		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 SOUTH CICERO AVENUE (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (708) 371-0400 **Fax #** (708) 371-5871

HFS ID Number: 36-3967295

Date of Initial License for Current Owners: 8/1/1994

Type of Ownership:

VOLUNTARY,NON-PROFIT	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: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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) SHAEL BELLOWS
	(Title) MANAGEMENT CONSULTANT
Paid Preparer	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
	(Print Name and Title) BOB KAGDA, VICE PRESIDENT
	(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
	(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	303	Skilled (SNF)	303	110,595	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	303	TOTALS	303	110,595	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,411	1,603	17,892	36,906	8
9	SNF/PED					9
10	ICF	47,880	4,410	2,177	54,467	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,291	6,013	20,069	91,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.62%

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 08/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 303 and days of care provided 11,641

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	520,209	47,099	19,674	586,982		586,982	(6,612)	580,370			1
2	Food Purchase		320,746		320,746	0	320,746	(1,325)	319,421			2
3	Housekeeping	338,128	58,233	0	396,361		396,361	2,824	399,185			3
4	Laundry	144,605	35,573	11,390	191,568	0	191,568	486	192,054			4
5	Heat and Other Utilities			213,615	213,615		213,615	0	213,615			5
6	Maintenance	136,082	51,870	69,882	257,834		257,834	(4,161)	253,673			6
7	Other (specify):*			144,077	144,077		144,077	0	144,077			7
8	**TOTAL General Services**	1,139,024	513,521	458,638	2,111,183	0	2,111,183	(8,788)	2,102,395			8
	B. Health Care and Programs											
9	Medical Director	0		37,472	37,472		37,472	0	37,472			9
10	Nursing and Medical Records	4,794,991	305,931	223,982	5,324,904		5,324,904	(115,111)	5,209,793			10
10a	Therapy	72,217		3,477	75,694		75,694	0	75,694			10a
11	Activities	217,942	7,824	5,198	230,964		230,964	(1,743)	229,221			11
12	Social Services	364,566		2,072	366,638		366,638	0	366,638			12
13	CNA Training			0	0		0	0	0			13
14	Program Transportation			336	336		336	0	336			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	5,449,716	313,755	272,537	6,036,008	0	6,036,008	(116,854)	5,919,154			16
	C. General Administration											
17	Administrative	285,768		1,246,553	1,532,321		1,532,321	(1,264,325)	267,996			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			685,816	685,816		685,816	(353,874)	331,942			19
20	Dues, Fees, Subscriptions & Promotions			183,196	183,196		183,196	(134,555)	48,641			20
21	Clerical & General Office Expenses	322,881	51,685	83,163	457,729		457,729	230,832	688,561			21
22	Employee Benefits & Payroll Taxes			1,453,885	1,453,885	0	1,453,885	0	1,453,885			22
23	Inservice Training & Education			7,496	7,496		7,496	0	7,496			23
24	Travel and Seminar			980	980		980	17,047	18,027			24
25	Other Admin. Staff Transportation			9,617	9,617		9,617	0	9,617			25
26	Insurance-Prop.Liab.Malpractice			405,982	405,982		405,982	9,597	415,579			26
27	Other (specify):*			115,749	115,749		115,749	(115,749)	0			27
28	**TOTAL General Administration**	608,649	51,685	4,192,437	4,852,771	0	4,852,771	(1,611,027)	3,241,744			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,197,389	878,961	4,923,612	12,999,962	0	12,999,962	(1,736,669)	11,263,293			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#: CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning: 01/01/2006** **Ending: 12/31/2006**

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	19,103	
	REPAIRS & MAINTENANCE		571	
			0	19,674
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		11,390	
			0	11,390
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		95,079	
	ELECTRICITY		97,202	
	WATER		21,334	
	CABLE TV - LOBBY		0	
			0	213,615
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,936	
	PAINTING & DECORATING		4,243	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		27,219	
	ELEVATOR MAINTENANCE & REPAIR		14,937	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,560	
	FIRE SERVICE		12,987	
			0	
			0	
			0	
			0	69,882
7	**OTHER**			
	SCAVENGER		44,970	
	SECURITY SERVICE		99,107	
			0	
			0	144,077
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	37,472	37,472

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	2,940	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	184,309	
	WOUND CARE	XVIII B 47-2	32,900	
	ALZHEIMERS	XVIII B 48-2	233	223,982
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,105	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		1,372	
	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	
				3,477
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		2,314	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,884	
			0	5,198
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,072	
			0	2,072
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		336	336
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,246,553	1,246,553
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	39,913	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	645,903	
			0	685,816
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	125,740	
	EMPLOYEE WANT ADS	XIX F	11,660	
	CONTRIBUTIONS	VI 20 XIX F	1,102	
	DUES & SUBSCRIPTIONS	XIX F	19,322	
	LICENSES & PERMITS	XIX F	2,902	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	6,420	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,900	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,510	
	PATIENT BACKGROUND CHECKS	XIX F	8,640	
				183,196
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		2,264	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	16,045	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		62,034	
	MESSENGER SERVICE		2,820	
			0	83,163

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	538,188	
	UNEMPLOYMENT COMPENSATION	XIX D	148,194	
	WORKERS COMPENSATION INSURANC	XIX D	179,347	
	HOSPITALIZATION INSURANCE	XIX D	542,734	
	EMPLOYEE BENEFITS - OTHER	XIX D	32,308	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,103	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	10,011	
	CHICAGO HEAD TAX	XIX D	0	
			0	1,453,885
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		7,496	
				7,496
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	980	
				980
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,617	
				9,617
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		405,982	
				405,982
27	**OTHER**			
	BAD DEBTS	VI 24	115,749	
				115,749

GRAND TOTAL COLUMN 3 OTHER 4,923,612

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

TOTAL FOOD PURCHASE	320,746	PATIENT MEALS	274119
LESS SALES TAX	(1,325)	ADD EMPLOYEE MEALS	0
	---		---
NET FOOD	319,421	TOTAL MEALS/YEAR	274119
TOTAL PATIENT CENSUS	91,373	NET FOOD	319421
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	274119

TOTAL PATIENT MEALS	274119	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			---
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	---		========
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,121	91,121		91,121	226,408	317,529			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			218,846	218,846		218,846	256,737	475,583			32
33	Real Estate Taxes			466,697	466,697		466,697	0	466,697			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,126,191)	56,409			34
35	Rent-Equipment & Vehicles			70,634	70,634		70,634	12,334	82,968			35
36	Other (specify):* STORAGE			5,730	5,730		5,730	23,861	29,591			36
37	TOTAL Ownership			2,035,628	2,035,628	0	2,035,628	(606,851)	1,428,777			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		732,782	1,151,800	1,884,582		1,884,582	0	1,884,582			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			165,893	165,893		165,893	0	165,893			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	732,782	1,317,693	2,050,475	0	2,050,475	0	2,050,475			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,197,389	1,611,743	8,276,933	17,086,065	0	17,086,065	(2,343,520)	14,742,545			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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	35,993	30		9
10	Interest and Other Investment Income	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,325)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(16,045)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,002)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(27,587)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,749)	27		24
25	Fund Raising, Advertising and Promotional	(125,740)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,420)	20		28
29	Other-Attach Schedule	(60,245)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (322,168)		$ 0	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 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)	(2,021,352)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,021,352)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,343,520)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (3,535)	6	1
2	VACATION ACCRUAL	(6,612)	1	2
3	VACATION ACCRUAL	2,824	3	3
4	VACATION ACCRUAL	486	4	4
5	VACATION ACCRUAL	(626)	6	5
6	VACATION ACCRUAL	(2,381)	10	6
7	VACATION ACCRUAL	(1,743)	11	7
8	VACATION ACCRUAL	(18,868)	17	8
9	VACATION ACCRUAL	(21,492)	21	9
10	MEDICARE A CONSULTANT	(3,000)	19	10
11	MEDICARE B BILLING	(200)	19	11
12	MEDICARE A BILLING	(748)	19	12
13	MARKETING CONSULTANT	(4,350)	19	13
14	NURSE CONSULTANT	(3,000)	19	14
15	NURSE CONSULTANT	3,000	10	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	(60,245)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(6,612)	0	0	0	0	0	0	0	0	0	0	(6,612)	1
2	Food Purchase	(1,325)	0	0	0	0	0	0	0	0	0	0	(1,325)	2
3	Housekeeping	2,824	0	0	0	0	0	0	0	0	0	0	2,824	3
4	Laundry	486	0	0	0	0	0	0	0	0	0	0	486	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,161)	0	0	0	0	0	0	0	0	0	0	(4,161)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,788)	0	0	0	0	0	0	0	0	0	0	(8,788)	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	619	0	0	(115,730)	0	0	0	0	0	0	0	(115,111)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,743)	0	0	0	0	0	0	0	0	0	0	(1,743)	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**	(1,124)	0	0	(115,730)	0	0	0	0	0	0	0	(116,854)	16
	C. General Administration													
17	Administrative	(18,868)	0	(934,915)	0	1,096	(311,638)	0	0	0	0	0	(1,264,325)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,885)	0	110,928	1,087	(427,004)	0	0	0	0	0	0	(353,874)	19
20	Fees, Subscriptions & Promotions	(137,162)	0	763	986	858	0	0	0	0	0	0	(134,555)	20
21	Clerical & General Office Expenses	(37,537)	0	3,750	6,439	258,180	0	0	0	0	0	0	230,832	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	5,002	5,965	6,080	0	0	0	0	0	0	17,047	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	4,296	3,011	2,290	0	0	0	0	0	0	9,597	26
27	Other (specify):*	(115,749)	0	0	0	0	0	0	0	0	0	0	(115,749)	27
28	**TOTAL General Administration**	(348,201)	0	(810,176)	17,488	(158,500)	(311,638)	0	0	0	0	0	(1,611,027)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(358,113)	0	(810,176)	(98,242)	(158,500)	(311,638)	0	0	0	0	0	(1,736,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	35,993	184,328	699	321	5,067	0	0	0	0	0	0	226,408	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48)	256,785	0	0	0	0	0	0	0	0	0	256,737	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,182,600)	0	2,647	53,762	0	0	0	0	0	0	(1,126,191)	34
35	Rent-Equipment & Vehicles	0	0	4,906	3,675	3,753	0	0	0	0	0	0	12,334	35
36	Other (specify):*	0	23,861	0	0	0	0	0	0	0	0	0	23,861	36
37	TOTAL Ownership	35,945	(717,626)	5,605	6,643	62,582	0	0	0	0	0	0	(606,851)	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)	(322,168)	(717,626)	(804,571)	(91,599)	(95,918)	(311,638)	0	0	0	0	0	(2,343,520)	45

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		CRESTWOOD HEIGHTS NURSING HOME		
		NURSING HOMES			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	$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ (1,182,600)	1
2	V	36	MORTGAGE INSURANCE		" "		23,861	23,861	2
3	V	30	DEPRECIATION - BLDG IMP		" "		183,736	183,736	3
4	V	30	DEPRECIATION - EQPT & FURN		" "		592	592	4
5	V	32	AMORTIZATION - MTG COST		" "		1,342	1,342	5
6	V	32	MORTGAGE INTEREST		" "		255,443	255,443	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,182,600			$ 464,974	$ * (717,626)	14

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 110,928	$ 110,928	15
16	V	20	DUES & SUBSCRIPTIONS		" "		763	763	16
17	V	21	CLERICAL		" "		3,750	3,750	17
18	V	24	TRAVEL		" "		5,002	5,002	18
19	V	26	INSURANCE		" "		4,296	4,296	19
20	V	35	RENT-EQPT & VEH		" "		4,906	4,906	20
21	V	17	ADMINISTRATIVE	934,915	" "			(934,915)	21
22	V	30	DEPRECIATION		" "		699	699	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			$ 934,915			$ 130,344	$ * (804,571)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 174,764	CARLYLE NURSING ASSOCIATES, LLC		$ 59,034	$ (115,730)	15
16	V	19	PROFESSIONAL FEES		" "		1,087	1,087	16
17	V	20	DUES & SUBSCRIPTIONS		" "		986	986	17
18	V	21	CLERICAL		" "		6,439	6,439	18
19	V	24	TRAVEL		" "		5,965	5,965	19
20	V	26	INSURANCE		" "		3,011	3,011	20
21	V	30	DEPRECIATION		" "		321	321	21
22	V	34	RENT		" "		2,647	2,647	22
23	V	35	RENT - EQPT & VEH		" "		3,675	3,675	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			$ 174,764			$ 83,165	$ * (91,599)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 431,262	THE KENSINGTON GROUP, LLC		$ 4,258	$ (427,004)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		858	858	16
17	V	21	CLERICAL		" "		258,180	258,180	17
18	V	24	TRAVEL		" "		6,080	6,080	18
19	V	26	INSURANCE		" "		2,290	2,290	19
20	V	30	DEPRECIATION		" "		5,067	5,067	20
21	V	34	RENT		" "		53,762	53,762	21
22	V	35	RENT-EQPT & VEH		" "		3,753	3,753	22
23	V	17	ADMINISTRATIVE		" "		1,096	1,096	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			$ 431,262			$ 335,344	$ * (95,918)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 311,638	CHESTERFIELD, LLC		$	$ (311,638)	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			$ 311,638			$ 0	$ * (311,638)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1	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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	345,796	6	$ 419,864	$	91,373	$ 110,928	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	6	2,888		91,373	763	2
3	21	CLERICAL	PATIENT DAYS	345,796	6	14,195		91,373	3,750	3
4	24	TRAVEL	PATIENT DAYS	345,796	6	18,932		91,373	5,002	4
5	26	INSURANCE	PATIENT DAYS	345,796	6	16,262		91,373	4,296	5
6	35	RENT-EQPT & VEH	PATIENT DAYS	345,796	6	18,569		91,373	4,906	6
7	30	DEPRECIATION	PATIENT DAYS	345,796	6	2,647		91,373	699	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	TOTALS					$ 493,357	$		$ 130,344	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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 HOURS	1	1	$ 59,034	$ 59,034	1	$ 59,034	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	6,221		91,373	1,087	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	5,639		91,373	986	3
4	21	CLERICAL	PATIENT DAYS	522,604	11	36,838		91,373	6,439	4
5	24	TRAVEL	PATIENT DAYS	522,604	11	34,123		91,373	5,965	5
6	26	INSURANCE	PATIENT DAYS	522,604	11	17,224		91,373	3,011	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	11	1,834		91,373	321	7
8	34	RENT	PATIENT DAYS	522,604	11	15,145		91,373	2,647	8
9	35	RENT - EQPT & VEH.	PATIENT DAYS	522,604	11	21,023		91,373	3,675	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					$ 197,081	$ 59,034		$ 83,165	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	522,604	9	$ 24,352	$	91,373	$ 4,258	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	9	4,910		91,373	858	2
3	21	CLERICAL	PATIENT DAYS	522,604	9	162,920		91,373	28,485	3
4	24	TRAVEL	PATIENT DAYS	522,604	9	34,777		91,373	6,080	4
5	26	INSURANCE	PATIENT DAYS	522,604	9	13,097		91,373	2,290	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	9	28,982		91,373	5,067	6
7	34	RENT	PATIENT DAYS	522,604	9	307,494		91,373	53,762	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	522,604	9	21,468		91,373	3,753	8
9	17	ADMINISTRATIVE	DIRECT HOURS	1	1	1,096	1,096	1	1,096	9
10	21	CLERICAL	DIRECT HOURS	1	1	229,695	229,695	1	229,695	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					$ 828,791	$ 230,791		$ 335,344	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$101,139.93	12/03	4,897,900	4,747,258	12/38	0.0535	255,443	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS						1,342	3
4												4
5												5
	Working Capital											
6	J.P. MORGAN - CHASE		X	WORKING CAPITAL	DEMAND	VARIES	323,671	1,293,000	DEMAND	PRIME +	106,966	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,291,428	1,946,897	DEMAND	VARIES	109,581	7
8	LETTER OF CREDIT FEE		X						DEMAND	8.2500	2,299	8
9	TOTAL Facility Related				$101,139.93		$ 6,512,999	$ 7,987,155			$ 475,631	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 6,512,999	$ 7,987,155			$ 475,631	15

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

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

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2005 report.	$ 491,587	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.)	$ 477,629	2
3. Under or (over) accrual (line 2 minus line 1).	$ (13,958)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 480,655	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.	$ 466,697	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2001	467,362	8
2002	471,212	9
2003	467,330	10
2004	488,444	11
2005	477,629	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 2005 TAX BILL.

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

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-03-303-011-0000	NURSING HOME	$ 165,249.50	$ 165,249.50
2.	28-03-303-012-0000	NURSING HOME	$ 299,589.35	$ 299,589.35
3.	28-03-303-038-0000	NURSING HOME	$ 12,789.81	$ 12,789.81
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 477,628.66	$ 477,628.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

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

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered 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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

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).

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:
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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	75,000	1972	$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		$ 335,752	3

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 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	303		1974		$ 2,091,708	$ 26,548	35	$ 59,673	$ 33,125	$ 1,967,019	4
5			1980		3,400		35	97	97	2,647	5
6	SEC 754 ADJ			1992	584,054	21,238	27.5	21,238		271,544	6
7	SEC 754 ADJ			2001	24,100	876	27.5	876		5,256	7
8											8
	Improvement Type**										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466		20			38,466	12
13	IMPROVEMENTS			1985	18,271		10			18,271	13
14	IMPROVEMENTS			1985	1,200		20			1,200	14
15	IMPROVEMENTS			1985	32,506		15			32,506	15
16	IMPROVEMENTS			1986	76,557	0	20	1,917	1,917	76,557	16
17	IMPROVEMENTS			1986	16,943	0	19			16,943	17
18	IMPROVEMENTS			1986	1,559	0	19	82	82	1,291	18
19	IMPROVEMENTS			1987	23,951	855	20	1,198	343	23,352	19
20	IMPROVEMENTS			1987	22,863	831	27.5	831		21,665	20
21	IMPROVEMENTS			1988	20,627	750	27.5	750		14,350	21
22	IMPROVEMENTS			1989	35,057	1,264	27.5	1,264		20,159	22
23	IMPROVEMENTS			1990	50,320	1,830	27.5	1,830		26,370	23
24	IMPROVEMENTS			1991	53,090	1,931	27.5	1,931		26,312	24
25	IMPROVEMENTS			1992	53,668	1,952	27.5	1,952		25,236	25
26	IMPROVEMENTS			1992	51,711	3,447	15	3,447		49,551	26
27	IMPROVEMENTS			1993	42,479	1,545	27.5	1,545		15,380	27
28	IMPROVEMENTS			1993	78,601	2,858	27.5	2,858		35,076	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		83,317	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		8,199	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		23,478	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		2,605	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		3,779	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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 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	COOLING TOWER REPLACEMENT	1995	$ 15,650	$ 569	27.5	$ 569	$	$ 6,304	37
38	HANDRAILS/TILING ROOF	1996	103,547	3,765	27.5	3,765		39,835	38
39	HANDRAILS/TILING ROOF	1996	877	32	27.5	32		330	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		22,089	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		23,190	41
42	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		142,708	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		15,313	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		26,032	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		10,427	45
46	ELECTRICAL WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		1,433	46
47	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		11,404	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		295	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		3,127	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		5,723	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		888	51
52	BOILER VALVE	1998	5,450	198	27.5	198		1,592	52
53	WALLCOVERING	1999	2,206	80	27.5	80		707	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		1,642	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		1,076	55
56	REMODEL - NURSES STATION	2000	25,135	914	27.5	914		5,979	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		6,568	57
58	ROOF WORK	2000	11,384	414	27.5	414		2,605	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAI	2000	23,240	845	27.5	845		5,246	59
60	REMODEL - NURSES STATION	2000	10,730	390	27.5	390		2,389	60
61	CLOSET DOORS-2,3, AND 4TH FLOOR NURSES STATION	2001	1,900	69	27.5	69		411	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		223	62
63	RENOVATE - 3A, 4B AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		1,330	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		3,583	64
65	DRYWALL AND PAINT ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		377	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		3,324	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	496	27.5	496		2,501	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,706,519	$ 114,608		$ 150,172	$ 35,564	$ 3,205,726	70

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 4,706,519	$ 114,608		$ 150,172	$ 35,564	$ 3,205,726	1
2	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		580	2
3	KITCHEN FLOOR - REMOVE OLD AND INSTALL NEW TILE	2002	3,086	112	27.5	112		546	3
4	REPLACE 49 DOORS AND 1ST AND 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		4,269	4
5	BUILD NEW SMOKING LOUNGE	2002	3,596	131	27.5	131		628	5
6	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	120	27.5	120		575	6
7	INSTALL WALL COVERING - ROOM 223	2002	1,800	65	27.5	65		312	7
8	REBUILD AND PREP WALLS - RMS 234, 334 AND LOUNGE	2002	4,000	145	27.5	145		683	8
9	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	55	27.5	55		254	9
10	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	550	27.5	550		2,452	10
11	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		352	11
12	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	80	27.5	80		350	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,150	27.5	4,150		17,465	13
14	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	11,488	27.5	11,488		39,730	14
15	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	636	27.5	636		2,200	15
16	RESURFACE AND PAVE PARKING LOT	2003	3,697	247	15	247		864	16
17	ALUMINUM ROOF	2003	1,700	62	27.5	62		214	17
18	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	336	27.5	336		1,162	18
19	FIRE DAMPERS	2004	3,417	124	27.5	124		304	19
20	INSTALLED A SOFSTART	2004	2,670	97	27.5	97		238	20
21	AMEREX KP FIRE SUPPRESSION SYSTEM	2004	1,457	53	27.5	53		129	21
22	OAK FLUSH FIRE DOORS - DIETARY/BATH AND BED RMS	2004	7,632	278	27.5	278		682	22
23	REMOVE & INSTALL NEW SHAMPOO STATION & TOILET	2004	1,945	71	27.5	71		173	23
24	WATER SYSTEM	2004	16,254	591	27.5	591		1,452	24
25	REPLACE ENTRY WALK	2004	5,500	200	27.5	200		491	25
26	NEW PANASONIC TELEPHONE SYSTEM	2004	26,934	979	27.5	979		2,406	26
27	REMOVE & INSTALL WALLCOVERING - REHAB ROOM	2004	2,786	186	15	186		465	27
28	PATCH TO THE FIELD/WALL FLASHING - ROOF	2004	1,500	55	27.5	55		134	28
29	REMOVE & INSTALL VINYL SHEET FLOORING & COVE								29
30	BASE	2005	28,921	1,052	27.5	1,052		2,060	30
31	REMOVE & INSTALL WALLPAPER IN PATIENT ROOM;								31
32	PAINT CEILINGS, BATHROOMS & DOOR FRAMES	2005	29,972	7,340	7	4,282	(3,058)	8,565	32
33	CUBUCLE CURTAINS	2005	8,040	1,969	7	1,149	(820)	2,298	33
34	TOTAL (lines 1 thru 33)		$ 5,370,195	$ 146,865		$ 178,551	$ 31,686	$ 3,297,759	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 5,370,195	$ 146,865		$ 178,551	$ 31,686	$ 3,297,759	1
2	RE-FOOR UPPER MAIN ROOF - APPROX, 23800	2005	67,950	2,471	27.5	2,471		4,633	2
3	2 FIRE DOORS FOR 2ND FLOOR	2005	1,702	62	27.5	62		101	3
4	PLUMBING WORK ON PIPES TO INCREASE HOT WATER	2005	10,923	397	27.5	397		645	4
5	NEW ANTENNA SYSTEM	2005	12,995	472	27.5	472		531	5
6	REMOVE & INSTL. DRAIN LINES, SINK, LAUNDRY TUBS	2006	5,527	176	27.5	176		176	6
7	REMOVE & INSTL. CEILING TILES - DOCTORS OFFICE	2006	980	31	27.5	31		31	7
8	REMOVE & INSTL. DRYWALL, TILES, CEILING - 1ST FLR	2006	1,985	63	27.5	63		63	8
9	PARTITIONS/WOVEN WIRE CUBICLES	2006	4,625	661	7	661		661	9
10	DIALYSIS RM - HANG DRYWALL, PLYWOOD ENCLOSURE	2006	43,811	597	27.5	597		597	10
11	NURSES STATION - NEW WALLS, SUPPORTS & CABINETS	2006	19,905	211	27.5	211		211	11
12	RAISE & RESTORE WALKWAY	2006	1,500	16	27.5	16		16	12
13	TEAR OUT & INSTL VCT & RUBBER BASE - ATRIUM LNGE	2006	2,380	11	27.5	11		11	13
14	INSTALL SPLASH GUARDS - DIALYSIS RM. SINK	2006	3,805	17	27.5	17		17	14
15									15
16			ADJ. TO SL	31,686			(31,686)		16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,548,283	$ 183,736		$ 183,736	$ 0	$ 3,305,452	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,235,023	$ 72,594	$ 122,482	$ 49,888	3-10 YRS	$ 857,992	71
72	Current Year Purchases	92,635	18,527	4,632	(13,895)	3-10 YRS	4,632	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	5,917	6,679	6,679	0		3,256	74
75	TOTALS	$ 1,333,575	$ 97,800	$ 133,793	$ 35,993		$ 865,880	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,217,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 281,536	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 317,529	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,993	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,171,332	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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 55,766 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	ADMINISTRATIVE	2005 TOYOTA CAMRY	$ 389.00	$ 10,200	17
18	FACILITY USE	2002 FORD CLUB WAG	675.97	4,668	18
19					19
20					20
21	TOTAL		$ #######	$ 14,868	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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	$		$ 422,413	$		$ 422,413	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			86,556			86,556	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			642,626			642,626	4
5	Physician Care	39-3	visits			205			205	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				423,308		423,308	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify): MEDICAL SUPPLY	39-2					309,474		309,474	13
14	TOTAL			$		$ 1,151,800	$ 732,782		$ 1,884,582	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 350,677	$ 790,521	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 134,462)	4,773,366	4,773,366	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,811	2,811	5
6	Prepaid Insurance	88,405	261,624	6
7	Other Prepaid Expenses	74,530	74,530	7
8	Accounts Receivable (owners or related parties)	301,271	302,771	8
9	Other(specify): ESCROW DEPOSITS		704,222	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,591,060	$ 6,909,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		2,085,992	11
12	Long-Term Investments			12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		3,214,659	15
16	Equipment, at Historical Cost	1,280,722	1,286,639	16
17	Accumulated Depreciation (book methods)	(1,121,900)	(4,053,657)	17
18	Deferred Charges		42,893	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 158,822	$ 5,149,121	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,749,882	$ 12,058,966	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,330,769	$ 3,332,994	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	594,663	594,663	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,408	115,408	30
31	Accrued Taxes Payable (excluding real estate taxes)	99,522	99,522	31
32	Accrued Real Estate Taxes(Sch.IX-B)		480,655	32
33	Accrued Interest Payable		21,165	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	408,045	408,045	36
37	DUE TO LESSOR	2,680,171	0	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,228,578	$ 5,052,452	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,239,897	3,239,897	39
40	Mortgage Payable		4,747,258	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)**	$ 3,239,897	$ 7,987,155	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,468,475	$ 13,039,607	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,718,593)	$ (980,641)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,749,882	$ 12,058,966	48

*(See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,826,420)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ	(6)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,826,426)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,892,167)	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)**	$ (1,892,167)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,718,593)	24 *

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	$ 15,193,850	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,193,850	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,193,898	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,111,183	31
32	Health Care	6,036,008	32
33	General Administration	4,852,771	33
	B. Capital Expense		
34	Ownership	2,035,628	34
	C. Ancillary Expense		
35	Special Cost Centers	1,884,582	35
36	Provider Participation Fee	165,893	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,086,065	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,892,167)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,892,167)	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 CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,957	2,086	$ 102,099	$ 48.94	1
2	Assistant Director of Nursing	4,035	4,580	165,480	36.13	2
3	Registered Nurses	44,098	48,426	1,259,989	26.02	3
4	Licensed Practical Nurses	56,965	62,063	1,455,221	23.45	4
5	CNAs & Orderlies	153,128	164,747	1,740,990	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,730	4,264	72,217	16.94	8
9	Activity Director	3,908	4,171	57,998	13.91	9
10	Activity Assistants	15,354	16,726	159,944	9.56	10
11	Social Service Workers	16,190	17,506	364,566	20.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,464	14,854	230,690	15.53	14
15	Cook Helpers/Assistants	30,494	32,532	289,519	8.90	15
16	Dishwashers					16
17	Maintenance Workers	7,291	8,015	136,082	16.98	17
18	Housekeepers	27,960	30,943	338,128	10.93	18
19	Laundry	14,863	16,254	144,605	8.90	19
20	Administrator	1,981	2,126	209,730	98.65	20
21	Assistant Administrator	2,405	2,614	76,038	29.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,245	16,742	322,881	19.29	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	5,018	5,448	71,212	13.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	418,086	454,097	$ 7,197,389 *	$ 15.85	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	295	$ 19,103	1-3	35
36	Medical Director	485	37,472	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	1,227	184,309	10-3	38
39	Pharmacist Consultant	96	3,600	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	52	2,884	11-3	44
45	Social Service Consultant	37	2,072	12-3	45
46	Other(specify) PSYCH/ SOC.	74	2,940	10-3	46
47	WOUND CARE	237	32,900	10-3	47
48	ALZHEIMERS	8	233	10-3	48
49	TOTAL (lines 35 - 48)	2,511	$ 285,513		49

C. CONTRACT NURSES

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY DUMONT	ADMINISTRATOR		$ 209,730
BENJAMIN FRIEDMAN	ASST ADMIN		31,786
MARIO LONGO	ASST ADMIN		16,970
KATHY SMITH	ASST ADMIN		27,282
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 285,768

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC. LLC	$ 934,915
CHESTERFIELD LLC	311,638
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,246,553

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		685,816
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 685,816

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 179,347
Unemployment Compensation Insurance	148,194
FICA Taxes	538,188
Employee Health Insurance	542,734
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	32,308
EMPLOYEE PHYSICAL EXAMS	3,103
PENSION/PROFIT SHARING PLANS	10,011
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,453,885

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	11,660
Health Care Worker Background Check	3,510
(Indicate # of checks performed 351)	
Patient Background Checks 864	8,640
TRUST/FRANCHISE/CONTRIB/ETC	5,002
MARKETING/ADV/PROMO	132,160
LICENSES/DUES/SUBSCRIPTIONS	22,224
MGMT CO ALLOC	2,607
TRUST/FRANCHISE/CONTRIB/ETC	(5,002)
Less: Public Relations Expense	(0)
Non-allowable advertising	(125,740)
Yellow page advertising	(6,420)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,641

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	980
RELATED PARTY	17,047
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,027

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	PAINT/DECORATING	06/2006	$ 4,243	3	$	$	$	$ 708	$ 1,414	$ 1,414	$ 707	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,243		$	$	$	$ 708	$ 1,414	$ 1,414	$ 707	$	$

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. COUNCIL ON LTC - $18158**

(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. $ **18,670** 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. $ **165,893**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? ____ If no, please explain.

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

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees