FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 PEARL STREET (Number) BELVIDERE (City) 61008 (Zip Code)

County: BOONE

Telephone Number: (815) 544-0358 **Fax #** (815) 544-5006

HFS ID Number:

Date of Initial License for Current Owners: 06/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MICHAEL BRAUN **Telephone Number:** (847) 583-0100 X 126
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) MICHAEL C. BRAUN
(Title) CONTROLLER

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,691	2,596	4,106	17,393	8
9	SNF/PED					9
10	ICF	17,016	4,131	480	21,627	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,707	6,727	4,586	39,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.61%

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 [X]

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

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 [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 113 and days of care provided 3,804

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	211,864	14,856	8,584	235,304		235,304	3,113	238,417			1
2	Food Purchase		183,908		183,908		183,908	(1,582)	182,326			2
3	Housekeeping	179,538	38,368		217,906		217,906	2,610	220,516			3
4	Laundry	31,192	24,793	4,334	60,319		60,319	2,864	63,183			4
5	Heat and Other Utilities			115,971	115,971		115,971		115,971			5
6	Maintenance	38,380	29,925	25,124	93,429		93,429	4,880	98,309			6
7	Other (specify):*			17,219	17,219		17,219		17,219			7
8	TOTAL General Services	460,974	291,850	171,232	924,056		924,056	11,885	935,941			8
	B. Health Care and Programs											
9	Medical Director			25,800	25,800		25,800		25,800			9
10	Nursing and Medical Records	1,793,120	97,452	95,119	1,985,691		1,985,691	31,084	2,016,775			10
10a	Therapy											10a
11	Activities	180,504	11,009	21,469	212,982		212,982	2,938	215,920			11
12	Social Services	68,790			68,790		68,790		68,790			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,042,414	108,461	142,388	2,293,263		2,293,263	34,022	2,327,285			16
	C. General Administration											
17	Administrative	97,088		281,982	379,070		379,070	(280,155)	98,915			17
18	Directors Fees											18
19	Professional Services			239,295	239,295		239,295	(50,515)	188,780			19
20	Dues, Fees, Subscriptions & Promotions			117,755	117,755		117,755	(101,994)	15,761			20
21	Clerical & General Office Expenses	80,221	23,861	33,516	137,598		137,598	156,290	293,888			21
22	Employee Benefits & Payroll Taxes			505,674	505,674		505,674		505,674			22
23	Inservice Training & Education			5,958	5,958		5,958		5,958			23
24	Travel and Seminar			148	148		148	9,665	9,813			24
25	Other Admin. Staff Transportation			6,230	6,230		6,230		6,230			25
26	Insurance-Prop.Liab.Malpractice			69,593	69,593		69,593	2,850	72,443			26
27	Other (specify):*			140,991	140,991		140,991	(140,991)				27
28	TOTAL General Administration	177,309	23,861	1,401,142	1,602,312		1,602,312	(404,850)	1,197,462			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,680,697	424,172	1,714,762	4,819,631		4,819,631	(358,943)	4,460,688			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,220	
	REPAIRS & MAINTENANCE		2,364	
			0	8,584
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,334	
			0	4,334
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		34,051	
	ELECTRICITY		48,754	
	WATER		33,166	
	CABLE TV - LOBBY		0	
			0	115,971
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,940	
	PAINTING & DECORATING		579	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,257	
	ELEVATOR MAINTENANCE & REPAIR		2,195	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		930	
	FIRE SERVICE		4,223	
			0	
			0	
			0	
			0	25,124
7	**OTHER**			
	SCAVENGER		17,219	
	SECURITY SERVICE		0	
			0	
			0	17,219
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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,788	
	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	61,331	
			0	
			0	95,119
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		18,100	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,369	
			0	21,469
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

Facility Name & ID Number NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	281,982	281,982
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	22,941	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	216,354	
			0	239,295
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	47,224	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	45,281	
	EMPLOYEE WANT ADS	XIX F	660	
	CONTRIBUTIONS	VI 20 XIX F	3,605	
	DUES & SUBSCRIPTIONS	XIX F	7,842	
	LICENSES & PERMITS	XIX F	5,217	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	616	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,780	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	480	
	PATIENT BACKGROUND CHECKS	XIX F	1,050	
				117,755
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,931	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,206	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,565	
	MESSENGER SERVICE		2,814	
			0	33,516

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	203,177	
	UNEMPLOYMENT COMPENSATION	XIX D	35,567	
	WORKERS COMPENSATION INSURANC	XIX D	57,790	
	HOSPITALIZATION INSURANCE	XIX D	193,686	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,904	
	EMPLOYEE PHYSICAL EXAMS	XIX D	600	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	6,950	
	CHICAGO HEAD TAX	XIX D	0	
			0	505,674
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,958	
				5,958
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	148	
				148
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,230	
				6,230
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		69,593	
				69,593
27	**OTHER**			
	BAD DEBTS	VI 24	140,991	
				140,991

GRAND TOTAL COLUMN 3 OTHER **1,714,762**

NORTHWOODS CARE CENTRE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	183,908
LESS SALES TAX	(1,582)
NET FOOD	182,326
TOTAL PATIENT CENSUS	39,020
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	117,060
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	117,060
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	117,060
NET FOOD	182,326
DIVIDE TOTAL MEALS/YEAR	117,060
COST PER MEAL	1.56
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			127,109	127,109		127,109	67,180	194,289			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			600	600		600	102,326	102,926			32
33	Real Estate Taxes			76,550	76,550		76,550		76,550			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(402,008)	35,992			34
35	Rent-Equipment & Vehicles			22,685	22,685		22,685	7,956	30,641			35
36	Other (specify):* STORAGE/MTG INS			1,970	1,970		1,970	9,490	11,460			36
37	**TOTAL Ownership**			666,914	666,914		666,914	(215,056)	451,858			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195,509	407,963	603,472		603,472		603,472			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**		195,509	469,831	665,340		665,340		665,340			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,680,697	619,681	2,851,507	6,151,885		6,151,885	(573,999)	5,577,886			45

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 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	(47,388)	30		9
10	Interest and Other Investment Income	(85)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,582)	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	(5,206)	21		18
19	Entertainment	(47,224)	20		19
20	Contributions	(9,385)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,870)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,991)	27		24
25	Fund Raising, Advertising and Promotional	(45,281)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(616)	20		28
29	Other-Attach Schedule	13,550			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (292,078)		$	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 Amount	2 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)	(281,921)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (281,921)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (573,999)		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 Yes	2 No	3 Amount	4 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

NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL	3,113	1	2
3	VACATION ACCRUAL	2,610	3	3
4	VACATION ACCRUAL	2,864	4	4
5	VACATION ACCRUAL	4,880	6	5
6	VACATION ACCRUAL	(2,261)	10	6
7	VACATION ACCRUAL	2,938	11	7
8	VACATION ACCRUAL	1,827	17	8
9	VACATION ACCRUAL	1,460	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(1,881)	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**	13,550		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE **#** 0044198 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	3,113	0	0	0	0	0	0	0	0	0	0	3,113	1
2	Food Purchase	(1,582)	0	0	0	0	0	0	0	0	0	0	(1,582)	2
3	Housekeeping	2,610	0	0	0	0	0	0	0	0	0	0	2,610	3
4	Laundry	2,864	0	0	0	0	0	0	0	0	0	0	2,864	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,880	0	0	0	0	0	0	0	0	0	0	4,880	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	11,885	0	0	0	0	0	0	0	0	0	0	11,885	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	(2,261)	0	0	33,345	0	0	0	0	0	0	0	31,084	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	2,938	0	0	0	0	0	0	0	0	0	0	2,938	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**	677	0	0	33,345	0	0	0	0	0	0	0	34,022	16
	C. General Administration													
17	Administrative	1,827	0	(140,991)	0	0	(140,991)	0	0	0	0	0	(280,155)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,751)	35,891	87,226	1,903	(163,784)	0	0	0	0	0	0	(50,515)	19
20	Fees, Subscriptions & Promotions	(102,506)	100	141	59	212	0	0	0	0	0	0	(101,994)	20
21	Clerical & General Office Expenses	(3,746)	0	9,593	4,283	146,160	0	0	0	0	0	0	156,290	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	1,891	3,293	4,481	0	0	0	0	0	0	9,665	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	553	1,381	916	0	0	0	0	0	0	2,850	26
27	Other (specify):*	(140,991)	0	0	0	0	0	0	0	0	0	0	(140,991)	27
28	**TOTAL General Administration**	(257,167)	35,991	(41,587)	10,919	(12,015)	(140,991)	0	0	0	0	0	(404,850)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(244,605)	35,991	(41,587)	44,264	(12,015)	(140,991)	0	0	0	0	0	(358,943)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(47,388)	110,310	1,282	640	2,336	0	0	0	0	0	0	67,180	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85)	102,411	0	0	0	0	0	0	0	0	0	102,326	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	1,165	34,827	0	0	0	0	0	0	(402,008)	34
35	Rent-Equipment & Vehicles	0	0	3,701	3,231	1,024	0	0	0	0	0	0	7,956	35
36	Other (specify):*	0	9,490	0	0	0	0	0	0	0	0	0	9,490	36
37	**TOTAL Ownership**	(47,473)	(215,789)	4,983	5,036	38,187	0	0	0	0	0	0	(215,056)	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)**	(292,078)	(179,798)	(36,604)	49,300	26,172	(140,991)	0	0	0	0	0	(573,999)	45

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 HEALTH CARE 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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		" "		9,490	9,490	2
3	V	30	DEPRECIATION - BLDG/IMP		" "		110,310	110,310	3
4	V	30	DEPRECIATION - EQPT/FURN		" "				4
5	V	32	AMORTIZATION - MTG COST		" "		807	807	5
6	V	32	INTEREST - MORTGAGE		" "		101,604	101,604	6
7	V	19	LEGAL		" "		2,756	2,756	7
8	V	19	ACCOUNTING FEES		" "		23,085	23,085	8
9	V	19	DATA PROCESSING		" "		50	50	9
10	V	19	OTHER PROFESSIONAL		" "		10,000	10,000	10
11	V	20	DUES & SUBSCRIPTIONS		" "		100	100	11
12	V								12
13	V								13
14	Total			$ 438,000			$ 258,202	$ * (179,798)	14

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES		$ 87,226	$ 87,226	15
16	V	20	DUES & SUBSCRIPTIONS		" "		141	141	16
17	V	21	CLERICAL		" "		9,593	9,593	17
18	V	24	TRAVEL		" "		1,891	1,891	18
19	V	26	INSURANCE		" "		553	553	19
20	V	35	RENT - EQPT & VEH		" "		3,701	3,701	20
21	V	17	ADMINISTRATIVE	140,991	" "			(140,991)	21
22	V	30	DEPRECIATION		" "		1,282	1,282	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			$ 140,991			$ 104,387	$ * (36,604)	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: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 61,331	CARLYLE NURSING ASSOCIATES, LLC		$ 94,676	$ 33,345	15
16	V	19	PROFESSIONAL FEES		" "		1,903	1,903	16
17	V	20	DUES & SUBSCRIPTIONS		" "		59	59	17
18	V	21	CLERICAL		" "		4,283	4,283	18
19	V	24	TRAVEL		" "		3,293	3,293	19
20	V	26	INSURANCE		" "		1,381	1,381	20
21	V	30	DEPRECIATION		" "		640	640	21
22	V	34	RENT		" "		1,165	1,165	22
23	V	35	RENT - EQPT & VEH		" "		3,231	3,231	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			$ 61,331			$ 110,631	$ * 49,300	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: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 165,103	THE KENSINGTON GROUP, LLC		$ 1,319	$ (163,784)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		212	212	16
17	V	21	CLERICAL		" "		146,160	146,160	17
18	V	24	TRAVEL		" "		4,481	4,481	18
19	V	26	INSURANCE		" "		916	916	19
20	V	30	DEPRECIATION		" "		2,336	2,336	20
21	V	34	RENT		" "		34,827	34,827	21
22	V	35	RENT - EQPT & VEH		" "		1,024	1,024	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			$ 191,275	$ * 26,172	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: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 140,991	CHESTERFIELD, LLC		$	$ (140,991)	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			$ 140,991			$ 0	$ * (140,991)	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: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 01/01/2010 Ending: 2/31/2010

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 [X] 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	361,812	7	$ 808,776	$	39,020	$ 87,226	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	361,812	7	1,305		39,020	141	2
3	21	CLERICAL	PATIENT DAYS	361,812	7	88,950		39,020	9,593	3
4	24	TRAVEL	PATIENT DAYS	361,812	7	17,533		39,020	1,891	4
5	26	INSURANCE	PATIENT DAYS	361,812	7	5,130		39,020	553	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	361,812	7	34,314		39,020	3,701	6
7	17	ADMINISTRATIVE	PATIENT DAYS	361,812	7			39,020	0	7
8	30	DEPRECIATION	PATIENT DAYS	361,812	7	11,887		39,020	1,282	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					$ 967,895	$		$ 104,387	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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	1	$ 94,676	$ 94,676	1	$ 94,676	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	11	26,955		39,020	1,903	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	11	842		39,020	59	3
4	21	CLERICAL	PATIENT DAYS	552,974	11	60,665		39,020	4,283	4
5	24	TRAVEL	PATIENT DAYS	552,974	11	46,637		39,020	3,293	5
6	26	INSURANCE	PATIENT DAYS	552,974	11	19,567		39,020	1,381	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	11	9,065		39,020	640	7
8	34	RENT	PATIENT DAYS	552,974	11	16,500		39,020	1,165	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	552,974	11	45,767		39,020	3,231	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					$ 320,674	$ 94,676		$ 110,631	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 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	552,954	11	$ 18,688	$	39,020	$ 1,319	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004		39,020	212	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775		39,020	14,169	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497		39,020	4,481	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980		39,020	916	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106		39,020	2,336	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503		39,020	34,827	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	552,954	11	14,513		39,020	1,024	8
9	21	CLERICAL	DIRECT COST	1	1	131,991	131,991	1	131,991	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					$ 972,057	$ 131,991		$ 191,275	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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	1,885,151	12/38	0.0540	101,604	2
3	BERKADIA		X	LOAN COST	AMORT - 35 YEARS		28,266	22,547			807	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	$ 1,907,698			$ 103,011	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,458,570	$ 1,907,698			$ 103,011	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **Line #** **36**

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

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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 75,400	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.)		$ 75,550	2
3. Under or (over) accrual (line 2 minus line 1).		$ 150	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,400	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.		$ 76,550	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	72,242	8
	2006	75,624	9
	2007	73,276	10
	2008	74,534	11
	2009	75,550	12

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 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT MICHAEL BRAUN

TELEPHONE (847) 583-0100 X 126 FAX #: (847) 583-8873

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-01-151-003	NURSING HOME	$ 75,549.88	$ 75,549.88
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,549.88	$ 75,549.88

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	NURSING HOME	105,000	1981	$ 50,050	1
2	754 BASIS ADJ.		1982	4,835	2
3	TOTALS	105,000		$ 54,885	3

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1981		$ 995,068	$	30	$ 33,167	$ 33,167	$ 995,068	4
5	754 BASIS ADJ.		1992		111,968	4,071	31.5	4,071		66,280	5
6											6
7											7
8											8
	Improvement Type**										
9	***RELATED PRTY - NORTHWOODS HEALTH CARE CENTRE										9
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			4,151	15
16	ROOF			1988	38,383	1,395	27.5	1,395		27,653	16
17	DECORATING			1989	1,921	70	27.5	70		1,308	17
18	VARIOUS IMPROVEMENTS			1990	10,047	365	27.5	365		6,666	18
19	VARIOUS IMPROVEMENTS			1991	2,683	97	27.5	97		1,665	19
20	VARIOUS IMPROVEMENTS			1992	38,565	1,403	27.5	1,403		22,585	20
21	CARPET			1993	6,854	249	27.5	249		3,907	21
22	DRIVEWAY			1993	1,655	61	27.5	61		757	22
23	SPRINKMAN SONS			1993	1,525	56	27.5	56		685	23
24	VARIOUS IMPROVEMENTS			1994	3,137		15			3,137	24
25	VARIOUS IMPROVEMENTS			1994	170,951	6,216	27.5	6,216		95,121	25
26	DOORS			1995	5,029	183	27.5	183		2,113	26
27	LANDSCAPING			1996	51,185	1,861	27.5	1,861		26,651	27
28	ROOF REPAIR			1996	20,000	727	27.5	727		10,286	28
29	DRIVEWAY REPAIR			1996	4,775	174	27.5	174		2,430	29
30	CONCRETE RETAINING WALL FOR RAMP			1997	1,500	54	27.5	54		731	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES			1997	46,256	1,682	27.5	1,682		22,311	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION			1997	30,000	1,091	27.5	1,091		14,365	32
33	450,000 GRAIN UNITS - WATER SOFTENER/COUNTER TOPS			1997	11,248	409	27.5	409		5,377	33
34	THREE WAY OVER BED RESIDENT LIGHTING			1998	12,600	459	27.5	459		5,618	34
35	GARBAGE DISPOSAL - KITCHEN REMODELING			1998	1,189	43	27.5	43		537	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WINDOWS AND AUTO DOOR SYSTEM	1998	$ 25,000	$ 909	27.5	$ 909	$	$ 11,173	37
38	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	68,941	2,508	27.5	2,508		31,899	38
39	TILES	1998	3,164	115	27.5	115		1,452	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		2,130	40
41	COUNTER TOPS	1998	17,763	646	27.5	646		8,043	41
42	ELECTRICAL WIRING	1998	3,675	134	27.5	134		1,679	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		56,574	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		12,627	44
45	REMODELING - HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		43,179	45
46	TILES	1999	3,924	143	27.5	143		1,590	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	95	27.5	95		1,066	47
48	REMODELING - ARCHITECTURE	2000	4,000	146	27.5	146		1,591	48
49	BLACKTOP STRIPPING AND SEALING	2000	4,050	270	15	270		2,835	49
50	AIRTHERM HEATERS	2000	34,363	1,249	27.5	1,249		12,857	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		1,607	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		729	52
53	FIRE ALARM PANEL	2001	2,388	86	27.5	86		836	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		2,280	54
55	CARPETING - 2ND 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		14,047	56
57	F & I.A.O SMITH WATER HEATER	2002	4,600	167	27.5	167		1,386	57
58	FURNISH & INSTALL BOILER	2003	25,591	930	27.5	930		7,404	58
59	COMPLETE CANTILEVER RE-CONSTRUCTION	2004	14,133	514	27.5	514		3,577	59
60	INSTALL FLOOR DRAIN AND VENT	2004	834	30	27.5	30		202	60
61	REPLACE OBSOLETE ELEVATOR VALVES AND PARTS	2004	22,539	819	27.5	819		5,499	61
62	REPLACE SEWER LINE BETWEEN GREASE TRAP & MACH	2004	1,990	72	27.5	72		460	62
63	INSTALL NEW EXHAUST FAN AND DUCT WORK IN LNDRY	2005	1,185	43	27.5	43		246	63
64	SMOKE BARRIERS INSTALLED IN 1ST & 2ND FLR CRDR	2005	14,945	544	27.5	544		2,921	64
65	REPLACED AND ADJUSTED DOORS	2005	6,902	251	27.5	251		1,349	65
66	INSTALL HOT WATER CONTROL VALVE	2005	4,142	150	27.5	150		759	66
67	CHANDELIERS/WALLCOVERING/DRAPERY	2006	18,235	2,100	10	1,824	(276)	8,662	67
68	INSTALL NEW CARPETS	2006	14,272	1,644	10	1,427	(217)	6,422	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,303,661	$ 45,817		$ 78,491	$ 32,674	$ 1,686,650	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,303,661	$ 45,817		$ 78,491	$ 32,674	$ 1,686,650	1
2	INSTALL GENERATOR & REMOTE ANNUNCIATOR	2006	34,720	1,262	27.5	1,262		5,418	2
3	GENERATOR RENTAL WHILE BEING INSTALLED	2006	2,007	73	27.5	73		313	3
4	DRAPERIES FOR RESIDENT ROOMS	2006	3,515	405	10	351	(54)	1,552	4
5	PAINTING/WALLPAPER 1ST & 2ND FLR RES. RMS	2006	33,768	3,890	10	3,376	(514)	14,351	5
6	TILE/DRYWALL - BASEMENT, 1ST & 2ND FLR RES. RMS	2006	34,231	1,245	27.5	1,245		5,342	6
7	ELEVATOR RECALL SYSTEM TIED TO FIRE ALARM SYS	2006	5,442	198	27.5	198		833	7
8	INSTALL SPEED BUMPERS	2006	31,206	2,161	15	2,081	(80)	11,675	8
9	RAISE & SUPPORT INTERIOR FLR -SW SIDE OF THE BLDG	2007	16,599	604	27.5	604		2,314	9
10	MINI BLINDS	2007	2,027	203	10	203		760	10
11	DEMOLISH EXISTING CEILING & SHORE UP FLEXICORE	2007	18,500	673	27.5	673		2,467	11
12	LOWER LEVEL KITCHEN CABINETS	2007	6,891	250	27.5	250		856	12
13	REMOVE/REPLACE ENTRANCE & ADJACENT CONC. SLAE	2007	7,850	285	27.5	285		975	13
14	DRIVEWAY - CLEAN & APPLY BREWER COAT	2007	4,100	410	10	410		1,333	14
15	HVAC CONTROL WORK	2007	65,900	2,396	27.5	2,396		7,588	15
16	2ND FLOOR ELEVATOR/NURSES STATION REMODELING	2007	182,698	6,644	27.5	6,644		21,592	16
17	INSTALL GALVANIZED INSULATED DOOR & CLOSER	2007	2,937	107	27.5	107		338	17
18	REPLACE FIRE ALARM CONTROL PANEL	2008	3,605	131	27.5	131		284	18
19	FABRICATE AND INSTALL FIRE DAMPERS	2009	5,496	200	27.5	200		400	19
20	MODIFY 3 SETS OF STAIR RAILINGS	2009	9,020	328	27.5	328		656	20
21	CABINET HEATERS FOR 2ND FLOOR	2009	26,755	973	27.5	973		1,865	21
22	TILES, TILE SPACERS, GROUT, CEMENT, DUROCK, PAINT								22
23	DRYWALL & DRYWALL STUDS FOR 1ST & 2ND FLR	2009	15,012	546	27.5	546		1,001	23
24	300 PIECES OF 4X12 NOCE CHARO PEWTER SCUDO TILES	2009	3,891	141	27.5	141		259	24
25	LABOR & MATERIALS TO INSTALL GAS CONNECTION	2009	3,995	145	27.5	145		254	25
26	REPAIR & PAINT CEILINGS & WALLS, REMOVE OLD TILES								26
27	AND INSTALL NEW, PAINT DOORS - 1ST & 2ND FLR RES. R	2009	149,980	5,454	27.5	5,454		9,090	27
28	REPLACEMENT OF BATH FIXTURES, TOILETS, TUBS	2009	23,500	854	27.5	854		1,424	28
29	TILES FOR SHOWER ROOM	2009	5,101	510	10	510		765	29
30	REPAIR & PAINT CEILINGS & WALLS, REMOVE OLD TILES								30
31	AND INSTALL NEW, PAINT DOORS - 2ND & 3RD FLR,								31
32	BASEMENT, RESIDENT RMS, MENS RESTROOMS, SHOW R	2010	61,500	2,143	27.5	2,143		2,143	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,063,907	$ 78,048		$ 110,074	$ 32,026	$ 1,782,498	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,063,907	$ 78,048		$ 110,074	$ 32,026	$ 1,782,498	1
2	APPLY A FULL ADHERED EPDM RUBBER ROOF MEMBRANE								2
3	ON ALL PARAPET WALL CAPS & BRICK PARAPET WALLS								3
4	ABOVE THE 2ND FLR DINING ROOM	2010	21,732	231	27.5	231		231	4
5	INSTALLED WATER LINE & GAS LINE FOR NEW								5
6	APPLIANCE, OPENED UP FLOOR DRAIN & INSTALL NEW								6
7	3" P-TRAP	2010	3,392	5	27.5	5		5	7
8									8
9									9
10			ADJ. TO SL	32,026			(32,026)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,089,031	$ 110,310		$ 110,310	$	$ 1,782,734	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: 01/01/2010 Ending: 12/31/2010

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	$ 872,407	$ 53,137	$ 74,874	$ 21,737	3-15 YRS	$ 482,973	71
72	Current Year Purchases	96,932	73,972	4,847	(69,125)	3-15 YRS	4,847	72
73	Fully Depreciated Assets	111,571					111,571	73
74	RELATED PARTIES		4,258	4,258				74
75	TOTALS	$ 1,080,910	$ 131,367	$ 83,979	$ (47,388)		$ 599,391	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)	$ 4,224,826	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 241,677	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 194,289	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (47,388)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,382,125	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.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 22,685 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					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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.

Facility Name & ID Number NORTHWOODS CARE CENTRE | STATE OF ILLINOIS # 0044198 | Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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	$		$ 168,607	$		$ 168,607	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,397			5,397	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			233,959			233,959	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 prescrpts				158,398		158,398	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					37,111		37,111	13
14	TOTAL			$		$ 407,963	$ 195,509		$ 603,472	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.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 912,520	$ 2,187,030	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 397,283)	422,214	422,214	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,585	61,531	6
7	Other Prepaid Expenses	35,665	35,665	7
8	Accounts Receivable (owners or related parties)	5,420	8,019	8
9	Other(specify): ESCROW DEPOSITS		73,948	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,406,404	$ 2,788,407	10
	B. Long-Term Assets			
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		2,977,064	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,072,186	1,072,186	16
17	Accumulated Depreciation (book methods)	(976,766)	(2,677,560)	17
18	Deferred Charges		22,547	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		133,251	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 908,675	$ 2,821,175	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,315,079	$ 5,609,582	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,832	$ 160,601	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,988	7,988	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,844	39,844	30
31	Accrued Taxes Payable (excluding real estate taxes)	38,890	38,890	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,400	32
33	Accrued Interest Payable		8,405	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	29,265	29,265	36
37	DUE TO LESSOR	58,821		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 316,640	$ 361,393	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,885,151	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)**	$	$ 1,885,151	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 316,640	$ 2,246,544	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,998,439	$ 3,363,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,315,079	$ 5,609,582	48

***(See instructions.)**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,159,996	1
2	Restatements (describe):		2
3	REPLACEMENT TAX	(3,170)	3
4	ROUNDING ADJ.	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,156,829	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	841,610	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	(1,000,000)	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)**	$ (158,390)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,998,439	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,993,410	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,993,410	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***	85	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 85	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)**	$ 6,993,495	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	924,056	31
32	Health Care	2,293,263	32
33	General Administration	1,602,312	33
	B. Capital Expense		
34	Ownership	666,914	34
	C. Ancillary Expense		
35	Special Cost Centers	603,472	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,151,885	40
41	**Income before Income Taxes (line 30 minus line 40)****	841,610	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 841,610	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: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,162	2,387	$ 97,921	$ 41.02	1
2	Assistant Director of Nursing	2,076	2,505	73,051	29.16	2
3	Registered Nurses	17,546	19,093	527,332	27.62	3
4	Licensed Practical Nurses	10,138	11,508	257,466	22.37	4
5	CNAs & Orderlies	60,208	64,504	764,568	11.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,901	2,126	31,886	15.00	9
10	Activity Assistants	15,777	17,171	148,618	8.66	10
11	Social Service Workers	3,568	4,181	68,790	16.45	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,180	37,060	17.00	13
14	Head Cook	854	902	7,609	8.44	14
15	Cook Helpers/Assistants	15,335	16,687	167,195	10.02	15
16	Dishwashers					16
17	Maintenance Workers	2,009	2,252	38,380	17.04	17
18	Housekeepers	17,459	18,886	179,538	9.51	18
19	Laundry	2,797	3,100	31,192	10.06	19
20	Administrator	1,893	2,126	97,088	45.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,885	2,180	29,090	13.34	23
24	Clerical	2,776	3,197	51,131	15.99	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	3,899	4,432	72,782	16.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,272	179,417	$ 2,680,697 *	$ 14.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	138	$ 6,220	1-3	35
36	Medical Director	232	25,800	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	390	61,331	10-3	38
39	Pharmacist Consultant	100	6,788	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	47	3,369	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)	1,075	$ 130,508		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN MEAD	ADMINISTRATOR		$ 97,088
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,088

B. Administrative - Other

Description		Amount
WITTINGHAM MNGMT ASSOC.	MANAGEMENT FEE	$ 140,991
CHESTERFIELD, LLC	MANAGEMENT FEES	140,991
TOTAL (agree to Schedule V, line 17, col. 3)		$ 281,982
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		239,295
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 239,295

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,790
Unemployment Compensation Insurance	35,567
FICA Taxes	203,177
Employee Health Insurance	193,686
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,904
EMPLOYEE PHYSICAL EXAMS	600
PENSION/PROFIT SHARING PLANS	6,950
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 505,674

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	660
Health Care Worker Background Check	480
(Indicate # of checks performed 48)	
Patient Background Checks 1050	1,050
TRUST/FRANCHISE/CONTRIB/ETC	9,385
MARKETING/ADV/PROMO	93,121
LICENSES/DUES/SUBSCRIPTIONS	13,059
MGMT CO ALLOC	512
TRUST/FRANCHISE/CONTRIB/ETC	(9,385)
Less: Public Relations Expense	(47,224)
Non-allowable advertising	(45,281)
Yellow page advertising	(616)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,761

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	148
RELATED PARTY	9,665
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,813

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. - $9850.95**

(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. $ **0** 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.