	14
15	Window Treatments 2015 Dr Expansion	2015	5,650		20	283	283	283	15
16	Penthouse Boiler Upgrade	2015	13,591		20	680	680	680	16
17	Penthouse Chiller Air Handler Coil	2015	6,891		20	345	345	345	17
18	Filters Housing For 3 Chillers	2015	9,444		20	472	472	472	18
19	Northcott Chiller	2015	4,088		20	204	204	204	19
20	Flooring Main Lobby	2015	7,163		20	358	358	358	20
21	Flooring Mulling Lobby	2015	7,163		20	358	358	358	21
22	Flooring Bandt Lobby	2015	7,163		20	358	358	358	22
23	Floor & Installation Admission Office	2015	4,954		20	248	248	248	23
24	Wander Guard System-Nursing	2015	95,641		20	4,782	4,782	4,782	24
25	Snf Roof	2015	31,950		20	1,598	1,598	1,598	25
26	Cameras Parking Lot Front	2015	8,357		20	418	418	418	26
27	Steam Coil Penthouse Heat Exchanger	2015	4,990		20	250	250	250	27
28	Sealcoating	2015	6,000		20	300	300	300	28
29	Transfer Swich Generator Notrhcott	2015	2,950		20	148	148	148	29
30	Lighting Retrofit	2015	21,465		20	1,073	1,073	1,073	30
31	Nurse Call System - Nursing	2015	14,047		20	702	702	702	31
32	Condensate Link In Link	2015	13,159		20	658	658	658	32
33	Nursing Offices Hvac	2015	4,680		20	234	234	234	33
34	TOTAL (lines 1 thru 33)		\$ 18,786,768	\$ 1,508,708		\$ 623,898	\$ (884,810)	\$ 9,730,378	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:

01/01/15

Ending:

12/31/15

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		\$ 18,786,768	\$ 1,508,708		\$ 623,898	\$ (884,810)	\$ 9,730,378	1
2	Hvac Loop /Northcott	2015	19,760		20	988	988	988	2
3	Le Office Windows	2015	4,950		20	248	248	248	3
4	Rear Entrance Awnings	2015	3,000		20	150	150	150	4
5	Siding - House	2015	8,040		20	402	402	402	5
6	Nursing Hvac Loop	2015	9,304		20	465	465	465	6
7	Replace Steam Valves	2015	2,778		20	139	139	139	7
8	Rapair Dry System	2015	3,504		20	175	175	175	8
9	Painting Of Common Areas And Resident Rooms	2015	4,367		20	218	218	218	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)		\$ 18,842,471	\$ 1,508,708		\$ 626,683	\$ (882,025)	\$ 9,733,163	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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

01/01/15

Ending:

12/31/15

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	\$ 289,165	\$	\$ 82,945	\$ 82,945	10	\$ 685,336	71
72	Current Year Purchases	273,212		27,321	27,321	10	27,321	72
73	Fully Depreciated Assets	2,801,603				10	2,801,603	73
74								74
75	TOTALS	\$ 3,363,980	\$	\$ 110,266	\$ 110,266		\$ 3,514,260	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		See Attached	1900	\$ 119,411	\$	\$ 1,182	\$ 1,182	5	\$ 113,885	76
77		2015 WC Van / Ford E350 Van T	2015	66,570		13,314	13,314	5	13,314	77
78										78
79										79
80	TOTALS			\$ 185,981	\$	\$ 14,496	\$ 14,496		\$ 127,199	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)	\$ 24,530,905	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,508,708	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 751,445	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (757,263)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,374,623	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Assets 2001 - 2014	\$ 27,061,877	\$	\$	86
87	Non-Care Assets - 2015	20,317			87
88					88
89					89
90					90
91	TOTALS	\$ 27,082,194	\$	\$	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? YES NO

If NO, see instructions.

		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: \$ 18,757 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$	662,113	\$		\$	662,113	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				130,366				130,366	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				764,925				764,925	4
5	Physician Care		visits									5
6	Dental Care	39 - 03	visits				1,375				1,375	6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					903			903	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>							649,427			649,427	13
14	TOTAL			\$		\$	1,558,779	\$	650,330	\$	2,209,109	14

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

Facility Name & ID Number **Norwood Crossing**# **0012237**Report Period Beginning: **01/01/15**

Ending:

12/31/15**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,146,283	\$	1
2	Cash-Patient Deposits	1,297,062		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,658,320		3
4	Supply Inventory (priced at)	55,117		4
5	Short-Term Investments			5
6	Prepaid Insurance	190,232		6
7	Other Prepaid Expenses	157,063		7
8	Accounts Receivable (owners or related parties)	1,411,253		8
9	Other(specify):	1,001,334		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,916,664	\$	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	32,503,716		14
15	Leasehold Improvements, at Historical Cost	7,334,854		15
16	Equipment, at Historical Cost	5,112,662		16
17	Accumulated Depreciation (book methods)	(19,325,513)		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):	1,390,473		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,449,598	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 39,366,262	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 504,258	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,310,155		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	457,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	116,738		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	39,905		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	573,977		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,002,179	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	21,396,899		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	13,307,496		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 34,704,395	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 37,706,574	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,659,688	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 39,366,262	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,067,318	1
2	Restatements (describe):		2
3	<u>AJE</u>	(351)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,066,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	592,721	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)	\$ 592,721	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)	\$ 1,659,688	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Norwood Crossing# 0012237Report Period Beginning: 01/01/15

Ending:

12/31/15**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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 24,109,927	1
2	Discounts and Allowances for all Levels	(7,867,023)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,242,904	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,790,535	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,790,535	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	62,621	13
14	Non-Patient Meals	23,730	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	470,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	23,799	20
21	Other Medical Services	824,191	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,405,024	23
D. Non-Operating Revenue			
24	Contributions	18,121	24
25	Interest and Other Investment Income***	732	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,853	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	104,888	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 104,888	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,562,204	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,083,344	31
32	Health Care	6,452,288	32
33	General Administration	3,976,465	33
B. Capital Expense			
34	Ownership	2,182,098	34
C. Ancillary Expense			
35	Special Cost Centers	5,023,121	35
36	Provider Participation Fee	252,167	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,969,483	40
41	Income before Income Taxes (line 30 minus line 40)**	592,721	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 592,721	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,222,711	44
45	Private Pay - Net Inpatient Revenue	6,054,945	45
46	Medicare - Net Inpatient Revenue	2,623,613	46
47	Other-(specify) <u>Assisted Living</u>	4,484,496	47
48	Other-(specify) <u>Charity</u>	(142,861)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 16,242,904	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:

01/01/15

Ending:

12/31/15

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	1,889	2,163	\$ 117,292	\$ 54.22	1
2	Assistant Director of Nursing	3,990	4,314	178,532	41.38	2
3	Registered Nurses	32,927	36,038	1,176,639	32.65	3
4	Licensed Practical Nurses	46,468	47,094	1,416,592	30.08	4
5	CNAs & Orderlies	149,755	164,061	2,306,702	14.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,959	18,336	269,361	14.69	10
11	Social Service Workers	10,916	11,943	333,574	27.93	11
12	Dietician	6,880	8,197	220,668	26.92	12
13	Food Service Supervisor					13
14	Head Cook	15,555	16,902	237,301	14.04	14
15	Cook Helpers/Assistants	28,230	30,419	324,876	10.68	15
16	Dishwashers					16
17	Maintenance Workers	14,864	16,223	306,450	18.89	17
18	Housekeepers	34,016	37,693	468,520	12.43	18
19	Laundry					19
20	Administrator	2,839	3,350	189,255	56.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,865	6,412	128,816	20.09	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>	88,360	96,580	1,807,617	18.72	33
34	TOTAL (lines 1 - 33)	459,513	499,726	\$ 9,482,195 *	\$ 18.97	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	Weekly	\$ 12,179	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	78	3,522	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per occup bed	11,816	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	2,448	11-03	44
45	Social Service Consultant	43	3,010	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	170	\$ 50,975		49

C. CONTRACT NURSES

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

Facility Name & ID Number Norwood Crossing# 0012237

Report Period Beginning:

01/01/15

Ending:

12/31/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age \$16,492
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 99,346 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. _____
- (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 _____ 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. \$ 252,167
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. \$ 38,544 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 23,730
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt/Marcum LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.