



Facility Name & ID Number NORTHWOODS CARE CENTRE

# 0044198 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	113	Skilled (SNF)	113	41,358	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	113	TOTALS	113	41,358	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	13,815	3,653	4,191	21,659	8
9	SNF/PED					9
10	ICF	11,555	3,055	620	15,230	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,370	6,708	4,811	36,889	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.19%

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 3,449

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICES)

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **NORTHWOODS CARE CENTRE** # **0044198** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

**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
	<b>A. General Services</b>										
1	Dietary	198,981	14,870	15,369	229,220		229,220	(1,323)	227,897		1
2	Food Purchase		165,936		165,936		165,936	(1,685)	164,251		2
3	Housekeeping	212,422	33,869		246,291		246,291	1,649	247,940		3
4	Laundry	41,217	25,516	791	67,524		67,524	(345)	67,179		4
5	Heat and Other Utilities			129,836	129,836		129,836		129,836		5
6	Maintenance	45,169	19,829	21,038	86,036		86,036	(1,561)	84,475		6
7	Other (specify):*			10,471	10,471		10,471		10,471		7
8	<b>TOTAL General Services</b>	497,789	260,020	177,505	935,314		935,314	(3,265)	932,049		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,900	8,900		8,900		8,900		9
10	Nursing and Medical Records	1,681,093	88,887	99,729	1,869,709		1,869,709	(13,820)	1,855,889		10
10a	Therapy			16,685	16,685		16,685		16,685		10a
11	Activities	165,586	8,841	3,134	177,561		177,561	(1,086)	176,475		11
12	Social Services	63,694		2,034	65,728		65,728		65,728		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,910,373	97,728	130,482	2,138,583		2,138,583	(14,906)	2,123,677		16
	<b>C. General Administration</b>										
17	Administrative	101,003		493,154	594,157		594,157	(493,326)	100,831		17
18	Directors Fees										18
19	Professional Services			239,401	239,401		239,401	(85,137)	154,264		19
20	Dues, Fees, Subscriptions & Promotions			156,538	156,538		156,538	(137,359)	19,179		20
21	Clerical & General Office Expenses	72,073	29,975	27,351	129,399		129,399	120,009	249,408		21
22	Employee Benefits & Payroll Taxes			455,226	455,226		455,226		455,226		22
23	Inservice Training & Education			6,325	6,325		6,325		6,325		23
24	Travel and Seminar							8,761	8,761		24
25	Other Admin. Staff Transportation			4,558	4,558		4,558		4,558		25
26	Insurance-Prop.Liab.Malpractice			52,130	52,130		52,130	11,992	64,122		26
27	Other (specify):*			511,373	511,373		511,373	(511,373)			27
28	<b>TOTAL General Administration</b>	173,076	29,975	1,946,056	2,149,107		2,149,107	(1,086,433)	1,062,674		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,581,238	387,723	2,254,043	5,223,004		5,223,004	(1,104,604)	4,118,400		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,191
	REPAIRS & MAINTENANCE	5,178
		0
		15,369
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	791
		0
		791
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	63,821
	ELECTRICITY	45,077
	WATER	18,615
	CABLE TV - LOBBY	2,323
		0
		129,836
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	7,278
	PAINTING & DECORATING	553
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,458
	ELEVATOR MAINTENANCE & REPAIR	1,645
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	560
	FIRE SERVICE	4,544
		0
		0
		0
		0
		21,038
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	10,471
	SECURITY SERVICE	0
		0
		0
		10,471
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	8,900
		8,900

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 47-2	19,200
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	5,423
	UTILIZATION REVIEW FEES XVIII B 46-2	8,200
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	66,906
		0
		0
		99,729
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	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	16,685
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		16,685
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,134
		0
		3,134
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,034
		0
		2,034
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	493,154
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	19,358
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	220,043
		0
		239,401
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	114,046
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	22,346
	EMPLOYEE WANT ADS XIX F	1,560
	CONTRIBUTIONS VI 20 XIX F	1,152
	DUES & SUBSCRIPTIONS XIX F	10,816
	LICENSES & PERMITS XIX F	3,118
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,390
	PATIENT BACKGROUND CHECKS XIX F	1,610
		156,538
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,948
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,965
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,601
	MESSENGER SERVICE	2,837
		0
		27,351

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	196,003
	UNEMPLOYMENT COMPENSATION XIX D	27,181
	WORKERS COMPENSATION INSURANC XIX D	54,514
	HOSPITALIZATION INSURANCE XIX D	160,929
	EMPLOYEE BENEFITS - OTHER XIX D	6,850
	EMPLOYEE PHYSICAL EXAMS XIX D	1,519
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	8,230
	CHICAGO HEAD TAX XIX D	0
		0
		455,226
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	6,325
		6,325
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	4,558
		4,558
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	52,130
		52,130
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	511,373
		511,373

GRAND TOTAL COLUMN 3 OTHER

**2,254,043**

**NORTHWOODS CARE CENTRE  
SCHEDULES  
12/31/2008**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	165,936
LESS SALES TAX	<u>(1,685)</u>
NET FOOD	164,251

TOTAL PATIENT CENSUS	36,889
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	110,667

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	110,667
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	110,667

NET FOOD	164,251
DIVIDE TOTAL MEALS/YEAR	<u>110,667</u>

COST PER MEAL	1.48
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name &amp; ID Number

NORTHWOODS CARE CENTRE

#0044198

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			59,583	59,583		59,583	103,581	163,164			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							77,776	77,776			32
33	Real Estate Taxes			70,876	70,876		70,876		70,876			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(412,997)	25,003			34
35	Rent-Equipment & Vehicles			32,595	32,595		32,595	6,983	39,578			35
36	Other (specify):*			1,968	1,968		1,968	9,759	11,727			36
37	<b>TOTAL Ownership</b>			603,022	603,022		603,022	(214,898)	388,124			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,104	271,314	430,418		430,418		430,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,038	62,038		62,038		62,038			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		159,104	333,352	492,456		492,456		492,456			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,581,238	546,827	3,190,417	6,318,482		6,318,482	(1,319,502)	4,998,980			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(4,817)	30		9
10	Interest and Other Investment Income	(40,206)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,685)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,965)	21		18
19	Entertainment	(114,046)	20		19
20	Contributions	(1,652)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,613)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(511,373)	27		24
25	Fund Raising, Advertising and Promotional	(22,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(7,678)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (711,381)		\$	30

<b>BHF USE ONLY</b>							
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(608,121)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (608,121)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,319,502)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0044198

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 756	6	1
2	VACATION ACCRUAL	(1,323)	1	2
3	VACATION ACCRUAL	1,649	3	3
4	VACATION ACCRUAL	(345)	4	4
5	VACATION ACCRUAL	(2,317)	6	5
6	VACATION ACCRUAL	508	10	6
7	VACATION ACCRUAL	(1,086)	11	7
8	VACATION ACCRUAL	(172)	17	8
9	VACATION ACCRUAL	(1,741)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(172)	19	11
12	MARKETING CONSULTANT	(1,435)	19	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				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	<b>Total</b>	(7,678)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(1,323)	0	0	0	0	0	0	0	0	0	0	(1,323)	1
2	Food Purchase	(1,685)	0	0	0	0	0	0	0	0	0	0	(1,685)	2
3	Housekeeping	1,649	0	0	0	0	0	0	0	0	0	0	1,649	3
4	Laundry	(345)	0	0	0	0	0	0	0	0	0	0	(345)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,561)	0	0	0	0	0	0	0	0	0	0	(1,561)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,265)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,265)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	508	0	0	(14,328)	0	0	0	0	0	0	0	(13,820)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,086)	0	0	0	0	0	0	0	0	0	0	(1,086)	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	<b>TOTAL Health Care and Programs</b>	<b>(578)</b>	<b>0</b>	<b>0</b>	<b>(14,328)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,906)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(172)	0	(369,865)	0	0	(123,289)	0	0	0	0	0	(493,326)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,220)	32,710	44,442	49	(154,118)	0	0	0	0	0	0	(85,137)	19
20	Fees, Subscriptions & Promotions	(138,044)	0	338	104	243	0	0	0	0	0	0	(137,359)	20
21	Clerical & General Office Expenses	(4,706)	0	10,347	1,818	112,550	0	0	0	0	0	0	120,009	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	3,040	2,650	3,071	0	0	0	0	0	0	8,761	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	1,074	1,378	9,540	0	0	0	0	0	0	11,992	26
27	Other (specify):*	(511,373)	0	0	0	0	0	0	0	0	0	0	(511,373)	27
28	<b>TOTAL General Administration</b>	<b>(662,515)</b>	<b>32,710</b>	<b>(310,624)</b>	<b>5,999</b>	<b>(28,714)</b>	<b>(123,289)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,086,433)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(666,358)</b>	<b>32,710</b>	<b>(310,624)</b>	<b>(8,329)</b>	<b>(28,714)</b>	<b>(123,289)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,104,604)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,817)	105,263	312	128	2,695	0	0	0	0	0	0	103,581	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(40,206)	117,982	0	0	0	0	0	0	0	0	0	77,776	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	0	25,003	0	0	0	0	0	0	(412,997)	34
35	Rent-Equipment & Vehicles	0	0	3,696	2,208	1,079	0	0	0	0	0	0	6,983	35
36	Other (specify):*	0	9,759	0	0	0	0	0	0	0	0	0	9,759	36
37	<b>TOTAL Ownership</b>	<b>(45,023)</b>	<b>(204,996)</b>	<b>4,008</b>	<b>2,336</b>	<b>28,777</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(214,898)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(711,381)</b>	<b>(172,286)</b>	<b>(306,616)</b>	<b>(5,993)</b>	<b>63</b>	<b>(123,289)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,319,502)</b>	<b>45</b>

**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		NORTHWOODS 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 CARE CENTRE		\$	(438,000)	1
2	V	36 MORTGAGE INSURANCE				9,759	9,759	2
3	V	30 DEPRECIATION - BLDG/IMP				104,973	104,973	3
4	V	30 DEPRECIATION - EQPT/FURN				290	290	4
5	V	32 AMORTIZATION - MTG COST				806	806	5
6	V	32 INTEREST - MORTGAGE				104,704	104,704	6
7	V	32 INTEREST - OTHER				12,472	12,472	7
8	V	19 ACCOUNTING FEES				11,600	11,600	8
9	V	19 DATA PROCESSING				194	194	9
10	V	19 PROFESSIONAL FEES				20,916	20,916	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,000			\$ 265,714	\$ * (172,286)	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		\$ 44,442	\$ 44,442
16	V	20 DUES & SUBSCRIPTION		"		338	338
17	V	21 CLERICAL		"		10,347	10,347
18	V	24 TRAVEL		"		3,040	3,040
19	V	26 INSURANCE		"		1,074	1,074
20	V	35 RENT - EQPT & VEH		"		3,696	3,696
21	V	17 ADMINISTRATIVE	369,865	"			(369,865)
22	V	30 DEPRECIATION		"		312	312
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		\$ 369,865			\$ 63,249	\$ * (306,616)

\* 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		\$ 52,578	\$ (14,328)
16	V	19 PROFESSIONAL FEES		"		49	49
17	V	20 DUES & SUBSCRIPTIONS		"		104	104
18	V	21 CLERICAL		"		1,818	1,818
19	V	24 TRAVEL		"		2,650	2,650
20	V	26 INSURANCE		"		1,378	1,378
21	V	30 DEPRECIATION		"		128	128
22	V	34 RENT		"			
23	V	35 RENT - EQPT & VEH		"		2,208	2,208
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			\$ 60,913	\$ * (5,993)

\* 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	\$ 163,375	THE KENSINGTON GROUP, LLC		\$ 9,257	\$ (154,118)
16	V	20 DUES & SUBSCRIPTIONS		"		243	243
17	V	21 CLERICAL		"		112,550	112,550
18	V	24 TRAVEL		"		3,071	3,071
19	V	26 INSURANCE		"		9,540	9,540
20	V	30 DEPRECIATION		"		2,695	2,695
21	V	34 RENT		"		25,003	25,003
22	V	35 RENT - EQPT & VEH		"		1,079	1,079
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		\$ 163,375			\$ 163,438	\$ * 63

\* 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	\$ 123,289	CHESTERFIELD, LLC		\$	\$ (123,289)
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	<b>Total</b>		\$ 123,289			\$ 0	\$ * (123,289)

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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: 01/01/2008 Ending: 2/31/2008

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 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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,373	7	\$ 431,773	\$ 36,889	\$ 44,442	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	36,889	338	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	36,889	10,347	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	36,889	3,040	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	36,889	1,074	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	358,373	7	35,906	36,889	3,696	6
7	17	ADMINISTRATIVE	PATIENT DAYS	358,373	7			0	7
8	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	36,889	312	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					\$ 614,484	\$	\$ 63,249	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

# 0044198 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT COST	1	\$ 52,578	\$	1	\$ 52,578	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	744	36,889	49	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	1,552	36,889	104	3
4	21	CLERICAL	PATIENT DAYS	554,294	11	27,317	36,889	1,818	4
5	24	TRAVEL	PATIENT DAYS	554,294	11	39,814	36,889	2,650	5
6	26	INSURANCE	PATIENT DAYS	554,294	11	20,700	36,889	1,378	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	11	1,923	36,889	128	7
8	34	RENT	PATIENT DAYS	554,294	11		36,889		8
9	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	33,179	36,889	2,208	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				\$ 177,807	\$		\$ 60,913	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

# 0044198 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 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

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	554,294	11	\$ 139,104	\$ 36,889	\$ 9,257	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	36,889	243	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	36,889	12,116	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	36,889	3,071	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	36,889	9,540	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	36,889	2,695	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	36,889	25,003	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	16,218	36,889	1,079	8
9	21	CLERICAL	DIRECT COST	1	1	100,434	1	100,434	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					\$ 1,047,139	\$	\$ 163,438	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

# 0044198

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10		
		YES	NO				Original	Balance						
<b>A. Directly Facility Related</b>														
<b>Long-Term</b>														
1	RELATED PARTY - NORTHWOODS HEALTH CARE CENTRE						\$		\$			\$	1	
2	CAPMARK		X	MORTGAGE	\$34,916.44			2,052,500	1,940,041				104,704	2
3	CAPMARK		X	LOAN COST		AMORT - 35 YEARS		28,266	24,160				806	3
4														4
5														5
<b>Working Capital</b>														
6														6
7	RELATED PARTIES	X		WORKING CAPITAL	DEMAND	VARIES		377,804	269,363				12,472	7
8														8
9	TOTAL Facility Related				\$34,916.44		\$	2,458,570	2,233,564			\$	117,982	9
<b>B. Non-Facility Related*</b>														
10	IRS, IDR, ETC		X	LATE FEES										10
11														11
12														12
13														13
14	TOTAL Non-Facility Related						\$					\$		14
15	TOTALS (line 9+line14)						\$	2,458,570	2,233,564			\$	117,982	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 2007 report.		\$	<b>76,500</b>	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.)		\$	<b>73,276</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(3,224)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>74,100</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>70,876</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>70,748</b>	8
	2004	<b>71,557</b>	9
	2005	<b>72,242</b>	10
	2006	<b>75,624</b>	11
	2007	<b>73,276</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 TAX BILL**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>73,275.76</u>	\$ <u>73,275.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>73,275.76</u>	\$ <u>73,275.76</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending:

12/31/2008

**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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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	<b>TOTALS</b>	<b>105,000</b>		<b>\$ 54,885</b>	<b>3</b>

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

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	\$ 928,732	4
5	754 BASIS ADJ	1992		111,968	3,554	31.5	3,554		58,654	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	RELATED PARTY - NORTHWOODS HEALTH CARE 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		25	166	166	3,735	15
16	ROOF	1988		38,383	1,218	31.5	1,218		25,039	16
17	DECORATING	1989		1,921	61	31.5	61		1,177	17
18	VARIOUS IMPROVEMENTS	1990		10,047	319	31.5	319		6,061	18
19	VARIOUS IMPROVEMENTS	1991		2,683	85	31.5	85		1,613	19
20	VARIOUS IMPROVEMENTS	1992		38,565	1,225	31.5	1,225		19,959	20
21	CARPET	1993		6,854	218	31.5	218		3,407	21
22	DRIVEWAY	1993		1,655	43	39	43		635	22
23	SPRINKMAN SONS	1993		1,525	39	39	39		556	23
24	VARIOUS IMPROVEMENTS	1994		3,137	209	15	209		3,030	24
25	VARIOUS IMPROVEMENTS	1994		170,951	6,218	27.5	6,218		82,689	25
26	DOORS	1995		5,029	129	39	129		1,787	26
27	LANDSCAPING	1996		51,185	1,861	27.5	1,861		22,930	27
28	ROOF REPAIR	1996		20,000	728	27.5	728		8,832	28
29	DRIVEWAY REPAIR	1996		4,775	174	27.5	174		2,082	29
30	CONCRETE RETAINING WALL FOR RAMP	1997		1,500	54	27.5	54		622	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES	1997		46,256	1,682	27.5	1,682		18,947	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION	1997		30,000	1,091	27.5	1,091		12,183	32
33	450,000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS	1997		11,248	409	27.5	409		4,559	33
34	THREE WAY OVER BED RESIDENT LIGHTING	1998		12,600	458	27.5	458		4,701	34
35	GARBAGE DISPOSAL-KITCHEN REMODELING	1998		1,189	43	27.5	43		450	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 &amp; ID Number NORTHWOODS CARE CENTRE

# 0044198

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## 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	\$	\$ 9,355	37
38	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	68,941	2,505	27.5	2,505		26,882	38
39	TILES	1998	3,164	115	27.5	115		1,222	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		1,788	40
41	COUNTER TOPS	1998	17,763	645	27.5	645		6,750	41
42	ELECTRICAL WIRING	1998	3,675	133	27.5	133		1,411	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,546	27.5	4,546		47,483	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		10,516	44
45	REMODELING - HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,637	27.5	3,637		35,907	45
46	TILES	1999	3,924	142	27.5	142		1,304	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	95	27.5	95		875	47
48	REMODELING - ARCHITECTURE	2000	4,000	146	27.5	146		1,300	48
49	BLACKTOP STRIPPING AND SEALING	2000	4,050	270	15	270		2,295	49
50	AIR THERM HEATERS	2000	34,363	1,249	27.5	1,249		10,358	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	170	15	170		1,269	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	76	27.5	76		579	52
53	FIRE ALARM PANEL	2001	2,388	87	27.5	87		663	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		1,800	54
55	CARPETING - 2ST FLR CRDR, NSG OFFICE, ENTRYWAY	2002	12,079		5			12,079	55
56	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	1,694	27.5	1,694		10,658	56
57	F & I.A.O SMITH WATER HEATER	2002	4,600	168	27.5	168		1,052	57
58	FURNISH & INSTALL BOILER	2003	25,591	930	27.5	930		5,543	58
59	COMPLETE CANTILEVER RE-CONSTRUCTION	2004	14,133	514	27.5	514		2,549	59
60	INSTALL FLOOR DRAIN AND VENT	2004	834	31	27.5	31		142	60
61	REPLACE OBSOLETE ELEVATOR VALVES AND PARTS	2004	22,539	819	27.5	819		3,860	61
62	REPLACE SEWER LINE BETWEEN GREASE TRAP & MACH	2004	1,990	73	27.5	73		316	62
63	INSTALL NEW EXHAUST FAN AND DUCT WORK IN LNDRY	2005	1,185	43	27.5	43		160	63
64	SMOKE BARRIERS INSTALLED IN 1ST & 2ND FLR CORRDI	2005	14,945	544	27.5	544		1,834	64
65	REPLACED AND ADJUSTED DOORS	2005	6,902	251	27.5	251		847	65
66	INSTALL HOT WATER CONTROL VALVE	2005	4,142	150	27.5	150		458	66
67	CHANDELIERS/WALLCOVERING/DRAPERY	2006	18,235	3,501	5	3,647	146	10,941	67
68	INSTALL NEW CARPETS	2006	14,272	2,740	5	2,854	114	8,562	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,303,661	\$ 47,468		\$ 81,063	\$ 33,595	\$ 1,541,226	70

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

Facility Name &amp; ID Number NORTHWOODS CARE CENTRE

# 0044198

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,303,661	\$ 47,468		\$ 81,063	\$ 33,595	\$ 1,541,226	1
2	INSTALL GENERATOR & REMOTE ANNUNCIATOR	2006	34,720	1,262	27.5	1,262		2,893	2
3	GENERATOR RENTAL WHILE BEING INSTALLED	2006	2,007	73	27.5	73		167	3
4	DRAPERIES FOR RESIDENT ROOMS	2006	3,515	675	5	703	28	2,109	4
5	PAINTING/WALLPAPER 1ST & 2ND FLR RES. ROOMS	2006	33,768	6,484	5	6,754	270	20,262	5
6	TILE/DRYWALL - BASEMENT, 1ST & 2ND FLR RES. RMS	2006	34,231	1,245	27.5	1,245		2,853	6
7	ELEVATOR RECALL SYSTEM TIED TO FIRE ALARM SYS.	2006	5,442	198	27.5	198		437	7
8	INSTALL SPEED BUMPERS	2006	31,206	2,668	15	2,080	(588)	5,720	8
9	RAISE & SUPPORT INTERIOR FLR - SW SIDE OF THE BLDG	2007	16,599	604	27.5	604		1,107	9
10	MINI BLINDS	2007	2,027	203	10	203		355	10
11	DEMOLISH EXISTING CEILING & SHORE UP FLEXICORE	2007	18,500	673	27.5	673		1,121	11
12	LOWER LEVEL KITCHEN CABINETS	2007	6,891	251	27.5	251		355	12
13	REMOVE/REPLACE ENTRANCE & ADJACENT CONC. SLAB	2007	7,850	285	27.5	285		404	13
14	DRIVEWAY - CLEAN & APPLY BREWER COAT	2007	4,100	410	10	410		513	14
15	HVAC CONTROL WORK	2007	65,900	2,397	27.5	2,397		2,796	15
16	2ND FLOOR ELEVATOR/NURSES STATION REMODELING	2007	182,698	6,643	27.5	6,643		8,304	16
17	INSTALL GALVANIZED INSULATED DOOR & CLOSER	2007	2,937	107	27.5	107		125	17
18	REPLACE FIRE ALARM CONTROL PANEL	2008	3,605	22	27.5	22		22	18
19									19
20									20
21			ADJ. TO SL	33,305			(33,305)		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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,759,657	\$ 104,973		\$ 104,973	\$	\$ 1,590,769	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:

01/01/2008

Ending:

12/31/2008

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	\$ 655,869	\$ 33,952	\$ 52,630	\$ 18,678	3-15 YRS	\$ 394,222	71
72	Current Year Purchases	42,719	25,631	2,136	(23,495)	3-15 YRS	2,136	72
73	Fully Depreciated Assets	55,362					55,362	73
74	<b>RELATED PARTIES</b>		3,425	3,425				74
75	TOTALS	\$ 753,950	\$ 63,008	\$ 58,191	\$ (4,817)		\$ 451,720	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 3,568,492	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,981	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,164	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,817)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,042,489	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		\$	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 RELATED PARTIES

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: \$ 13,716 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			\$	\$	17
18	ADMINISTRATIVE	2004 FORD CLUB WGN	850.00	18,879	18
19					19
20					20
21	TOTAL		\$ 850.00	\$ 18,879	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	\$		\$ 128,007	\$		\$ 128,007	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,991			13,991	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			128,494			128,494	4
5	Physician Care		visits							5
6	Dental Care		visits			822			822	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				139,038		139,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	LAB, X-RAY, I.V. THERAPY Other (specify): <b>RENTALS</b>	39-2					20,066		20,066	13
14	<b>TOTAL</b>			\$		\$ 271,314	\$ 159,104		\$ 430,418	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 &amp; ID Number NORTHWOODS CARE CENTRE

# 0044198

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 580,130	\$ 841,033	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 448,019 )	1,319,163	1,319,163	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,310	65,621	6
7	Other Prepaid Expenses	28,693	28,693	7
8	Accounts Receivable (owners or related parties)	4,400	4,400	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		607,690	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,960,696	\$ 2,866,600	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	813,255	1,243,637	11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,652,623	15
16	Equipment, at Historical Cost	753,950	753,950	16
17	Accumulated Depreciation (book methods)	(692,627)	(2,242,525)	17
18	Deferred Charges	1,568	25,728	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 876,146	\$ 2,478,531	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,836,842	\$ 5,345,131	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 426,810	\$ 426,910	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	189,558	189,558	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,702	116,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,219	14,219	31
32	Accrued Real Estate Taxes(Sch.IX-B)		74,100	32
33	Accrued Interest Payable		8,649	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MANAGEMENT FEES</u>	100,333	100,333	36
37	<u>DUE TO LESSOR</u>	629,160		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,476,782	\$ 930,471	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,940,041	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,940,041	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,476,782	\$ 2,870,512	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,360,060	\$ 2,474,619	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,836,842	\$ 5,345,131	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,776,428</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>REPLACEMENT TAX</b>	(1,861)	<b>4</b>
<b>5</b>	<b>ROUNDING ADJ.</b>	4	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,774,571</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(89,511)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(325,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(414,511)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,360,060</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,188,765	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,188,765	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
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		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	40,206	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 40,206	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,228,971	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	935,314	31
32	Health Care	2,138,583	32
33	General Administration	2,149,107	33
	<b>B. Capital Expense</b>		
34	Ownership	603,022	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	430,418	35
36	Provider Participation Fee	62,038	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,318,482	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(89,511)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (89,511)	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: **01/01/2008**

Ending:

**12/31/2008**

**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	2,085	2,514	\$ 101,783	\$ 40.49	1
2	Assistant Director of Nursing	1,993	2,298	66,836	29.08	2
3	Registered Nurses	13,092	14,424	389,438	27.00	3
4	Licensed Practical Nurses	14,905	16,412	362,766	22.10	4
5	CNAs & Orderlies	56,073	59,710	688,056	11.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,131	31,971	15.00	9
10	Activity Assistants	14,810	15,958	133,615	8.37	10
11	Social Service Workers	3,698	4,160	63,694	15.31	11
12	Dietician					12
13	Food Service Supervisor	1,938	2,220	37,740	17.00	13
14	Head Cook	817	840	8,223	9.79	14
15	Cook Helpers/Assistants	15,149	16,407	153,018	9.33	15
16	Dishwashers					16
17	Maintenance Workers	2,594	2,861	45,169	15.79	17
18	Housekeepers	20,889	22,730	212,422	9.35	18
19	Laundry	3,733	4,290	41,217	9.61	19
20	Administrator	1,962	2,211	101,003	45.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,962	2,131	27,709	13.00	23
24	Clerical	2,229	2,614	44,364	16.97	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	3,833	4,406	72,214	16.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,668	178,317	\$ 2,581,238 *	\$ 14.48	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	217	\$ 10,191	1-3	35
36	Medical Director	80	8,900	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	430	66,906	10-3	38
39	Pharmacist Consultant	96	5,423	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	273	16,685	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	46	3,134	11-3	44
45	Social Service Consultant	31	2,034	12-3	45
46	Other(specify) <u>UTILIZATION REV.</u>	76	8,200	10-3	46
47	<u>PSYCHOSOCIAL</u>	96	19,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,345	\$ 140,673		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. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount	
SUSAN MEAD	ADMINISTRATOR		\$ 101,003	Workers' Compensation Insurance	\$ 54,514	IDPH License Fee	\$		
	ASST ADMIN		0	Unemployment Compensation Insurance	27,181	Advertising: Employee Recruitment		1,560	
	OTHER ADMIN		0	FICA Taxes	196,003	Health Care Worker Background Check		1,390	
				Employee Health Insurance	160,929	(Indicate # of checks performed <u>139</u> )			
				Employee Meals	0	Patient Background Checks	<u>161</u>	1,610	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		1,652	
				EMPLOYEE BENEFITS - OTHER	6,850	MARKETING/ADV/PROMO		136,392	
				EMPLOYEE PHYSICAL EXAMS	1,519	LICENSES/DUES/SUBSCRIPTIONS		13,934	
				PENSION/PROFIT SHARING PLANS	8,230	MGMT CO ALLOC		685	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC		(1,652)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense		(114,046)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising		(22,346)	
						Yellow page advertising	(	0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,003	TOTAL (agree to Schedule V, line 22, col.8)	\$ 455,226	TOTAL (agree to Sch. V, line 20, col. 8)	\$	19,179	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
WITTINGHAM MNGMT ASSOC.	MANAGEMENT FEES		\$ 369,865				Out-of-State Travel	\$	
CHESTERFIELD, LLC	MANAGEMENT FEES		123,289						
							In-State Travel		
							TRAVEL	0	
							MANAGEMENT COMPANY ALLOC.	8,761	
							Seminar Expense		
								0	
							Entertainment Expense	(	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 493,154	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$	
C. Professional Services							TOTAL	8,761	
Vendor/Payee	Type		Amount						
			\$						
SEE SCHEDULE ATTACHED			239,401						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 239,401						

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1	<b>PAINT/DECORATING</b>	<b>06/2006</b>	<b>\$ 2,269</b>	<b>3</b>	<b>\$</b>	<b>\$ 379</b>	<b>\$ 756</b>	<b>\$ 756</b>	<b>\$ 378</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>								
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20	<b>TOTALS</b>		<b>\$ 2,269</b>		<b>\$</b>	<b>\$ 379</b>	<b>\$ 756</b>	<b>\$ 756</b>	<b>\$ 378</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>								

Facility Name &amp; ID Number NORTHWOODS CARE CENTRE

# 0044198

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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. ILL COUNCIL ON LTC. - \$9264
- (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. \$ 1,692 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. \$ 62,038  
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 \$5,000, 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