

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	41,245	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	41,245	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,549	263	4,697	6,509	8
9	SNF/PED					9
10	ICF	26,903	4,572	180	31,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,452	4,835	4,877	38,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.53%

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 113 and days of care provided 3,496

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

NORTHWOODS CARE CENTRE

0044198

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	207,114	12,980	14,291	234,385		234,385	1,674	236,059		1
2	Food Purchase		180,184		180,184		180,184	(1,454)	178,730		2
3	Housekeeping	172,923	28,254		201,177		201,177	(1,365)	199,812		3
4	Laundry	39,825	22,251	6,269	68,345		68,345	(2,415)	65,930		4
5	Heat and Other Utilities			132,180	132,180		132,180		132,180		5
6	Maintenance	46,024	22,163	20,198	88,385		88,385	(3,000)	85,385		6
7	Other (specify):*			13,403	13,403		13,403		13,403		7
8	TOTAL General Services	465,886	265,832	186,341	918,059		918,059	(6,560)	911,499		8
	B. Health Care and Programs										
9	Medical Director			25,800	25,800		25,800		25,800		9
10	Nursing and Medical Records	1,770,163	89,369	100,372	1,959,904		1,959,904	(6,679)	1,953,225		10
10a	Therapy										10a
11	Activities	160,342	10,228	20,060	190,630		190,630	1,852	192,482		11
12	Social Services	67,027			67,027		67,027		67,027		12
13	CNA Training										13
14	Program Transportation			308	308		308		308		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,997,532	99,597	146,540	2,243,669		2,243,669	(4,827)	2,238,842		16
	C. General Administration										
17	Administrative	100,974		263,354	364,328		364,328	(265,181)	99,147		17
18	Directors Fees										18
19	Professional Services			246,410	246,410		246,410	(71,077)	175,333		19
20	Dues, Fees, Subscriptions & Promotions			123,291	123,291		123,291	(110,248)	13,043		20
21	Clerical & General Office Expenses	72,654	25,599	35,252	133,505		133,505	142,746	276,251		21
22	Employee Benefits & Payroll Taxes			464,588	464,588		464,588		464,588		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,636	6,636		6,636	9,290	15,926		24
25	Other Admin. Staff Transportation			3,390	3,390		3,390		3,390		25
26	Insurance-Prop.Liab.Malpractice			91,146	91,146		91,146	4,099	95,245		26
27	Other (specify):*			131,677	131,677		131,677	(131,677)			27
28	TOTAL General Administration	173,628	25,599	1,365,744	1,564,971		1,564,971	(422,048)	1,142,923		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,637,046	391,028	1,698,625	4,726,699		4,726,699	(433,435)	4,293,264		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	8,309
	REPAIRS & MAINTENANCE	5,982
		0
		14,291
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	6,269
		0
		6,269
5	HEAT & OTHER UTILITIES	
	GAS HEAT	61,697
	ELECTRICITY	38,141
	WATER	32,342
	CABLE TV - LOBBY	0
		0
		132,180
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,245
	PAINTING & DECORATING	333
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,481
	ELEVATOR MAINTENANCE & REPAIR	2,449
	OUTSIDE LABOR	200
	EXTERMINATING SERVICE	550
	FIRE SERVICE	2,940
		0
		0
		0
		0
		20,198
7	OTHER	
	SCAVENGER	13,403
	SECURITY SERVICE	0
		0
		0
		13,403
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	25,800
		25,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 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	5,657
	UTILIZATION REVIEW FEES XVIII B 46-2	7,800
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	67,715
		0
		0
		100,372
10a	THERAPY	
	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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	16,862
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,198
		0
		20,060
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
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	308
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	263,354
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	20,256
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	226,154
		0
		246,410
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	59,820
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	46,401
	EMPLOYEE WANT ADS XIX F	1,517
	CONTRIBUTIONS VI 20 XIX F	325
	DUES & SUBSCRIPTIONS XIX F	8,681
	LICENSES & PERMITS XIX F	628
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	80
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,309
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	560
	PATIENT BACKGROUND CHECKS XIX F	970
		123,291
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,206
	EQUIPMENT REPAIR & MAINTENANCE	3,060
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,438
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	19,274
	MESSENGER SERVICE	2,274
		0
		35,252

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	200,039
	UNEMPLOYMENT COMPENSATION XIX D	25,282
	WORKERS COMPENSATION INSURANCE XIX D	54,575
	HOSPITALIZATION INSURANCE XIX D	171,553
	EMPLOYEE BENEFITS - OTHER XIX D	4,743
	EMPLOYEE PHYSICAL EXAMS XIX D	1,860
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	6,536
	CHICAGO HEAD TAX XIX D	0
		0
		464,588
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	6,636
	TRAVEL XIX G	0
		6,636
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,390
		3,390
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	91,146
		91,146
27	OTHER	
	BAD DEBTS VI 24	131,677
		131,677

GRAND TOTAL COLUMN 3 OTHER

1,698,625

**NORTHWOODS CARE CENTRE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	180,184
LESS SALES TAX	<u>(1,454)</u>
NET FOOD	178,730

TOTAL PATIENT CENSUS	38,164
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	114,492

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	114,492
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	114,492

NET FOOD	178,730
DIVIDE TOTAL MEALS/YEAR	<u>114,492</u>

COST PER MEAL	1.56
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

NORTHWOODS CARE CENTRE

#0044198

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			165,753	165,753		165,753	8,888	174,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			600	600		600	103,434	104,034			32
33	Real Estate Taxes			75,834	75,834		75,834		75,834			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(407,056)	30,944			34
35	Rent-Equipment & Vehicles			13,915	13,915		13,915	8,147	22,062			35
36	Other (specify):* STORAGE/MTG INS			2,286	2,286		2,286	9,628	11,914			36
37	TOTAL Ownership			696,388	696,388		696,388	(276,959)	419,429			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,046	332,543	530,589		530,589		530,589			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868		61,868			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		198,046	394,411	592,457		592,457		592,457			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,637,046	589,074	2,789,424	6,015,544		6,015,544	(710,394)	5,305,150			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	BHF 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	(99,738)	30		9
10	Interest and Other Investment Income	(600)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,454)	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	(2,438)	21		18
19	Entertainment	(59,820)	20		19
20	Contributions	(4,634)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(6,730)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(131,677)	27		24
25	Fund Raising, Advertising and Promotional	(46,401)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(80)	20		28
29	Other-Attach Schedule	3,699			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (349,873)		\$	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)	(360,521)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (360,521)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (710,394)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0044198
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 378	6	1
2	VACATION ACCRUAL	1,674	1	2
3	VACATION ACCRUAL	(1,365)	3	3
4	VACATION ACCRUAL	(2,415)	4	4
5	VACATION ACCRUAL	(3,378)	6	5
6	VACATION ACCRUAL	11,897	10	6
7	VACATION ACCRUAL	1,852	11	7
8	VACATION ACCRUAL	(1,827)	17	8
9	VACATION ACCRUAL	698	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(1,815)	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	Total	3,699		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,674	0	0	0	0	0	0	0	0	0	0	1,674	1
2	Food Purchase	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	2
3	Housekeeping	(1,365)	0	0	0	0	0	0	0	0	0	0	(1,365)	3
4	Laundry	(2,415)	0	0	0	0	0	0	0	0	0	0	(2,415)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,560)	0	0	0	0	0	0	0	0	0	0	(6,560)	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	11,897	0	0	(18,576)	0	0	0	0	0	0	0	(6,679)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,852	0	0	0	0	0	0	0	0	0	0	1,852	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	13,749	0	0	(18,576)	0	0	0	0	0	0	0	(4,827)	16
	C. General Administration													
17	Administrative	(1,827)	0	(131,677)	0	0	(131,677)	0	0	0	0	0	(265,181)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,545)	13,151	89,032	671	(163,386)	0	0	0	0	0	0	(71,077)	19
20	Fees, Subscriptions & Promotions	(110,935)	100	128	42	417	0	0	0	0	0	0	(110,248)	20
21	Clerical & General Office Expenses	(1,740)	0	7,230	1,494	135,762	0	0	0	0	0	0	142,746	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	2,242	2,968	4,080	0	0	0	0	0	0	9,290	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	962	1,307	1,830	0	0	0	0	0	0	4,099	26
27	Other (specify):*	(131,677)	0	0	0	0	0	0	0	0	0	0	(131,677)	27
28	TOTAL General Administration	(256,724)	13,251	(32,083)	6,482	(21,297)	(131,677)	0	0	0	0	0	(422,048)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(249,535)	13,251	(32,083)	(12,094)	(21,297)	(131,677)	0	0	0	0	0	(433,435)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(99,738)	104,706	720	257	2,943	0	0	0	0	0	0	8,888	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(600)	104,034	0	0	0	0	0	0	0	0	0	103,434	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	1,131	29,813	0	0	0	0	0	0	(407,056)	34
35	Rent-Equipment & Vehicles	0	0	3,801	3,405	941	0	0	0	0	0	0	8,147	35
36	Other (specify):*	0	9,628	0	0	0	0	0	0	0	0	0	9,628	36
37	TOTAL Ownership	(100,338)	(219,632)	4,521	4,793	33,697	0	0	0	0	0	0	(276,959)	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)	(349,873)	(206,381)	(27,562)	(7,301)	12,400	(131,677)	0	0	0	0	0	(710,394)	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		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		" "		9,628	9,628	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		104,566	104,566	3
4	V	30 DEPRECIATION - EQPT/FURN		" "		140	140	4
5	V	32 AMORTIZATION - MTG COST		" "		806	806	5
6	V	32 INTEREST - MORTGAGE		" "		103,228	103,228	6
7	V	32 INTEREST - OTHER		" "				7
8	V	19 ACCOUNTING FEES		" "		13,001	13,001	8
9	V	19 DATA PROCESSING		" "		150	150	9
10	V	20 DUES & SUBSCRIPTIONS		" "		100	100	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 438,000			\$ 231,619	\$ * (206,381)	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		\$ 89,032	\$ 89,032
16	V	20 DUES & SUBSCRIPTIONS		"		128	128
17	V	21 CLERICAL		"		7,230	7,230
18	V	24 TRAVEL		"		2,242	2,242
19	V	26 INSURANCE		"		962	962
20	V	35 RENT - EQPT & VEH		"		3,801	3,801
21	V	17 ADMINISTRATIVE	131,677	"			(131,677)
22	V	30 DEPRECIATION		"		720	720
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		\$ 131,677			\$ 104,115	\$ * (27,562)

* 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		\$ 48,330	\$ (18,576)
16	V	19 PROFESSIONAL FEES		" "		671	671
17	V	20 DUES & SUBSCRIPTIONS		" "		42	42
18	V	21 CLERICAL		" "		1,494	1,494
19	V	24 TRAVEL		" "		2,968	2,968
20	V	26 INSURANCE		" "		1,307	1,307
21	V	30 DEPRECIATION		" "		257	257
22	V	34 RENT		" "		1,131	1,131
23	V	35 RENT - EQPT & VEH		" "		3,405	3,405
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			\$ 59,605	\$ * (7,301)

* 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		\$ 1,717	\$ (163,386)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		417	417	16
17	V	21	CLERICAL		" "		135,762	135,762	17
18	V	24	TRAVEL		" "		4,080	4,080	18
19	V	26	INSURANCE		" "		1,830	1,830	19
20	V	30	DEPRECIATION		" "		2,943	2,943	20
21	V	34	RENT		" "		29,813	29,813	21
22	V	35	RENT - EQPT & VEH		" "		941	941	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 165,103			\$ 177,503	\$ * 12,400	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$ 131,677	CHESTERFIELD, LLC		\$	\$	(131,677) 15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 131,677			\$ 0	\$ *	(131,677) 39

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

Facility Name & ID Number

NORTHWOODS CARE CENTRE

#

0044198

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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:

01/01/2009

Ending: 2/31/2009

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	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	355,386	7	\$ 829,056	\$ 38,164	\$ 89,032	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	355,386	7	1,188	38,164	128	2
3	21	CLERICAL	PATIENT DAYS	355,386	7	67,323	38,164	7,230	3
4	24	TRAVEL	PATIENT DAYS	355,386	7	20,875	38,164	2,242	4
5	26	INSURANCE	PATIENT DAYS	355,386	7	8,960	38,164	962	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	355,386	7	35,397	38,164	3,801	6
7	17	ADMINISTRATIVE	PATIENT DAYS	355,386	7		38,164	0	7
8	30	DEPRECIATION	PATIENT DAYS	355,386	7	6,701	38,164	720	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					\$ 969,500	\$	\$ 104,115	25

Facility Name & ID Number NORTHWOODS CARE CENTRE

0044198

Report Period Beginning: 01/01/2009

Ending: 2/31/2009

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	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	\$ 48,330	\$ 48,330	1	\$ 48,330	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,656	38,164	671	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	38,164	42	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	38,164	1,494	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	38,164	2,968	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	38,164	1,307	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	38,164	257	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	38,164	1,131	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	48,990	38,164	3,405	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				\$ 210,561	\$ 48,330		\$ 59,605	25

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

0044198

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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	549,185	11	\$ 24,702	\$ 38,164	\$ 1,717	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	38,164	417	2
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	38,164	14,951	3
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	38,164	4,080	4
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	38,164	1,830	5
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	38,164	2,943	6
7	34	RENT	PATIENT DAYS	549,185	11	428,990	38,164	29,813	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	13,546	38,164	941	8
9	21	CLERICAL	DIRECT COST	1	1	120,811	120,811	1	120,811
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					\$ 936,608	\$ 120,811	\$ 177,503	25

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		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 HEALTH CARE CENTRE						\$	\$			\$	1					
2	BERKADIA		X	MORTGAGE	\$34,916.44	12/03	2,052,500	1,913,328	12/38	0.0540	103,228	2					
3	BERKADIA		X	LOAN COST	AMORT - 35 YEARS		28,266	23,354			806	3					
4												4					
5												5					
	Working Capital																
6												6					
7	RELATED PARTIES	X		WORKING CAPITAL	DEMAND	VARIES	377,804				600	7					
8												8					
9	TOTAL Facility Related				\$34,916.44		\$ 2,458,570	\$ 1,936,682			\$ 104,634	9					
	B. Non-Facility Related*																
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	\$ 1,936,682			\$ 104,634	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

1. Real Estate Tax accrual used on 2008 report.		\$	74,100	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.)		\$	74,534	2
3. Under or (over) accrual (line 2 minus line 1).		\$	434	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,400	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.		\$	75,834	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	71,557	8
	2005	72,242	9
	2006	75,624	10
	2007	73,276	11
	2008	74,534	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 105% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- 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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-01-151-003</u>	<u>NURSING HOME</u>	\$ <u>74,534.36</u>	\$ <u>74,534.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>74,534.36</u>	\$ <u>74,534.36</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

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	TOTALS	105,000		\$ 54,885	3

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	\$ 961,901	4
5	754 BASIS ADJ.		1992		111,968	3,555	31.5	3,555		62,209	5
6											6
7											7
8											8
	Improvement Type**										
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	3,901	15
16	ROOF		1988		38,383	1,219	31.5	1,219		26,258	16
17	DECORATING		1989		1,921	61	31.5	61		1,238	17
18	VARIOUS IMPROVEMENTS		1990		10,047	319	31.5	319		6,380	18
19	VARIOUS IMPROVEMENTS		1991		2,683	86	31.5	86		1,699	19
20	VARIOUS IMPROVEMENTS		1992		38,565	1,223	31.5	1,223		21,182	20
21	CARPET		1993		6,854	218	31.5	218		3,625	21
22	DRIVEWAY		1993		1,655	42	39	42		677	22
23	SPRINKMAN SONS		1993		1,525	39	39	39		595	23
24	VARIOUS IMPROVEMENTS		1994		3,137	107	15	107		3,137	24
25	VARIOUS IMPROVEMENTS		1994		170,951	6,216	27.5	6,216		88,905	25
26	DOORS		1995		5,029	129	39	129		1,916	26
27	LANDSCAPING		1996		51,185	1,860	27.5	1,860		24,790	27
28	ROOF REPAIR		1996		20,000	727	27.5	727		9,559	28
29	DRIVEWAY REPAIR		1996		4,775	174	27.5	174		2,256	29
30	CONCRETE RETAINING WALL FOR RAMP		1997		1,500	55	27.5	55		677	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES		1997		46,256	1,682	27.5	1,682		20,629	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION		1997		30,000	1,091	27.5	1,091		13,274	32
33	450,000 GRAIN UNITS - WATER SOFTENER/COUNTER TOPS		1997		11,248	409	27.5	409		4,968	33
34	THREE WAY OVER BED RESIDENT LIGHTING		1998		12,600	458	27.5	458		5,159	34
35	GARBAGE DISPOSAL - KITCHEN REMODELING		1998		1,189	44	27.5	44		494	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWOODS CARE CENTRE# 0044198

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1998	\$ 25,000	\$ 909	27.5	\$ 909	\$	\$ 10,264	37
38	1998	68,941	2,509	27.5	2,509		29,391	38
39	1998	3,164	115	27.5	115		1,337	39
40	1998	4,705	171	27.5	171		1,959	40
41	1998	17,763	647	27.5	647		7,397	41
42	1998	3,675	134	27.5	134		1,545	42
43	1998	125,000	4,546	27.5	4,546		52,029	43
44	1999	29,035	1,055	27.5	1,055		11,571	44
45	1999	100,000	3,636	27.5	3,636		39,543	45
46	1999	3,924	143	27.5	143		1,447	46
47	1999	2,628	96	27.5	96		971	47
48	2000	4,000	145	27.5	145		1,445	48
49	2000	4,050	270	15	270		2,565	49
50	2000	34,363	1,250	27.5	1,250		11,608	50
51	2001	2,540	169	15	169		1,438	51
52	2001	2,070	75	27.5	75		654	52
53	2001	2,388	87	27.5	87		750	53
54	2001	3,600	240	15	240		2,040	54
55	2002	12,079		5			12,079	55
56	2002	46,590	1,695	27.5	1,695		12,353	56
57	2002	4,600	167	27.5	167		1,219	57
58	2003	25,591	931	27.5	931		6,474	58
59	2004	14,133	514	27.5	514		3,063	59
60	2004	834	30	27.5	30		172	60
61	2004	22,539	820	27.5	820		4,680	61
62	2004	1,990	72	27.5	72		388	62
63	2005	1,185	43	27.5	43		203	63
64	2005	14,945	543	27.5	543		2,377	64
65	2005	6,902	251	27.5	251		1,098	65
66	2005	4,142	151	27.5	151		609	66
67	2006	18,235	2,101	10	1,824	(277)	12,765	67
68	2006	14,272	1,644	10	1,427	(217)	9,989	68
69								69
70		\$ 2,303,661	\$ 44,873		\$ 77,714	\$ 32,841	\$ 1,618,940	70

**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:

01/01/2009 Ending: 12/31/2009

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	\$ 44,873		\$ 77,714	\$ 32,841	\$ 1,618,940	1
2	INSTALL GENERATOR & REMOTE ANNUNCIATOR	2006	34,720	1,263	27.5	1,263		4,156	2
3	GENERATOR RENTAL WHILE BEING INSTALLED	2006	2,007	73	27.5	73		240	3
4	DRAPERIES FOR RESIDENT ROOMS	2006	3,515	405	5	352	(53)	2,461	4
5	PAINTING/WALLPAPER 1ST & 2ND FLR RES. RMS	2006	33,768	3,890	5	3,377	(513)	23,639	5
6	TILE/DRYWALL - BASEMENT, 1ST & 2ND FLR RES. RMS	2006	34,231	1,244	27.5	1,244		4,097	6
7	ELEVATOR RECALL SYSTEM TIED TO FIRE ALARM SYS.	2006	5,442	198	27.5	198		635	7
8	INSTALL SPEED BUMPERS	2006	31,206	2,401	15	2,080	(321)	7,800	8
9	RAISE & SUPPORT INTERIOR FLR - SW SIDE OF THE BLDG	2007	16,599	603	27.5	603		1,710	9
10	MINI BLINDS	2007	2,027	202	10	202		557	10
11	DEMOLISH EXISTING CEILING & SHORE UP FLEXICORE	2007	18,500	673	27.5	673		1,794	11
12	LOWER LEVEL KITCHEN CABINETS	2007	6,891	251	27.5	251		606	12
13	REMOVE/REPLACE ENTRANCE & ADJACENT CONC. SLAB	2007	7,850	286	27.5	286		690	13
14	DRIVEWAY - CLEAN & APPLY BREWER COAT	2007	4,100	410	10	410		923	14
15	HVAC CONTROL WORK	2007	65,900	2,396	27.5	2,396		5,192	15
16	2ND FLOOR ELEVATOR/NURSES STATION REMODELING	2007	182,698	6,644	27.5	6,644		14,948	16
17	INSTALL GALVANIZED INSULATED DOOR & CLOSER	2007	2,937	106	27.5	106		231	17
18	REPLACE FIRE ALARM CONTROL PANEL	2008	3,605	131	27.5	131		153	18
19	FABRICATE AND INSTALL FIRE DAMPERS	2009	5,496	200	27.5	200		200	19
20	MODIFY 3 SETS OF STAIR RAILINGS	2009	9,020	328	27.5	328		328	20
21	CABINER HEATERS FOR 2ND FLOOR	2009	26,755	892	27.5	892		892	21
22	CONSTRUCTION MATERIALS FOR 1ST & 2ND FLR RMDL	2009	15,012	455	27.5	455		455	22
23	CONSTRUCTION MATERIALS FOR 2ND FLR SHOWER RM	2009	3,891	118	27.5	118		118	23
24	LABOR & MATERIALS TO INSTALL GAS CONNECTION	2009	3,995	109	27.5	109		109	24
25	REMODELING 1ST & 2ND FLR RESIDENT RMS	2009	149,980	3,636	27.5	3,636		3,636	25
26	REPLACEMENT OF BATH FIXTURES, TOILETS, TUBS	2009	23,500	570	27.5	570		570	26
27	TILES FOR SHOWER ROOM	2009	5,101	255	10	255		255	27
28									28
29			ADJ. TO SL	31,954			(31,954)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,002,407	\$ 104,566		\$ 104,566	\$	\$ 1,695,335	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:

01/01/2009

Ending:

12/31/2009

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	\$ 672,779	\$ 27,736	\$ 54,511	\$ 26,775	3-15 YRS	\$ 425,047	71
72	Current Year Purchases	230,028	138,017	11,504	(126,513)	3-15 YRS	11,504	72
73	Fully Depreciated Assets	81,171					81,171	73
74	RELATED PARTIES		4,060	4,060				74
75	TOTALS	\$ 983,978	\$ 169,813	\$ 70,075	\$ (99,738)		\$ 517,722	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)	\$ 4,041,270	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 274,379	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,641	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (99,738)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,213,057	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?

16. Rental Amount for movable equipment: \$ 13,915 Description: YES NO

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					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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?</p> <p><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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 146,963	\$		\$ 146,963	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,597			10,597	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			174,983			174,983	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				149,632		149,632	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): RENTALS	39-2					48,414		48,414	13
14	TOTAL			\$		\$ 332,543	\$ 198,046		\$ 530,589	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,462,501	\$ 1,827,100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	952,308	952,308	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,588	62,278	6
7	Other Prepaid Expenses	7,097	7,097	7
8	Accounts Receivable (owners or related parties)	817,655	1,250,631	8
9	Other(specify): ESCROW DEPOSITS		157,431	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,268,149	\$ 4,256,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		2,890,440	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	975,256	975,256	16
17	Accumulated Depreciation (book methods)	(849,657)	(2,472,167)	17
18	Deferred Charges	523	23,877	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 126,122	\$ 1,467,456	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,394,271	\$ 5,724,301	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 125,148	\$ 226,099	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,706	21,706	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,010	31,010	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,806	32,806	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,400	32
33	Accrued Interest Payable		8,530	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	101,858	101,858	36
37	DUE TO LESSOR			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 312,528	\$ 497,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	921,747		39
40	Mortgage Payable		1,913,328	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)	\$ 921,747	\$ 1,913,328	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,234,275	\$ 2,410,737	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,159,996	\$ 3,313,564	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,394,271	\$ 5,724,301	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,360,060	1
2	Restatements (describe):		2
3	REPLACEMENT TAX - 2008	(2,793)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,357,267	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	802,729	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)	\$ 802,729	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,159,996	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	\$ 6,818,706	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,818,706	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)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,041	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,041	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)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,823,747	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	918,059	31
32	Health Care	2,243,669	32
33	General Administration	1,564,971	33
B. Capital Expense			
34	Ownership	696,388	34
C. Ancillary Expense			
35	Special Cost Centers	530,589	35
36	Provider Participation Fee	61,868	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	5,474	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,021,018	40
41	Income before Income Taxes (line 30 minus line 40)**	802,729	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 802,729	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:

01/01/2009

Ending:

12/31/2009

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	2,229	2,513	\$ 105,340	\$ 41.92	1
2	Assistant Director of Nursing	2,020	2,284	66,306	29.03	2
3	Registered Nurses	15,052	16,455	444,192	26.99	3
4	Licensed Practical Nurses	13,203	14,905	333,356	22.37	4
5	CNAs & Orderlies	58,717	62,451	743,687	11.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,909	2,126	31,886	15.00	9
10	Activity Assistants	13,893	15,118	128,456	8.50	10
11	Social Service Workers	3,710	4,181	67,027	16.03	11
12	Dietician					12
13	Food Service Supervisor	1,973	2,197	37,351	17.00	13
14	Head Cook	1,432	1,466	12,721	8.68	14
15	Cook Helpers/Assistants	14,354	15,630	157,042	10.05	15
16	Dishwashers					16
17	Maintenance Workers	2,608	2,875	46,024	16.01	17
18	Housekeepers	17,339	18,698	172,923	9.25	18
19	Laundry	3,057	3,774	39,825	10.55	19
20	Administrator	1,917	2,206	100,974	45.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,877	2,166	28,954	13.37	23
24	Clerical	2,234	2,579	43,700	16.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care CLERICAL	4,060	4,649	77,282	16.62	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,584	176,273	\$ 2,637,046 *	\$ 14.96	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	177	\$ 8,309	1-3	35
36	Medical Director	232	25,800	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	430	67,715	10-3	38
39	Pharmacist Consultant	100	5,657	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	3,198	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify) UTILIZATION REV.	72	7,800	10-3	46
47	PSYCHOSOCIAL	96	19,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,155	\$ 137,679		49

C. CONTRACT NURSES

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

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	
SUSAN MEAN	ADMINISTRATOR		\$ 100,974	Workers' Compensation Insurance	\$ 54,575	IDPH License Fee	\$	
	ASST ADMIN		0	Unemployment Compensation Insurance	25,282	Advertising: Employee Recruitment	1,517	
	OTHER ADMIN		0	FICA Taxes	200,039	Health Care Worker Background Check	560	
				Employee Health Insurance	171,553	(Indicate # of checks performed <u>56</u>)		
				Employee Meals	0	Patient Background Checks	97	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,634	
				EMPLOYEE BENEFITS - OTHER	4,743	MARKETING/ADV/PROMO	106,301	
				EMPLOYEE PHYSICAL EXAMS	1,860	LICENSES/DUES/SUBSCRIPTIONS	9,309	
				PENSION/PROFIT SHARING PLANS	6,536	MGMT CO ALLOC	687	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,634)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(59,820)	
						Non-allowable advertising	(46,401)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Yellow page advertising	(80)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,974	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
WITTINGHAM MNGMT ASSOC. MANAGEMENT FEES			\$ 131,677					
CHESTERFIELD, LLC MANAGEMENT FEES			131,677					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 263,354					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
		\$			\$	Out-of-State Travel	\$	
						In-State Travel		
						TRAVEL	0	
						RELATED PARTY	9,290	
						Seminar Expense		
							6,636	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
SEE SCHEDULE ATTACHED			246,410	TOTAL		TOTAL	\$ 15,926	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 246,410					

* 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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$ 2,269	3	\$ 379	\$ 756	\$ 756	\$ 378	\$	\$	\$	\$	\$
2												
3												
4												
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16												
17												
18												
19												
20	TOTALS	\$ 2,269		\$ 379	\$ 756	\$ 756	\$ 378	\$	\$	\$	\$	\$

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. - \$8712
- (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. \$ 2,200 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. \$ 61,868
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: _____
- (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.