FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051813

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: 01/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2014 to 12/31/2014 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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			4,848	4,848	8
9	SNF/PED			0		9
10	ICF	22,515	8,822	1,033	32,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,515	8,822	5,881	37,218	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.24%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2011 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 3,893

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	228,367	20,049	5,650	254,066		254,066		254,066			1
2	Food Purchase		208,790		208,790		208,790		208,790			2
3	Housekeeping	155,353	32,120		187,473		187,473		187,473			3
4	Laundry	78,602	10,643	4,839	94,084		94,084		94,084			4
5	Heat and Other Utilities			97,483	97,483		97,483	457	97,940			5
6	Maintenance	41,693	337	86,244	128,274		128,274	4,205	132,479			6
7	Other (specify):*											7
8	TOTAL General Services	504,015	271,939	194,216	970,170		970,170	4,662	974,832			8
	B. Health Care and Programs											
9	Medical Director			29,640	29,640		29,640		29,640			9
10	Nursing and Medical Records	1,832,607	87,200	17,335	1,937,142		1,937,142	34,486	1,971,628			10
10a	Therapy											10a
11	Activities	184,557		15,745	200,302		200,302		200,302			11
12	Social Services	43,056		20,077	63,133		63,133		63,133			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							6,890	6,890			15
16	TOTAL Health Care and Programs	2,060,220	87,200	82,797	2,230,217		2,230,217	41,376	2,271,593			16
	C. General Administration											
17	Administrative	92,296		373,302	465,598		465,598	(373,302)	92,296			17
18	Directors Fees											18
19	Professional Services			216,690	216,690		216,690	12,287	228,977			19
20	Dues, Fees, Subscriptions & Promotions			26,421	26,421		26,421	(1,480)	24,941			20
21	Clerical & General Office Expenses	107,838	15,235	46,006	169,079		169,079	141,411	310,490			21
22	Employee Benefits & Payroll Taxes			537,334	537,334		537,334		537,334			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,745	4,745		4,745	10,200	14,945			24
25	Other Admin. Staff Transportation			3,558	3,558		3,558		3,558			25
26	Insurance-Prop.Liab.Malpractice			256,528	256,528		256,528	5,698	262,226			26
27	Other (specify):*							20,074	20,074			27
28	TOTAL General Administration	200,134	15,235	1,464,584	1,679,953		1,679,953	(185,112)	1,494,841			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,764,369	374,374	1,741,597	4,880,340		4,880,340	(139,074)	4,741,266			29

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

Facility Name & ID Number Northwoods Care Centre #0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			72,132	72,132		72,132	2,889	75,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,480	2,480		2,480	(2,480)				32
33	Real Estate Taxes			83,586	83,586		83,586		83,586			33
34	Rent-Facility & Grounds			883,638	883,638		883,638	(91,068)	792,570			34
35	Rent-Equipment & Vehicles			37,066	37,066		37,066	2,547	39,613			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,078,902	1,078,902		1,078,902	(88,112)	990,790			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			829	829		829		829			38
39	Ancillary Service Centers		105,603	977,732	1,083,335		1,083,335	(4,848)	1,078,487			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			264,151	264,151		264,151		264,151			42
43	Other (specify):* **Non-Allowable Cos**			221,261	221,261		221,261	(221,261)				43
44	**TOTAL Special Cost Centers**		105,603	1,463,973	1,569,576		1,569,576	(226,109)	1,343,467			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,764,369	479,977	4,284,472	7,528,818		7,528,818	(453,295)	7,075,523			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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Refer-ence	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	(20,638)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,480)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,919)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(858)	43		18
19	Entertainment				19
20	Contributions	(5,499)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,434)	43		24
25	Fund Raising, Advertising and Promotional	(11,153)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(70,707)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (237,688)		$	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)	(215,607)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (215,607)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (453,295)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Northwoods Care Centre

ID# 0051813

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (38,633)	43	1
2	Laboratory Costs	(10,677)	43	2
3	X-Ray Costs	(7,450)	43	3
4	Lobbying Expense Offset	(3,736)	20	4
5	Nonallowable Legal	(5,363)	19	5
6	Other Medicare & Medicare HMO	(4,848)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(70,707)		49

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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 [X] 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			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 457	$ 457	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	4,205	4,205	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	34,486	34,486	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	6,890	6,890	18
19	V	17	Administrative	373,302	Symphony Financial Services, LLC	100.00%		(373,302)	19
20	V	19	Professional Services-Other		Symphony Financial Services, LLC	100.00%	17,650	17,650	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	2,256	2,256	21
22	V	21	Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	141,411	141,411	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	10,200	10,200	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	5,698	5,698	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	20,074	20,074	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	2,889	2,889	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(91,068)	(91,068)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	2,547	2,547	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			$ 373,302			$ 157,695	$ * (215,607)	39

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony o	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere				5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00						8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	NuCare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	No owners receive compensation from this facility.								$		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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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: Symphony Financial Services, LLC
Street Address: 7257 N. Lincoln Ave,
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 933-2600
Fax Number: ( )

	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	5	Utilities	Occupied Bed Days	418,769	8	$ 5,138	$	37,218	$ 457	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		37,218	4,205	2
3	10	Nursing & Med. Records Salary	Occupied Bed Days	418,769	8	388,030	388,030	37,218	34,486	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		37,218	6,890	4
5	19	Professional Service Legal	Occupied Bed Days	418,769	8	14,326		37,218	1,273	5
6	19	Professional Service Other	Occupied Bed Days	418,769	8	184,271		37,218	16,377	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		37,218	2,256	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	37,218	132,448	8
9	21	Clerical & Gen ofc expenses	Occupied Bed Days	418,769	8	100,854		37,218	8,963	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		37,218	10,200	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		37,218	5,698	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		37,218	20,074	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		37,218	2,889	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		37,218	(91,068)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		37,218	1,535	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		37,218	1,012	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 1,878,306		$ 157,695	25

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	27,000,000	535,680	12/30/15	0.0450	2,480	6
7												7
8												8
9	TOTAL Facility Related						$ 27,000,000	$ 535,680			$ 2,480	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(2,480)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,480)	14
15	TOTALS (line 9+line14)						$ 27,000,000	$ 535,680			$	15

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

*** 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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 82,700	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.)	2013	$ 81,086	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,614)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 85,200	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.		$ 83,586	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	75,550	8
	2010	62,972	9
	2011	68,552	10
	2012	78,717	11
	2013	81,086	12

2013 Tax Accural = $81,086 x 1.05 = 85,140.30; Use $85,200

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Northwoods Care Centre COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0051813

CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-01-151-003	Nursing Home	$ 81,086.12	$ 81,086.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,086.12	$ 81,086.12

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2/Basement

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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).

N/A

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Concrete Sidewalk Repair			2012	3,115	156	20	156		378	9
10	Valley - Egineering/Design throughout facility			2013	155,300	7,765	20	7,765		9,706	10
11	Wi-Fi Cables for Nurses Station			2013	5,108	255	20	255		404	11
12											12
13	Facility Remodeling			2014	696,403	38,355	5 - 20	38,355		38,355	13
14	-Demolition/carpentry/soffits throughout facility										14
15	-Wall coverings, painting - 1st floor dining room, front offices,										15
16	resident rooms and lower level										16
17	-Plumbing - cafeteria										17
18	-Interior soffit enclosure - throughout facility										18
19	-Counter tops, laminate - coffee, reception areas and nurses statior										19
20	-Electrical work - throughout facility										20
21	-Floor covering - Basement, 1st Floor Corridors/Offices/										21
22	Nurses Station/Resident Rooms/Dining Room/Vestibule										22
23	-Interior painting - 1st floor dining room, front offices, resident rooms										23
24	and lower level										24
25	-Interior electrical / alarm - throughout facility										25
26	-Gazebo - outside										26
27	-Tile Flooring - South & East Lobby around Elevator										27
28	-Landscaping - along the building & by fire hydrant										28
29	-Room signage - hallways & restrooms										29
30	-Dining room window treatments										30
31	-Concrete Steps - outside building										31
32	-General Contractors Fee										32
33	-Permits										33
34											34
35											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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 859,926	$ 46,531		$ 46,531	$	$ 48,843	70

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 126,696	$ 21,713	$ 21,713	$	5-7	$ 33,030	71
72	Current Year Purchases	44,853	3,888	3,888		5-7	3,888	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	15,808		2,889	2,889	5-7	4,339	74
75	TOTALS	$ 187,357	$ 25,601	$ 28,490	$ 2,889		$ 41,256	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	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)	$ 1,047,283	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,132	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,021	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,889	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 90,099	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC
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. [X] 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:	1972	113	12/31/2011	$ 881,518	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(91,068)			6
7	TOTAL		113		$ 790,450 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 2,120
   This amount was calculated by dividing the total amount to be amortized 21,207
   by the length of the lease 10 .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning 12/31/2011
    Ending 12/31/2021

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$ 714,000
13.	/2016	$ 728,280
14.	/2017	$ 742,846

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: $ 39,420 Description: See Schedule 14A
    (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	Administration	2014 Acura MDX	$ 193.23	$ 193	17
18					18
19					19
20					20
21	TOTAL		$ 193.23	$ 193	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: **Northwoods Care Centre**
IDPH License ID Number: **0051813**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Vac Freedom	4,203
Mattresses	1,736
Compressor	82
Msg Repeater	432
Oxygen	10,227
Sleep System	398
Dishmachine	1,629
Copier	17,027
Computer	959
Cooler	180
Allocated from HO	2,547
Total - Line 16	**39,420**

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

It is the policy of this facility to only hire certified nurses aides.

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

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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	5,607	$ 403,720	$	5,607	$ 403,720	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,806	130,030		1,806	130,030	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,869	422,600		5,869	422,600	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				104,406		104,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)				16,534			16,534	12
13	Other (specify): Oxygen	39(2)					1,197		1,197	13
14	TOTAL			$	13,282	$ 972,884	$ 105,603	13,282	$ 1,078,487	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: **Northwoods Care Centre**
IDPH License ID Number: **0051813**
Fiscal Year End: **12/31/2014**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

	Description	Units	Amount
5301	INHALATION THERAPY-PRIVATE		1,435
5305	INHALATION THERAPY-MEDICAID		6,892
15888	CONSULTANT		1,123
15862	UTILIZATION REVIEW FEES		7,800
15885	RESPIRATORY		407
	Total - Line 12	**-**	**17,657**

STATE OF ILLINOIS

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 59,629	$ 59,629	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 305,221)	2,773,879	2,773,879	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,870	1,870	6
7	Other Prepaid Expenses	111,674	111,674	7
8	Accounts Receivable (owners or related parties)	171,574	171,574	8
9	Other(specify): See Schedule 17A	22,448	22,448	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,141,074	$ 3,141,074	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	859,926	859,926	15
16	Equipment, at Historical Cost	171,549	187,357	16
17	Accumulated Depreciation (book methods)	(85,761)	(90,099)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Lease Cost, Net	14,846	14,846	22
23	Other(specify): See Schedule 17A	309,585	309,585	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,270,145	$ 1,281,615	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,411,219	$ 4,422,689	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 565,323	$ 565,323	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,519	94,519	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,200	85,200	32
33	Accrued Interest Payable	91	91	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,136,755	1,136,755	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,881,888	$ 1,881,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	535,680	535,680	39
40	Mortgage Payable			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)**	$ 535,680	$ 535,680	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,417,568	$ 2,417,568	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,993,651	$ 2,005,121	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,411,219	$ 4,422,689	48

***(See instructions.)**

Facility Name: **Northwoods Care Centre**
IDPH License ID Number: **0051813**
Fiscal Year End: **12/31/2014**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

	Description	Operating	After Consolidation
1106	PATIENT PERSONAL FUNDS	22,448	22,448
	Total - Line 9	**22,448**	**22,448**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

	Description	Operating	After Consolidation
1125	SECURITY DEPOSIT	152,960	152,960
1126	REAL ESTATE ESCROW	156,625	156,625
	Total - Line 23	**309,585**	**309,585**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
1204	EXCHANGE FORMATION LEASHOLD	436,491	436,491
1209	SECURITY DEPOSIT PAYABLE	37,113	37,113
1210	OPERATING EXPENSES	39,763	39,763
1212	MANAGEMENT FEES - SYMPHONY	218,822	218,822
1214	INS WRKS COMP - DEDUCT/SETTLEMENT	44,077	44,077
1220	ACCUMULATED AMORTIZATION DEFERREI	(29,099)	(29,099)
1221	STATE UNEMPLOYMENT TAX	2,848	2,848
1222	FEDERAL UNEMPLOYMENT TAX	473	473

1223	SALES TAX	166	166
1224	PAYROLL TAXES OTHER	8,965	8,965
1226	ACCRUED EMPLOYEE BENEFITS	273,536	273,536
1232	FICA & W/H FED	34	34
1242	DUE TO IDPA - ADDTL IL BED TAX	33,676	33,676
1244	DUE TO TKG	22,983	22,983
1249	EXCHANGE	14,757	14,757
1252	DUE TO NUCARE	15,075	15,075
1257	WAGE ASSIGN & GARNISHMENTS	1,961	1,961
1258	PATIENT PERSONAL FUNDS	15,114	15,114
	Total - Line 36	**1,136,755**	**1,136,755**

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,232,514	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	3,447	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,235,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	757,690	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)**	$ 757,690	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)**	$ 1,993,651	24 *

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

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,696,285	1
2	Discounts and Allowances for all Levels	(1,408,178)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,288,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,803,191	6
7	Oxygen	975	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,804,166	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	149,266	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,365	19
20	Radiology and X-Ray	7,924	20
21	Other Medical Services	8,208	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 187,763	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,148	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,148	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rentals and Other Unclassified Income	1,324	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,324	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,286,508	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	970,170	31
32	Health Care	2,230,217	32
33	General Administration	1,679,953	33
	B. Capital Expense		
34	Ownership	1,078,902	34
	C. Ancillary Expense		
35	Special Cost Centers	1,305,425	35
36	Provider Participation Fee	264,151	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,528,818	40
41	**Income before Income Taxes (line 30 minus line 40)****	757,690	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 757,690	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,566,366	44
45	Private Pay - Net Inpatient Revenue	1,437,450	45
46	Medicare - Net Inpatient Revenue	921,707	46
47	Other-(specify) Hospice	167,584	47
48	Other-(specify) Managed Care	195,000	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,288,107	49

* **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.**

*** **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.**

^ **Tax return prepared on cash basis**

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,814	2,110	$ 73,455	$ 34.81	1
2	Assistant Director of Nursing	1,717	2,110	72,714	34.46	2
3	Registered Nurses	21,056	22,534	652,412	28.95	3
4	Licensed Practical Nurses	7,555	8,527	182,477	21.40	4
5	CNAs & Orderlies	58,415	63,602	851,549	13.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20,351	22,002	184,557	8.39	9
10	Activity Assistants					10
11	Social Service Workers	1,526	1,863	43,056	23.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,335	20,268	228,367	11.27	15
16	Dishwashers					16
17	Maintenance Workers	2,285	2,700	41,693	15.44	17
18	Housekeepers	15,700	17,145	155,353	9.06	18
19	Laundry	6,288	7,221	78,602	10.89	19
20	Administrator	2,215	2,709	92,296	34.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,705	7,680	107,838	14.04	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,962	180,471	$ 2,764,369 *	$ 15.32	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	Monthly	$ 5,650	1(3)	35
36	Medical Director	Monthly	29,640	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,123	10(3)	38
39	Pharmacist Consultant	Monthly	10,521	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,311	11(3)	44
45	Social Service Consultant	Monthly	19,200	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 69,445		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	379	5,691	10(3)	52
53	TOTAL (lines 50 - 52)	379	$ 5,691		53

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bernard Esguerra	Administrator	0	$ 75,341
Jennifer Cook	Administrator	0	16,955
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,296

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 373,302
TOTAL (agree to Schedule V, line 17, col. 3)	$ 373,302
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21A		$ 216,690
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 216,690

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,862
Unemployment Compensation Insurance	28,540
FICA Taxes	209,776
Employee Health Insurance	196,590
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	9,905
Employee Benefits - Other	5,139
Employees' Physical Exams	522
TOTAL (agree to Schedule V, line 22, col.8)	$ 537,334

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,292
Health Care Worker Background Check	
(Indicate # of checks performed 8)	1,708
Patient Background Checks 102	1,560
Miscellaneous Licenses & Fees	3,314
Illinois Council on Long Term Care	11,323
Miscellaneous Dues & Subscriptions	5,234
Lobbying Expense Offset	(3,736)
Allocated from Mgmt. Co.	2,256
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,745
Allocated from Mgmt. Co.	10,200
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,945

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Northwoods Care Centre**
IDPH License ID Number: **0051813**
Fiscal Year End: **12/31/2014**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
ABILITY NETWORK , INC.	SECURE EXCHANGE MANAGED SERV	1,937
ACHIEVE ACCREDITATION	ACCREDITATlON ASSISTANCE	14,142
ADMINISTRATIVE CONSULTANTS	ADMINISTRATIVE CONSULTING	678
ADOBE	WEB HOSTING	21
COMCAST	CABLE	30,193
CREATIVE TECHNOLOGY	IT SUPPORT	9,353
E-HEALTH DATA SOLUTIONS	CAREWATCH/RISKW ATCH SERVICE	5,112
EVAULT	PROTECTONE- 36 MO-SERVERONE	1,584
HDSI	MICRO-FICHE SFTWR MAINTENANCE	3,829
HIPP LAW OFFICE	LEGAL	5,363
HK PAYROLL	WOTC PROGRAM	808
JEREMY PIERSON	SEO IMPROVEMENTS	64
lIT/SOURCETECH	OPERATOR MONTHLY SUPPORT FEE	1,380
MARKET METRIX	SURVEYS	1,030
MCGLADREY LLP	ACCOUNTING	20,306
MOEO	CMS & API	195
MUCH SHELIST	STATUTORY REGISTERED AGENT	1,003
PERSONNEL PLANNERS	QTRLY UNEMPLOYMENT CLAIMS	905
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION PROGRAM	2,220
POINT B COMMUNICATIONS	YEARLY WEB HOSTING	1,586
PROVINET SOLUTIONS	OUTSOURCED IT SERVICES	1,074
ROSI	MICRO-FICHE OR ARCHVAL REPORTS	215
STONE, MCGUIRE & SIEGEL	LEGAL FEES-COMPLIANCE	14,189
SYMPHONY FINANCIAL SERVICES	CONSULTING	60,086
TELEMEDICINE SOLUTIONS	WOUNDCARE MGT SYSTEM IMPLEMEN	10,144
THE JOINT COMMISSION	MANAGED CARE ACCREDITATION	3,315

WESCOM SOLUTIONS INC.	CLINICAL/BOOKKEEPING/DATA PROC	16,925
WILLIAM COOK	LIFE SAFETY CONSULTATION	8,730
ZIR-MED	ELGIBILITY VERIFICATION	305
	Total (agree to Schedule V, line 19, column 3)	216,690

Allocated from Management Company Legal Fees	1,273
Allocated from Management Company Professional Services	16,377
Less: Non-Allowable Legal Fees	(20,555)
Total (agree to Schedule V, line 19, column 8)	213,785

Facility Name & ID Number Northwoods Care Centre # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
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 # 0051813 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council LTC - $7,587**

(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? **5-7 Yrs**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **264,151**
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. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **Adequate records have been maintained.**
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? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.