

		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.

<p>I. IDPH Facility ID Number: <u>0033589</u></p> <p>Facility Name: <u>Kenwood Healthcare Center</u></p> <p>Address: <u>6125 South Kenwood</u> <u>Chicago</u> <u>60637</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 752-6000</u> Fax # <u>(773) 752-4857</u></p> <p>HFS ID Number: <u>363559960001</u></p> <p>Date of Initial License for Current Owners: <u>04/01/98</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>		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
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	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	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	190	Intermediate/DD	190	69,350	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,875	7	3,356	7,238	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	60,400	868	12	61,280	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,275	875	3,368	68,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.03%

D. How many bed-hold days during this year were paid by the Department?

None (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

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

I. On what date did you start providing long term care at this location?

Date started 04/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/88 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 64 and days of care provided 3,356

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Kenwood Healthcare Center # 0033589 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	442,551	30,626	24,816	497,993		497,993		497,993		1
2	Food Purchase		335,902		335,902		335,902	(7,000)	328,902		2
3	Housekeeping	421,754	78,745		500,499		500,499	766	501,265		3
4	Laundry	162,060	23,343		185,403		185,403		185,403		4
5	Heat and Other Utilities			225,899	225,899		225,899	3,712	229,611		5
6	Maintenance	167,456	99,999	22,898	290,353		290,353	2,935	293,288		6
7	Other (specify):*										7
8	TOTAL General Services	1,193,821	568,615	273,613	2,036,049		2,036,049	413	2,036,462		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	2,367,557	41,380	11,936	2,420,873		2,420,873	(3,457)	2,417,416		10
10a	Therapy			580,556	580,556		580,556		580,556		10a
11	Activities	89,193	3,756		92,949		92,949		92,949		11
12	Social Services	146,961		5,000	151,961		151,961		151,961		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,603,711	45,136	603,492	3,252,339		3,252,339	(3,457)	3,248,882		16
	C. General Administration										
17	Administrative	210,000		525,375	735,375		735,375	(479,020)	256,355		17
18	Directors Fees										18
19	Professional Services			105,652	105,652		105,652	8,459	114,111		19
20	Dues, Fees, Subscriptions & Promotions			24,731	24,731		24,731	(4,686)	20,045		20
21	Clerical & General Office Expenses	676,618		61,940	738,558		738,558	134,608	873,166		21
22	Employee Benefits & Payroll Taxes			639,590	639,590		639,590	6,852	646,442		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,005	2,005		2,005	3	2,008		24
25	Other Admin. Staff Transportation			45,209	45,209		45,209	1,087	46,296		25
26	Insurance-Prop.Liab.Malpractice			39,039	39,039		39,039	1,525	40,564		26
27	Other (specify):* Mgmt Alloc of Benefit							32,754	32,754		27
28	TOTAL General Administration	886,618		1,443,541	2,330,159		2,330,159	(298,418)	2,031,741		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,684,150	613,751	2,320,646	7,618,547		7,618,547	(301,462)	7,317,085		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Kenwood Healthcare Center

#0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			77,782	77,782		77,782	196,534	274,316			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,040	46,040		46,040	107,261	153,301			32
33	Real Estate Taxes			334,790	334,790		334,790	7,366	342,156			33
34	Rent-Facility & Grounds			986,592	986,592		986,592	(986,592)				34
35	Rent-Equipment & Vehicles			7,852	7,852		7,852	2,374	10,226			35
36	Other (specify):*											36
37	TOTAL Ownership			1,453,056	1,453,056		1,453,056	(673,057)	779,999			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,733		82,733		82,733		82,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,105	174,105		174,105		174,105			42
43	Other (specify):* Nonallowable Cost			58,177	58,177		58,177	(58,177)				43
44	TOTAL Special Cost Centers		82,733	232,282	315,015		315,015	(58,177)	256,838			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,684,150	696,484	4,005,984	9,386,618		9,386,618	(1,032,696)	8,353,922			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	189,777	30		9
10	Interest and Other Investment Income	(59,232)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(930)	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	(2,325)	43		18
19	Entertainment				19
20	Contributions	(10,340)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,636)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,518)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(39,878)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,024)	43		28
29	Other-Attach Schedule See Pg 5A	(245,210)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,316)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(842,380)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (842,380)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,032,696)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Kenwood Healthcare Center

ID# 0033589

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense - Med A	\$ (7,290)	43	1
2	Advertising	(150)	43	2
3	Trust Fees	(100)	43	3
4	Non-Allowable Dues	(5,016)	20	4
5	Office Expense	(2,941)	21	5
6	Management Fees	(221,254)	17	6
7	Management Fees	(8,459)	21	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
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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	(245,210)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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 Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fees	\$	KTNC Associates	100.00%	\$ 56,250	\$ 56,250	1
2	V	19 Professional Services		KTNC Associates	100.00%	2,765	2,765	2
3	V	21 Clerical & General Office Exp		KTNC Associates	100.00%	112	112	3
4	V	32 Interest		KTNC Associates	100.00%	163,021	163,021	4
5	V	34 Rent-Facility & Grounds	986,592	KTNC Associates	100.00%		(986,592)	5
6	V	43 Other		KTNC Associates	100.00%	11,378	11,378	6
7	V	19 Bookkeeping Fees		KTNC Associates	100.00%	4,000	4,000	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 986,592			\$ 237,526	\$ * (749,066)	14

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

Kenwood Healthcare Center, Inc.
Provider #: 0033589
12/31/2006

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO
Rancho Manor Healthcare and Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 17	\$ 17
16	V	3 Housekeeping		SW Management Co.	100.00%	766	766
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	3,712	3,712
18	V	6 Maintenance		SW Management Co.	100.00%	2,935	2,935
19	V	17 Administrative	525,375	SW Management Co.	100.00%	207,359	(318,016)
20	V	19 Professional Services		SW Management Co.	100.00%	19,330	19,330
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	330	330
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	145,896	145,896
23	V	24 Travel and Seminar		SW Management Co.	100.00%	3	3
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	1,087	1,087
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	1,525	1,525
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	32,754	32,754
27	V	30 Depreciation		SW Management Co.	100.00%	6,757	6,757
28	V	32 Interest		SW Management Co.	100.00%	3,472	3,472
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	7,366	7,366
30	V	35 Rent - Equipment & Vehicles		SW Management Co.	100.00%	2,374	2,374
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 525,375			\$ 435,683	\$ * (89,692)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 11,736	S & E Medical Supply Co.	100.00%	\$ 11,571	\$ (165)
16	V	3 Housekeeping	100	S & E Medical Supply Co.	100.00%	100	
17	V	10 Medical Supplies	13,062	S & E Medical Supply Co.	100.00%	9,605	(3,457)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 24,898			\$ 21,276	\$ * (3,622)

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

Facility Name & ID Number

Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	29.88	See Schedule 7A	12	27.00	Salary	\$ 46,980	L17, C7	1
2	Ronnie Klein	Administrator	Administrative	6.92	See Schedule 7B	20	50.00	Salary&Fees	153,125	17,3&21,7	2
3	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	8.8	20.00	Salary	34,452	L21, C7	3
4											4
5											5
6											6
7			Note : All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 234,557		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization SW Management Co.
 Street Address 7434 Skokie Boulevard
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	608,840	11	\$ 89	\$ 116,070	\$ 17	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	116,070	766	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	116,070	3,712	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	116,070	2,935	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	116,070	19,330	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	116,070	330	6	
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	145,896	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	116,070	3	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	116,070	1,087	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	608,840	11	8,000	116,070	1,525	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	116,070	32,754	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	116,070	3,472	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	116,070	7,366	13	
14	35	Rent - Equipment & Vehicles	Bed Days Available	608,840	11	12,454	116,070	2,374	14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	12	207,359	17
18										18
19										19
20	30	Depreciation	Direct Cost						6,757	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,905,268	\$ 1,454,705		\$ 435,683	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			\$		\$ 11,571	1
2	3	Housekeeping	Direct Cost					100	2
3	10	Medical Supplies	Direct Cost					9,605	3
4									4
5									5
6									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	TOTALS					\$		\$ 21,276	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	LaSalle Bank		X	Mortgage	\$49,744.15	9/23/99	\$ 4,000,000	\$ 1,552,481	9/1/08	0.0800	\$ 153,240	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank One		X	Line of Credit			500,000	225,000		0.0825	46,040	6						
7												7						
8												8						
9	TOTAL Facility Related				\$49,744.15		\$ 4,500,000	\$ 1,777,481			\$ 199,280	9						
B. Non-Facility Related*																		
10											(59,232)	10						
11											9,781	11						
12											3,472	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (45,979)	14						
15	TOTALS (line 9+line14)						\$ 4,500,000	\$ 1,777,481			\$ 153,301	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	400,000	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.)	2005	\$	388,984	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(11,016)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	400,000	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.)		\$	27,195	5
	Allocated from Management Co.		7,366	
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 \$ <u>81,389</u> For <u>99/01/04</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(81,389)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	342,156	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	<u>422,671</u>	8	
	2002	<u>427,410</u>	9	
	2003	<u>376,696</u>	10	
	2004	<u>385,063</u>	11	
	2005	<u>388,984</u>	12	
2006 Accrual : 388,984 X 1.04 = 404,543. Use 400,000.				
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 Kenwood Healthcare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033589

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>20-14-408-017-0000</u>	<u>Long-term care property</u>	\$ <u>1,190.22</u>	\$ <u>1,190.22</u>
2. <u>20-14-408-015-0000</u>	<u>Long-term care property</u>	\$ <u>2,478.17</u>	\$ <u>2,478.17</u>
3. <u>20-14-409-005-0000</u>	<u>Long-term care property</u>	\$ <u>287,323.83</u>	\$ <u>287,323.83</u>
4. <u>20-14-408-016-0000</u>	<u>Long-term care property</u>	\$ <u>2,342.16</u>	\$ <u>2,342.16</u>
5. <u>20-14-409-004-0000</u>	<u>Long-term care property</u>	\$ <u>95,649.53</u>	\$ <u>95,649.53</u>
6. <u>10-28-412-049-0000</u>	<u>Allocated from SW Management</u>	\$ <u>39,720.37</u>	\$ <u>7,366.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>428,704.28</u>	\$ <u>396,349.91</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 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 Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories Six

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>1991</u>	\$ <u>70,784</u>	<u>1</u>
2	<u>Resident Care</u>		<u>1997</u>	<u>265,000</u>	<u>2</u>
3	TOTALS			\$ 335,784	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	318	1986		\$ 5,300,000	\$	35	\$ 101,379	\$ 101,379	\$ 5,300,000	4
5										5
6	Allocation From Management Co.	1995		83,519		39	2,386	2,386	27,813	6
7										7
8										8
	Improvement Type**									
9	Various		1987	643		20	15	15	643	9
10	Various		1989	5,500		20			4,606	10
11	Various		1990	46,719	185	20	291	106	45,757	11
12	Various		1991	7,602	242	20	379	137	5,807	12
13	Various		1992	80,208	2,546	20	3,912	1,366	56,410	13
14	Various		1993	325,411	8,211	20	15,879	7,668	219,769	14
15	Various		1994	35,487	667	20	645	(22)	30,973	15
16	Various		1995	66,379	951	20	3,318	2,367	39,128	16
17	Various		1996	72,786	1,359	20	3,639	2,280	39,012	17
18	Various		1997	200,247	10,441	20	10,011	(430)	98,401	18
19	Various		1998	65,468	636	20	3,273	2,637	30,441	19
20	Various		1999	54,327	517	20	2,991	2,474	21,671	20
21	Wall Guard		2000	1,498		20	75	75	494	21
22	Elevator Repair		2000	1,800		20	90	90	608	22
23	Window Treatment		2000	1,020		20	51	51	323	23
24	Wallpaper		2000	883		20	44	44	297	24
25	Wallpaper		2000	1,196		20	60	60	405	25
26	Wallpaper		2000	1,470		20	74	74	498	26
27	Wallpaper		2000	3,324		20	166	166	1,121	27
28	Wallpaper		2000	21,712		20	1,086	1,086	7,330	28
29	Wallpaper		2000	825		20	41	41	278	29
30	Mini-Blinds		2000	65		20	3	3	21	30
31	Wallpaper		2000	2,081		20	104	104	702	31
32	Wallpaper		2000	4,663		20	233	233	1,573	32
33	Wallpaper		2000	1,099		20	55	55	367	33
34	Wallpaper		2000	3,146		20	157	157	1,048	34
35	Wallpaper		2000	1,451		20	73	73	486	35
36	Wallpaper		2000	826		20	41	41	274	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wallpaper	2000	\$ 3,115	\$	20	\$ 156	\$ 156	\$ 1,001	37
38	Window Treatment	2000	18,430		20	922	922	5,914	38
39	Wallpaper Install	2000	63,355		20	3,168	3,168	20,064	39
40	Radiator	2000	5,900		20	295	295	1,893	40
41	Boilers	2000	4,514		20	226	226	1,449	41
42	Dishwasher Exhaust	2000	5,907		20	295	295	1,919	42
43	Elevator	2001	84,968	2,179	20	4,248	2,069	22,657	43
44	Wood Doors	2001	5,867		20	293	293	1,710	44
45	Carpeting	2001	4,657		20	233	233	1,262	45
46	Doors	2001	2,200		20	110	110	660	46
47	Door Locks	2001	1,115		20	56	56	322	47
48	Door Handles	2001	2,158		20	108	108	648	48
49	Valve	2001	2,657		20	133	133	754	49
50	Door Locks	2001	1,261		20	63	63	336	50
51	Door Locks	2001	1,960		20	98	98	498	51
52	Mechanical Equipment	2001	7,255		20	363	363	2,087	52
53	Electrical Breakers	2001	9,294		20	465	465	2,673	53
54	Sewage Pump	2001	8,495		20	425	425	2,373	54
55	Steamer	2001	14,992		20	750	750	3,937	55
56	3 Circuit Breaker	2001	2,400		20	120	120	620	56
57	Doors & Frames	2002	2,687		5	537	537	2,462	57
58	Drapes & Blinds	2002	1,022		10	102	102	476	58
59	Fire Alarm	2002	8,775		7	1,254	1,254	5,329	59
60	Fire Alarm	2002	4,100		7	586	586	2,637	60
61	Kitchen Plumbing	2002	3,150		5	630	630	2,940	61
62	Hot Water Heater	2002	6,300		12	525	525	2,406	62
63	Fire Protection	2002	3,333		7	476	476	2,222	63
64	Fire Stopping	2002	18,015		10	1,802	1,802	8,408	64
65	Sprinkler Hydraulic	2002	3,200		7	457	457	2,133	65
66	Elevator	2002	20,538	527	10	2,054	1,527	10,270	66
67	Plumbing	2002	2,617		10	262	262	1,222	67
68	Locks	2002	4,838		10	484	484	2,420	68
69	Elevator	2002	16,471		20	824	824	3,569	69
70	TOTAL (lines 4 thru 69)		\$ 6,736,901	\$ 28,461		\$ 172,991	\$ 144,489	\$ 6,055,527	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,736,901	\$ 28,461		\$ 172,991	\$ 144,530	\$ 6,055,527	1
2	<u>Carpeting</u>	2003	4,606		20	230	230	921	2
3	<u>Elevator</u>	2003	50,950	1,306	20	2,548	1,242	11,464	3
4	<u>Elevator</u>	2003	15,286	392	20	764	372	3,057	4
5	<u>85 Gal. Hot Water Heater</u>	2003	8,745		20	437	437	3,061	5
6	<u>Generator Repair</u>	2003	1,396		20	70	70	251	6
7	<u>Hot Water Heater Repair</u>	2003	1,649		20	82	82	302	7
8	<u>Roof Repair</u>	2003	1,821		20	91	91	303	8
9	<u>Telephone System Repair</u>	2003	1,271		20	64	64	212	9
10	<u>Door Locks</u>	2003	1,261		20	63	63	205	10
11	<u>Boiler Repair</u>	2003	1,013		20	51	51	160	11
12	<u>Tile</u>	2004	3,078	73	20	154	81	385	12
13	<u>Furnish and Install Doors</u>	2004	2,584	72	20	129	57	323	13
14	<u>Exit Devices, Pull Cylinders and Locks</u>	2004	6,030	39	20	302	263	754	14
15	<u>Wallpaper</u>	2004	29,363	2,517	20	1,468	(1,049)	3,670	15
16	<u>Generator</u>	2004	118,100	1,514	20	5,905	4,391	14,763	16
17	<u>Door</u>	2004	1,200	143	20	60	(83)	150	17
18	<u>Door</u>	2004	1,000	143	20	50	(93)	125	18
19	<u>Door</u>	2004	1,200	143	20	60	(83)	150	19
20	<u>Painting</u>	2004	40,374	1,035	20	2,019	984	5,047	20
21	<u>Painting</u>	2004	8,623	221	20	431	210	1,078	21
22	<u>Boiler and Storage Tank</u>	2004	13,350	200	20	668	468	1,669	22
23	<u>Sprinkler</u>	2004	6,800	40	7	340	300	850	23
24	<u>Damper for Generator</u>	2004	2,580	66	20	129	63	323	24
25	<u>Boiler and Storage</u>	2004	13,350	143	20	668	525	1,669	25
26	<u>Cabinets and Countertops</u>	2005	245,929	8,943	20	12,296	3,353	18,445	26
27	<u>Inside Drain Line</u>	2005	3,431	125	20	172	47	257	27
28	<u>Floor Tiles</u>	2005	3,276	119	20	164	45	246	28
29	<u>Alarm System</u>	2005	1,578	57	20	79	22	118	29
30	<u>Boiler</u>	2005	14,900	542	20	745	203	1,118	30
31	<u>Parking Lot - Asphalt Surface</u>	2005	36,233	3,580	20	1,812	(1,768)	2,717	31
32									32
33	<u>Adjustment per Desk Review</u>	2002	(7,800)						33
34	TOTAL (lines 1 thru 33)		\$ 7,370,078	\$ 49,874		\$ 205,041	\$ 155,167	\$ 6,129,320	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,370,078	\$ 49,874		\$ 205,041	\$ 155,167	\$ 6,129,320	1
2	Water Heater	2006	7,073	1,415	20	177	(1,238)	177	2
3	Asphalt Path/Concrete Replacement	2006	14,951	748	20	374	(374)	374	3
4	Roof Repairs	2006	4,218	32	20	105	73	105	4
5	Water Heater	2006	7,452	1,490	20	187	(1,303)	186	5
6									6
7									7
8									8
9									9
10									10
11	Allocated From Management Co. - leasehold improvements	1995	8,911		20	446	446	5,821	11
12	Allocated From Management Co. - leasehold improvements	1996	1,556		20	78	78	822	12
13	Allocated From Management Co. - leasehold improvements	1997	2,241		20	112	112	1,341	13
14	Allocated From Management Co. - leasehold improvements	1998	1,543		20	77	77	675	14
15	Allocated From Management Co. - leasehold improvements	1999	4,284		20	214	214	1,517	15
16	Allocated From Management Co. - leasehold improvements	2005	8,862		20	443	443	665	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)		\$ 7,431,168	\$ 53,559		\$ 207,254	\$ 153,695	\$ 6,141,003	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 527,857	\$ 24,223	\$ 64,060	\$ 39,837	10	\$ 399,814	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,073,735					1,073,735	73
74	Allocation from Management	22,544		765	765	10	21,341	74
75	TOTALS	\$ 1,624,136	\$ 24,223	\$ 64,825	\$ 40,602		\$ 1,494,890	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	Allocated from Mgmt. Co.	2004 Cadillac	2004	\$ 11,184	\$	\$ 2,237	\$ 2,237	5	\$ 5,592	76
77										77
78										78
79										79
80	TOTALS			\$ 11,184	\$	\$ 2,237	\$ 2,237		\$ 5,592	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)	\$ 9,402,272	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,782	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 274,316	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 196,534	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,641,485	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(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	<u>Facility</u>	<u>2005 Lexus</u>	\$ <u>654.00</u>	\$ <u>7,852</u>	17
18					18
19					19
20	<u>Allocated from Management Co.</u>			<u>2,374</u>	20
21	TOTAL		\$ <u>654.00</u>	\$ <u>10,226</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	23,248	\$ 337,096	\$	23,248	\$ 337,096	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		609	8,527		609	8,527	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		15,898	233,547		15,898	233,547	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				82,733		82,733	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	39,755	\$ 579,170	\$ 82,733	39,755	\$ 661,903	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,500	\$ 1,500	1
2	Cash-Patient Deposits	12,393	12,393	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	2,620,273	2,620,273	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,068	11,068	6
7	Other Prepaid Expenses	82,216	82,216	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	406,454	346,058	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,133,904	\$ 3,073,508	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,784	335,784	13
14	Buildings, at Historical Cost		5,300,000	14
15	Leasehold Improvements, at Historical Cost	1,314,075	2,131,168	15
16	Equipment, at Historical Cost	1,710,194	1,635,320	16
17	Accumulated Depreciation (book methods)	(1,883,669)	(7,641,485)	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 (specify): <u>See Schedule 17A</u>		17,118	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,211,384	\$ 1,777,905	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,345,288	\$ 4,851,413	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 220,447	\$ 92,730	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,488	13,488	28
29	Short-Term Notes Payable	225,000	225,000	29
30	Accrued Salaries Payable	95,703	95,703	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,365	24,365	31
32	Accrued Real Estate Taxes(Sch.IX-B)	400,000	400,000	32
33	Accrued Interest Payable		11,521	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	721,773	733,151	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,700,776	\$ 1,595,958	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,552,481	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)	\$	\$ 1,552,481	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,700,776	\$ 3,148,439	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,644,512	\$ 1,702,974	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,345,288	\$ 4,851,413	48

Kenwood Healthcare Center, Inc.
Provider #: 0033589
12/31/2006

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due from State	36,284	36,284
Due from State - Interest	47,055	47,055
Employee Loans	2,496	2,496
Short Term Loan Exchange	227,543	255,390
Real Estate Tax Escrow	88,243	-
State Withholding	4,833	4,833
Total Line 9-Other Current Assets (Specify)	406,454	346,058

Other Long-Term Assets (Specify)

Mortgage Costs	-	88,031
Accumulated Amortization	-	(70,913)
Total Line 22-Other Long-Term Assets (specify)	-	17,118

Other Current Liabilities (Specify)

Reimbursement Due	615,262	615,262
Insurance Premiums Payable	2,936	2,936
Credit Union	3,467	3,467
Accrued Expenses	100,108	111,486
Total Line 36-Other Current Liabilities (Specify)	721,773	733,151

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,892,291	1
2	Restatements (describe):		2
3	Prior Period Adjustments		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,892,291	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(247,779)	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)	\$ (247,779)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,644,512	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,511,812	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,511,812	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	556,903	6
7	Oxygen	8,551	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 565,454	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59,232	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,232	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	2,341	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,341	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,138,839	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,036,049	31
32	Health Care	3,252,339	32
33	General Administration	2,330,159	33
	B. Capital Expense		
34	Ownership	1,453,056	34
	C. Ancillary Expense		
35	Special Cost Centers	140,910	35
36	Provider Participation Fee	174,105	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,386,618	40
41	Income before Income Taxes (line 30 minus line 40)**	(247,779)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (247,779)	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.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,160	\$ 86,850	\$ 40.21	1
2	Assistant Director of Nursing	3,833	3,993	125,916	31.53	2
3	Registered Nurses	5,918	6,274	147,562	23.52	3
4	Licensed Practical Nurses	36,260	37,381	829,676	22.20	4
5	CNAs & Orderlies	115,852	122,332	1,177,553	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,874	9,363	89,193	9.53	10
11	Social Service Workers	12,161	12,952	146,961	11.35	11
12	Dietician					12
13	Food Service Supervisor	5,906	6,394	99,935	15.63	13
14	Head Cook	3,191	3,506	32,890	9.38	14
15	Cook Helpers/Assistants	32,284	34,982	309,726	8.85	15
16	Dishwashers					16
17	Maintenance Workers	9,509	10,189	167,456	16.43	17
18	Housekeepers	45,676	48,308	421,754	8.73	18
19	Laundry	16,597	17,770	162,060	9.12	19
20	Administrator	2,080	2,080	210,000	100.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	44,279	47,468	676,618	14.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	344,500	365,152	\$ 4,684,150 *	\$ 12.83	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	Monthly	\$ 24,816	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	Monthly	585	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	227	11,351	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	25	1,386	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	5,000	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	252	\$ 49,138		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kenwood Healthcare Center**

0033589

Report Period Beginning: **01/01/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Ronnie Klein	Administrator	6.92	\$ 210,000	Workers' Compensation Insurance	\$ 108,861	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	122,407	Advertising: Employee Recruitment			
				FICA Taxes	342,275	Health Care Worker Background Check			
				Employee Health Insurance	48,057	(Indicate # of checks performed _____)			
				Employee Meals	6,852	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*	0	See Schedule 21A	22,741		
				Employee Retirement	1,954				
				Uniforms	4,268				
				Disability Insurance	3,168	Allocation from Management Company	330		
				Miscellaneous Employee Benefits	8,600	Less: Non-Allowable Dues	(5,016)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 210,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 646,442	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,045
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Central Bookkeeping Office			\$ 255,375	N/A		\$	Out-of-State Travel	\$	
SW Management Co.-Management Fees (Eliminated in Col 7)			270,000						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 525,375				Seminar Expense	2,005	
							Allocation from Management Co.	3	
							Entertainment Expense	()	
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount	\$				\$ 2,008	
Stone Pogrund & Korey	Legal		\$ 9,893						
Ashman & Stein	Legal		76,835						
Winston & Strawn	Legal		1,235						
RSM McGladrey	Accounting		14,476						
Personnel Planners	U/E Consultant		3,213						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 105,652						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Kenwood Healthcare Center, Inc.

Provider # : 0033589

12/31/2006

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3) 105,652

Allocated from Real Estate Entity - Accounting 2,165

Allocated from Real Estate Entity - Legal 600

Allocated from Mangement Company - Accounting 3,405

Allocated from Mangement Company - Legal 15,925

Less : Non-Allowable Legal Costs (13,636)

Total (Agree to Schedule V, Line 19, Column 8) 114,111

F. Dues, Fees, Subscriptions and Promotions

Illinois Council on Long Term Care 8,872

City of Chicago Licenses 11,113

Miscellaneous Dues & Permits 222

Miscellaneous Inspections & Licenses 2,534

Total to Page 21, Section F 22,741

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2	N/A																			
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center# 0033589Report Period Beginning: 01/01/06Ending: 12/31/06**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 on LTC, \$3,856
- (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? N/a
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 400 Line 10
- (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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
KTNC Associates
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 174,105
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 6,852 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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