

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 _____

	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	116	Skilled (SNF)	116	42,340	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	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	11,711	3,579	3,657	18,947	8
9	SNF/PED					9
10	ICF	13,547	4,140		17,687	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,258	7,719	3,657	36,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.52%

D. How many bed-hold days during this year were paid by the Department? 0 (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 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/01/94 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 116 and days of care provided 3,095

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **NORTHWOODS CARE CENTRE** # **0044198** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	176,433	12,509	13,050	201,992		201,992	551	202,543		1
2	Food Purchase		137,402		137,402	0	137,402	(2,153)	135,249		2
3	Housekeeping	222,558	28,412	0	250,970		250,970	1,524	252,494		3
4	Laundry	41,281	48,719	2,312	92,312	0	92,312	(1,748)	90,564		4
5	Heat and Other Utilities			110,534	110,534		110,534	0	110,534		5
6	Maintenance	41,769	24,235	17,784	83,788		83,788	(2,370)	81,418		6
7	Other (specify):*			6,061	6,061		6,061	0	6,061		7
8	TOTAL General Services	482,041	251,277	149,741	883,059	0	883,059	(4,196)	878,863		8
	B. Health Care and Programs										
9	Medical Director	0		7,800	7,800		7,800	0	7,800		9
10	Nursing and Medical Records	1,514,742	69,158	95,816	1,679,716		1,679,716	(54,469)	1,625,247		10
10a	Therapy	0		3,616	3,616		3,616	0	3,616		10a
11	Activities	150,246	7,680	3,080	161,006		161,006	(525)	160,481		11
12	Social Services	51,214		1,233	52,447		52,447	0	52,447		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,716,202	76,838	111,545	1,904,585	0	1,904,585	(54,994)	1,849,591		16
	C. General Administration										
17	Administrative	95,555		439,659	535,214		535,214	(438,808)	96,406		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			254,581	254,581		254,581	(134,308)	120,273		19
20	Dues, Fees, Subscriptions & Promotions			63,935	63,935		63,935	(48,322)	15,613		20
21	Clerical & General Office Expenses	74,081	32,555	23,621	130,257		130,257	105,404	235,661		21
22	Employee Benefits & Payroll Taxes			448,953	448,953	0	448,953	0	448,953		22
23	Inservice Training & Education			3,274	3,274		3,274	0	3,274		23
24	Travel and Seminar			0	0		0	6,835	6,835		24
25	Other Admin. Staff Transportation			3,454	3,454		3,454	0	3,454		25
26	Insurance-Prop.Liab.Malpractice			112,820	112,820		112,820	3,847	116,667		26
27	Other (specify):*			14,580	14,580		14,580	(14,580)	0		27
28	TOTAL General Administration	169,636	32,555	1,364,877	1,567,068	0	1,567,068	(519,932)	1,047,136		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,367,879	360,670	1,626,163	4,354,712	0	4,354,712	(579,122)	3,775,590		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	9,568
	REPAIRS & MAINTENANCE	3,482
		0
		13,050
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	2,312
		0
		2,312
5	HEAT & OTHER UTILITIES	
	GAS HEAT	53,412
	ELECTRICITY	36,648
	WATER	17,952
	CABLE TV - LOBBY	2,522
		0
		110,534
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,937
	PAINTING & DECORATING	2,269
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	7,226
	ELEVATOR MAINTENANCE & REPAIR	4,114
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	680
	FIRE SERVICE	1,558
		0
		0
		0
		0
		17,784
7	OTHER	
	SCAVENGER	5,821
	SECURITY SERVICE	240
		0
		0
		6,061
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	7,800
		7,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	19,200
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B 47-2	7,800
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	67,376
		0
		0
		95,816
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	2,005
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	1,611
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		3,616
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,080
		0
		3,080
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,233
		0
		1,233
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	439,659
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	27,922
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	226,659
		0
		254,581
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	44,567
	EMPLOYEE WANT ADS XIX F	1,303
	CONTRIBUTIONS VI 20 XIX F	805
	DUES & SUBSCRIPTIONS XIX F	6,080
	LICENSES & PERMITS XIX F	3,065
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	192
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,803
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,420
	PATIENT BACKGROUND CHECKS XIX F	2,700
		63,935
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,608
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,463
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	17,429
	MESSENGER SERVICE	1,121
		0
		23,621

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	179,861
	UNEMPLOYMENT COMPENSATION XIX D	39,196
	WORKERS COMPENSATION INSURANC XIX D	55,903
	HOSPITALIZATION INSURANCE XIX D	159,330
	EMPLOYEE BENEFITS - OTHER XIX D	6,157
	EMPLOYEE PHYSICAL EXAMS XIX D	1,896
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	6,610
	CHICAGO HEAD TAX XIX D	0
		0
		448,953
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,274
		3,274
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,454
		3,454
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	112,820
		112,820
27	OTHER	
	BAD DEBTS VI 24	14,580
		14,580

GRAND TOTAL COLUMN 3 OTHER

1,626,163

NORTHWOODS CARE CENTRE
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2006

TOTAL FOOD PURCHASE	137,402	PATIENT MEALS	109902
LESS SALES TAX	(2,153)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	135,249	TOTAL MEALS/YEAR	109902
TOTAL PATIENT CENSUS	36,634	NET FOOD	135249
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	109902

TOTAL PATIENT MEALS	109902	COST PER MEAL	1.23
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,939	38,939		38,939	106,139	145,078			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			600	600		600	82,414	83,014			32
33	Real Estate Taxes			72,931	72,931		72,931	0	72,931			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(415,383)	22,617			34
35	Rent-Equipment & Vehicles			25,671	25,671		25,671	4,945	30,616			35
36	Other (specify):* STORAGE			1,872	1,872		1,872	10,000	11,872			36
37	TOTAL Ownership			578,013	578,013	0	578,013	(211,885)	366,128			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		125,248	202,164	327,412		327,412	0	327,412			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			63,510	63,510		63,510	0	63,510			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	125,248	265,674	390,922	0	390,922	0	390,922			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,367,879	485,918	2,469,850	5,323,647	0	5,323,647	(791,007)	4,532,640			45

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

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	10,087	30		9
10	Interest and Other Investment Income	(36,970)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,153)	2		13
14	Non-Care Related Interest	(3)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(2,463)	21		18
19	Entertainment	0	20		19
20	Contributions	(4,608)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(7,192)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,580)	27		24
25	Fund Raising, Advertising and Promotional	(44,567)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(192)	20		28
29	Other-Attach Schedule	(20,468)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (123,109)		\$ 0	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	(667,898)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (667,898)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (791,007)		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.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (1,620)	6	1
2	VACATION ACCRUAL	551	1	2
3	VACATION ACCRUAL	1,524	3	3
4	VACATION ACCRUAL	(1,748)	4	4
5	VACATION ACCRUAL	(750)	6	5
6	VACATION ACCRUAL	(10,080)	10	6
7	VACATION ACCRUAL	(525)	11	7
8	VACATION ACCRUAL	412	17	8
9	VACATION ACCRUAL	388	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(2,320)	19	11
12	MARKETING CONSULTANT	(3,900)	19	12
13	MEDICARE B BILLING	(400)	19	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				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	(20,468)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	551	0	0	0	0	0	0	0	0	0	0	551	1
2	Food Purchase	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	2
3	Housekeeping	1,524	0	0	0	0	0	0	0	0	0	0	1,524	3
4	Laundry	(1,748)	0	0	0	0	0	0	0	0	0	0	(1,748)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,370)	0	0	0	0	0	0	0	0	0	0	(2,370)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,196)	0	0	0	0	0	0	0	0	0	0	(4,196)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,080)	0	0	(44,389)	0	0	0	0	0	0	0	(54,469)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(525)	0	0	0	0	0	0	0	0	0	0	(525)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(10,605)	0	0	(44,389)	0	0	0	0	0	0	0	(54,994)	16
	C. General Administration													
17	Administrative	412	0	(329,744)	0	439	(109,915)	0	0	0	0	0	(438,808)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,812)	0	44,464	436	(163,396)	0	0	0	0	0	0	(134,308)	19
20	Fees, Subscriptions & Promotions	(49,367)	0	306	395	344	0	0	0	0	0	0	(48,322)	20
21	Clerical & General Office Expenses	(2,075)	0	1,503	2,582	103,394	0	0	0	0	0	0	105,404	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,005	2,392	2,438	0	0	0	0	0	0	6,835	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,722	1,207	918	0	0	0	0	0	0	3,847	26
27	Other (specify):*	(14,580)	0	0	0	0	0	0	0	0	0	0	(14,580)	27
28	TOTAL General Administration	(81,422)	0	(279,744)	7,012	(55,863)	(109,915)	0	0	0	0	0	(519,932)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(96,223)	0	(279,744)	(37,377)	(55,863)	(109,915)	0	0	0	0	0	(579,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	10,087	93,611	280	129	2,032	0	0	0	0	0	0	106,139	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(36,973)	119,387	0	0	0	0	0	0	0	0	0	82,414	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(438,000)	0	1,062	21,555	0	0	0	0	0	0	(415,383)	34
35	Rent-Equipment & Vehicles	0	0	1,966	1,474	1,505	0	0	0	0	0	0	4,945	35
36	Other (specify):*	0	10,000	0	0	0	0	0	0	0	0	0	10,000	36
37	TOTAL Ownership	(26,886)	(215,002)	2,246	2,665	25,092	0	0	0	0	0	0	(211,885)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(123,109)	(215,002)	(277,498)	(34,712)	(30,771)	(109,915)	0	0	0	0	0	(791,007)	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 OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		NORTHBROOK HEALTHCARE CENTRE	MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

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)	
1	V	34 RENT	\$ 438,000	NORTHWOOD HEALTH CENTRE		\$	(438,000)	1
2	V	36 MORTGAGE INSURANCE		" "		10,000	10,000	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		93,285	93,285	3
4	V	30 DEPRECIATION - EQPT/FURN		" "		326	326	4
5	V	32 AMORTIZATION -MTG COST		" "		806	806	5
6	V	32 INTEREST - MORTGAGE		" "		107,235	107,235	6
7	V	32 INTEREST - OTHER		" "		11,346	11,346	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,000			\$ 222,998	\$ * (215,002)	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	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 44,464	\$ 44,464
16	V	20 DUES & SUBSCRIPTION		"		306	306
17	V	21 CLERICAL		"		1,503	1,503
18	V	24 TRAVEL		"		2,005	2,005
19	V	26 INSURANCE		"		1,722	1,722
20	V	35 RENT - EQPT & VEH		"		1,966	1,966
21	V	17 ADMINISTRATIVE	329,744	"			(329,744)
22	V	30 DEPRECIATION		"		280	280
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 329,744			\$ 52,246	\$ * (277,498)

* 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	10 NURSING	\$ 66,906	CARLYLE NURSING ASSOCIATES, LLC		\$ 22,517	\$ (44,389)
16	V	19 PROFESSIONAL FEES		"		436	436
17	V	20 DUES & SUBSCRIPTIONS		"		395	395
18	V	21 CLERICAL		"		2,582	2,582
19	V	24 TRAVEL		"		2,392	2,392
20	V	26 INSURANCE		"		1,207	1,207
21	V	30 DEPRECIATION		"		129	129
22	V	34 RENT		"		1,062	1,062
23	V	35 RENT - EQPT & VEH		"		1,474	1,474
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,906			\$ 32,194	\$ * (34,712)

* 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	19 PROFESSIONAL FEES	\$ 165,103	THE KENSINGTON GROUP, LLC		\$ 1,707	\$ (163,396)
16	V	20 DUES & SUBSCRIPTIONS		" "		344	344
17	V	21 CLERICAL		" "		103,394	103,394
18	V	24 TRAVEL		" "		2,438	2,438
19	V	26 INSURANCE		" "		918	918
20	V	30 DEPRECIATION		" "		2,032	2,032
21	V	34 RENT		" "		21,555	21,555
22	V	35 RENT- EQPT & VEH		" "		1,505	1,505
23	V	17 ADMINISTRATIVE		" "		439	439
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 165,103			\$ 134,332	\$ * (30,771)

* 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	17 ADMINISTRATIVE	\$ 109,915	CHESTERFIELD, LLC		\$	\$ (109,915)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 109,915			\$ 0	\$ * (109,915)

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

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

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583- 0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	345,796	7	\$ 419,864	\$ 36,634	\$ 44,464	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	7	2,888	36,634	306	2
3	21	CLERICAL	PATIENT DAYS	345,796	7	14,195	36,634	1,503	3
4	24	TRAVEL	PATIENT DAYS	345,796	7	18,932	36,634	2,005	4
5	26	INSURANCE	PATIENT DAYS	345,796	7	16,262	36,634	1,722	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	345,796	7	18,569	36,634	1,966	6
7	17	ADMINISTRATIVE	PATIENT DAYS	345,796	7		36,634	0	7
8	30	DEPRECIATION	PATIENT DAYS	345,796	7	2,647	36,634	280	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					\$ 493,357	\$	\$ 52,246	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CARLYLE NURSING ASSOC, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583- 0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT COST	1	\$ 22,517	\$ 22,517	1	\$ 22,517	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221	36,634	436	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639	36,634	395	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838	36,634	2,582	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123	36,634	2,392	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224	36,634	1,207	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834	36,634	129	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145	36,634	1,062	8
9	35	RENT & EQPT & VEH	PATIENT DAYS	522,604	11	21,023	36,634	1,474	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				\$ 160,564	\$ 22,517		\$ 32,194	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583 - 0100
 Fax Number (847) 583 - 8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	\$ 24,352	\$ 36,634	\$ 1,707	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	36,634	344	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	36,634	11,420	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	36,634	2,438	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	36,634	918	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	36,634	2,032	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	36,634	21,555	7
8	35	RENT & EQPT & VEH	PATIENT DAYS	522,604	11	21,468	36,634	1,505	8
9	17	ADMINISTRATIVE	DIRECT COST	1	1	439	439	1	439
10	21	CLERICAL	DIRECT COST	1	1	91,974	91,974	1	91,974
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					\$ 690,413	\$ 92,413	\$ 134,332	25

Facility Name & ID Number

NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE						\$	\$			\$	1						
2	GMAC		X	MORTGAGE	\$34,916.44	12/03	2,052,500	1,989,372	12/38	5.3500	107,235	2						
3	GMAC		X	LOAN COST	AMORT- 35 YEARS		28,266	25,772			806	3						
4												4						
5												5						
Working Capital																		
6	LETTER OF CREDIT FEE		X									6						
7	RELATED PARTIES	X		WORKING CAPITAL	DEMAND	VARIES	377,804	0			11,943	7						
8												8						
9	TOTAL Facility Related				\$34,916.44		\$ 2,458,570	\$ 2,015,144			\$ 119,984	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							3	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 3	14						
15	TOTALS (line 9+line14)						\$ 2,458,570	\$ 2,015,144			\$ 119,987	15						

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

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

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

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 2005 report.		\$	72,348	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.)		\$	72,242	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(106)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	73,037	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.		\$	72,931	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	67,798	8
	2002	70,821	9
	2003	70,748	10
	2004	71,557	11
	2005	72,242	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. <u>07-01-151-003</u>	<u>NURSING HOME</u>	\$ <u>72,242.18</u>	\$ <u>72,242.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>72,242.18</u>	\$ <u>72,242.18</u>

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 X NO

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2/BASEMENT

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).

N/A

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>NURSING HOME</u>	<u>105,000</u>	<u>1981</u>	<u>\$ 50,050</u>	<u>1</u>
2	<u>754 BASIS ADJ</u>		<u>1982</u>	<u>4,835</u>	<u>2</u>
3	TOTALS	105,000		\$ 54,885	3

Facility Name & ID Number **NORTHWOODS CARE CENTRE**# **0044198**

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	116	1981		\$ 995,068	\$	30	\$ 33,169	\$ 33,169	\$ 862,394	4
5	754 BASIS ADJ	1992		111,968	3,555	31.5	3,555		51,545	5
6										6
7										7
8										8
	Improvement Type**									
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE									
10	VARIOUS IMPROVEMENTS	1981		4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS	1982		73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS	1983		6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS	1984		11,372		20			11,372	13
14	PAVING	1986		13,000		15			13,000	14
15	SHOWER	1986		4,151	0	25	166	166	3,403	15
16	ROOF	1988		38,383	1,219	31.5	1,219		22,602	16
17	DECORATING	1989		1,921	61	31.5	61		1,055	17
18	VARIOUS IMPROVEMENTS	1990		10,047	319	31.5	319		5,423	18
19	VARIOUS IMPROVEMENTS	1991		2,683	85	31.5	85		1,443	19
20	VARIOUS IMPROVEMENTS	1992		38,565	1,224	31.5	1,224		17,510	20
21	CARPET	1993		6,854	217	31.5	217		2,972	21
22	DRIVEWAY	1993		1,655	42	39	42		550	22
23	SPRINKMAN SONS	1993		1,525	39	39	39		478	23
24	VARIOUS IMPROVEMENTS	1994		3,137	209	15	209		2,612	24
25	VARIOUS IMPROVEMENTS	1994		170,951	6,216	27.5	6,216		70,255	25
26	DOORS	1995		5,029	129	39	129		1,529	26
27	LANDSCAPING	1996		51,185	1,861	27.5	1,861		19,208	27
28	ROOF REPAIR	1996		20,000	727	27.5	727		7,377	28
29	DRIVEWAY REPAIR	1996		4,775	174	27.5	174		1,734	29
30	CONCRETE RETAINING WALL FOR RAMP	1997		1,500	55	27.5	55		513	30
31	WALLCOVERING/HANDRAIL /FLOOR TILES	1997		46,256	1,682	27.5	1,682		15,583	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION	1997		30,000	1,091	27.5	1,091		10,001	32
33	450000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS	1997		11,248	409	27.5	409		3,741	33
34	THREE WAY OVER BED RESIDENT LIGHTING	1998		12,600	458	27.5	458		3,785	34
35	GARBAGE DISPOSAL-KITCHEN REMODELING	1998		1,189	43	27.5	43		364	35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
37	WINDOWS AND AUTO DOOR SYSTEM	1998	\$ 25,000	\$ 909	27.5	\$ 909	\$	\$ 7,537	37
38	WALLCOVERINGS/ CARPET/FLOOR TILES/ GUARD RAILS	1998	68,941	2,507	27.5	2,507		21,870	38
39	TILES	1998	3,164	115	27.5	115		992	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		1,446	40
41	COUNTER TOPS	1998	17,763	646	27.5	646		5,459	41
42	ELECTRICAL WIRING	1998	3,675	134	27.5	134		1,144	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		38,392	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		8,404	44
45	REMODELING - HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		28,634	45
46	TILES	1999	3,924	143	27.5	143		1,019	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		684	47
48	REMODELING - ARCHITECTURE	2000	4,000	145	27.5	145		1,009	48
49	BLACKTOP STRIPPING AND SEALING	2000	4,050	270	15	270		1,755	49
50	AIR THERM HEATERS	2000	34,363	1,249	27.5	1,249		7,859	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		930	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		428	52
53	FIRE ALARM PANEL	2001	2,388	87	27.5	87		489	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		1,320	54
55	CARPETING - 1ST FLR CRDR, NSG OFFICE, ENTRYWAY	2002	12,079	1,392	5	2,416	1,024	13,529	55
56	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	1,694	27.5	1,694		7,270	56
57	F & I.A.O SMITH WATER HEATER	2002	4,600	167	27.5	167		717	57
58	FURNISH & INSTALL BOILER	2003	25,591	930	27.5	930		3,682	58
59	COMPLETE CANTILEVER RE-CONSTRUCTION	2004	14,133	514	27.5	514		1,521	59
60	INSTALL FLOOR DRAIN AND VENT	2004	834	30	27.5	30		81	60
61	REPLACE OBSOLETE ELEVATOR VALVES AND PARTS	2004	22,539	820	27.5	820		2,221	61
62	REPLACE SEWER LINE BETWEEN GREASE TRAP & MACH	2004	1,990	72	27.5	72		171	62
63	INSTALL NEW EXHAUST FAN AND DUCT WORK IN LNDRY	2005	1,185	43	27.5	43		74	63
64	SMOKE BARRIERS INSTALLED IN 1ST & 2ND FLR CORRDI	2005	14,945	543	27.5	543		747	64
65	REPLACED AND ADJUSTED DOORS	2005	6,902	251	27.5	251		345	65
66	INSTALL HOT WATER CONTROL VALVE	2005	4,142	151	27.5	151		157	66
67	CHANDELIERS/WALLCOVERING/DRAPERY	2006	18,235	3,647	5	3,647		3,647	67
68	INSTALL NEW CARPETS	2006	14,272	2,854	5	2,854		2,854	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,303,661	\$ 49,116		\$ 83,475	\$ 34,359	\$ 1,380,552	70

**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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,303,661	\$ 49,116		\$ 83,475	\$ 34,359	\$ 1,380,552	1
2	INSTALL GENERATOR & REMOTE ANNUNCIATOR	2006	34,720	368	27.5	368		368	2
3	GENERATOR RENTAL WHILE BEING INSTALLED	2006	2,007	21	27.5	21		21	3
4	DRAPERIES FOR RESIDENT ROOMS	2006	3,515	703	5	703		703	4
5	PAINTING/WALLPAPER 1ST & 2ND FLR RES. ROOMS	2006	33,768	6,754	5	6,754		6,754	5
6	TILE/DRYWALL - BASEMENT, 1ST & 2ND FLR RES. RMS	2006	34,231	363	27.5	363		363	6
7	ELEVATOR RECALL SYSTEM TIED TO FIRE ALARM SYS.	2006	5,442	41	27.5	41		41	7
8	INSTALL SPEED BUMPERS	2006	31,206	1,560	15	1,560		1,560	8
9									9
10			ADJ TO SL	34,359			(34,359)		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)		\$ 2,448,550	\$ 93,285		\$ 93,285	\$ 0	\$ 1,390,362	34

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

Facility Name & ID Number **NORTHWOODS CARE CENTRE**

0044198

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 590,143	\$ 32,943	\$ 47,527	\$ 14,584	3-15 YRS	\$ 307,273	71
72	Current Year Purchases	29,984	5,996	1,499	(4,497)	3-15 YRS	1,499	72
73	Fully Depreciated Assets	36,859			0		36,859	73
74	RELATED PARTIES		2,767	2,767	0			74
75	TOTALS	\$ 656,986	\$ 41,706	\$ 51,793	\$ 10,087		\$ 345,631	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 3,160,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,991	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,078	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,087	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,735,993	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	THIRD FLR REMODELING	\$ 81,758	92
93			93
94			94
95		\$ 81,758	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 RELATED PARTY

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: \$ 12,880 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM - VAN	\$ 295.13	\$ 2,580	17
18	ADMINISTRATIVE	2004 FORD CLUB WGN	850.00	10,211	18
19					19
20					20
21	TOTAL		\$ #####	\$ 12,791	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 98,248	\$		\$ 98,248	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,743			11,743	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			92,042			92,042	4
5	Physician Care	39-3	visits			131			131	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				100,722		100,722	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					24,526		24,526	13
14	TOTAL			\$		\$ 202,164	\$ 125,248		\$ 327,412	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 NORTHWOODS CARE CENTRE

0044198

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 337,342	\$ 637,099	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>142,391</u>)	1,479,109	1,479,109	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,123	75,846	6
7	Other Prepaid Expenses	12,590	12,590	7
8	Accounts Receivable (owners or related parties)	4,400	4,400	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		569,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,864,564	\$ 2,778,584	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	739,690	1,084,425	11
12	Long-Term Investments	1,081	1,081	12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,341,516	15
16	Equipment, at Historical Cost	656,986	693,942	16
17	Accumulated Depreciation (book methods)	(594,725)	(2,036,407)	17
18	Deferred Charges	2,866	28,638	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>CONSTRUCTION IN PROG</u>		81,758	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 805,898	\$ 2,240,071	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,670,462	\$ 5,018,655	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 454,727	\$ 454,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	178,363	178,363	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,052	92,052	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,313	14,313	31
32	Accrued Real Estate Taxes(Sch.IX-B)		73,037	32
33	Accrued Interest Payable		8,869	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	59,412	59,412	36
37	<u>DUE TO LESSOR</u>	293,919	0	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,092,786	\$ 880,773	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,989,372	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 1,989,372	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,092,786	\$ 2,870,145	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,577,676	\$ 2,148,510	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,670,462	\$ 5,018,655	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,390,771	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,390,769	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	186,907	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)	\$ 186,907	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,577,676	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,472,446	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,472,446	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	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	1,138	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,138	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,970	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,510,554	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	883,059	31
32	Health Care	1,904,585	32
33	General Administration	1,567,068	33
	B. Capital Expense		
34	Ownership	578,013	34
	C. Ancillary Expense		
35	Special Cost Centers	327,412	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,323,647	40
41	Income before Income Taxes (line 30 minus line 40)**	186,907	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 186,907	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 **NORTHWOODS CARE CENTRE**

0044198

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

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	2,359	2,568	\$ 97,010	\$ 37.78	1
2	Assistant Director of Nursing	2,152	2,353	63,457	26.97	2
3	Registered Nurses	10,604	11,946	321,726	26.93	3
4	Licensed Practical Nurses	15,762	17,302	365,357	21.12	4
5	CNAs & Orderlies	51,819	55,351	602,986	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	2,126	31,886	15.00	9
10	Activity Assistants	13,903	14,947	118,360	7.92	10
11	Social Service Workers	3,255	3,555	51,214	14.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,182	4,546	57,814	12.72	14
15	Cook Helpers/Assistants	12,794	13,738	118,619	8.63	15
16	Dishwashers					16
17	Maintenance Workers	2,590	2,786	41,769	14.99	17
18	Housekeepers	21,977	23,891	222,558	9.32	18
19	Laundry	3,946	4,392	41,281	9.40	19
20	Administrator	1,876	2,086	95,555	45.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,518	5,230	74,081	14.16	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	3,788	4,250	64,206	15.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,394	171,067	\$ 2,367,879 *	\$ 13.84	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	200	\$ 9,568	1-3	35
36	Medical Director	72	7,800	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	417	67,376	10-3	38
39	Pharmacist Consultant	96	1,440	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	3,080	11-3	44
45	Social Service Consultant	19	1,233	12-3	45
46	Other(specify) PSYCHO SOCIAL	96	19,200	10-3	46
47	UTILIZATION REVIEW	72	7,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,020	\$ 117,497		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	06/2003	\$ 1,623	3	\$ 271	\$ 541	\$ 541	\$ 270												
2	PAINT/DECORATING	06/2006	2,269	3				379	756	756	378									
3																				
4																				
5																				
6																				
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17																				
18																				
19																				
20	TOTALS		\$ 3,892		\$ 271	\$ 541	\$ 541	\$ 649	\$ 756	\$ 756	\$ 378	\$								

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL . COUNCIL ON LONG TERM CARE-\$6624
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 850 Line 10-2
- (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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,510
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? NO 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. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees