

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,075	1,833	18,594	37,502	8
9	SNF/PED					9
10	ICF	48,713	5,228		53,941	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,788	7,061	18,594	91,443	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.68%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 08/01/94

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 303 and days of care provided 13,083

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICES)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	527,079	44,840	18,859	590,778		590,778	(10,703)	580,075		1
2	Food Purchase		350,322		350,322		350,322	(1,451)	348,871		2
3	Housekeeping	278,846	46,993		325,839		325,839	2,644	328,483		3
4	Laundry	169,473	45,746	10,341	225,560		225,560	(6,507)	219,053		4
5	Heat and Other Utilities			248,201	248,201		248,201		248,201		5
6	Maintenance	121,897	42,565	75,078	239,540		239,540	(5,559)	233,981		6
7	Other (specify):*			135,653	135,653		135,653		135,653		7
8	TOTAL General Services	1,097,295	530,466	488,132	2,115,893		2,115,893	(21,576)	2,094,317		8
	B. Health Care and Programs										
9	Medical Director			25,000	25,000		25,000		25,000		9
10	Nursing and Medical Records	4,468,765	211,096	221,333	4,901,194		4,901,194	(130,882)	4,770,312		10
10a	Therapy	152,714			152,714		152,714		152,714		10a
11	Activities	203,573	9,994	5,394	218,961		218,961	(1,628)	217,333		11
12	Social Services	338,760		2,900	341,660		341,660		341,660		12
13	CNA Training										13
14	Program Transportation			288	288		288		288		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,163,812	221,090	254,915	5,639,817		5,639,817	(132,510)	5,507,307		16
	C. General Administration										
17	Administrative	303,891		1,330,160	1,634,051		1,634,051	(1,327,925)	306,126		17
18	Directors Fees										18
19	Professional Services			818,401	818,401		818,401	(378,414)	439,987		19
20	Dues, Fees, Subscriptions & Promotions			152,303	152,303		152,303	(93,480)	58,823		20
21	Clerical & General Office Expenses	271,200	50,233	72,211	393,644		393,644	299,036	692,680		21
22	Employee Benefits & Payroll Taxes			1,304,760	1,304,760		1,304,760		1,304,760		22
23	Inservice Training & Education			9,425	9,425		9,425		9,425		23
24	Travel and Seminar			1,120	1,120		1,120	18,787	19,907		24
25	Other Admin. Staff Transportation			2,208	2,208		2,208		2,208		25
26	Insurance-Prop.Liab.Malpractice			405,450	405,450		405,450	11,285	416,735		26
27	Other (specify):*			340,376	340,376		340,376	(340,376)			27
28	TOTAL General Administration	575,091	50,233	4,436,414	5,061,738		5,061,738	(1,811,087)	3,250,651		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,836,198	801,789	5,179,461	12,817,448		12,817,448	(1,965,173)	10,852,275		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	17,981
	REPAIRS & MAINTENANCE	878
		0
		18,859
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	10,341
		0
		10,341
5	HEAT & OTHER UTILITIES	
	GAS HEAT	114,006
	ELECTRICITY	109,854
	WATER	24,341
	CABLE TV - LOBBY	0
		0
		248,201
6	MAINTENANCE	
	GROUNDS MAINTENANCE	9,070
	PAINTING & DECORATING	3,210
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	34,959
	ELEVATOR MAINTENANCE & REPAIR	14,101
	OUTSIDE LABOR	2,415
	EXTERMINATING SERVICE	4,200
	FIRE SERVICE	7,123
		0
		0
		0
		0
		75,078
7	OTHER	
	SCAVENGER	41,937
	SECURITY SERVICE	93,716
		0
		0
		135,653
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	25,000
		25,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	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	187,733
	WOUND CARE CONSULTANT XVIII B 46-2	30,000
		0
		221,333
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	2,650
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,744
		0
		5,394
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,900
		0
		2,900
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	288
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	1,330,160
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	45,958
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	772,443
		0
		818,401
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	88,822
	EMPLOYEE WANT ADS XIX F	27,408
	CONTRIBUTIONS VI 20 XIX F	825
	DUES & SUBSCRIPTIONS XIX F	16,254
	LICENSES & PERMITS XIX F	1,372
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,618
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,944
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	6,380
	PATIENT BACKGROUND CHECKS XIX F	5,680
		152,303
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	3,917
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	7,157
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	1,225
	TELEPHONE	55,681
	MESSENGER SERVICE	4,231
		0
		72,211

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	509,214
	UNEMPLOYMENT COMPENSATION XIX D	137,262
	WORKERS COMPENSATION INSURANC XIX D	124,278
	HOSPITALIZATION INSURANCE XIX D	485,821
	EMPLOYEE BENEFITS - OTHER XIX D	30,165
	EMPLOYEE PHYSICAL EXAMS XIX D	5,261
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	12,759
	CHICAGO HEAD TAX XIX D	0
		0
		1,304,760
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,425
		9,425
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,120
		1,120
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	2,208
		2,208
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	405,450
		405,450
27	OTHER	
	BAD DEBTS VI 24	340,376
		340,376

GRAND TOTAL COLUMN 3 OTHER

5,179,461

**CRESTWOOD CARE CENTRE
SCHEDULES
12/31/2007**

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

TOTAL FOOD PURCHASE	350,322
LESS SALES TAX	<u>(1,451)</u>
NET FOOD	348,871

TOTAL PATIENT CENSUS	91,443
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	274,329

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

PATIENT MEALS	274,329
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	274,329

NET FOOD	348,871
DIVIDE TOTAL MEALS/YEAR	<u>274,329</u>

COST PER MEAL	1.27
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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

#0044164

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			87,699	87,699		87,699	197,929	285,628			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			252,035	252,035		252,035	243,522	495,557			32
33	Real Estate Taxes			490,142	490,142		490,142		490,142			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,113,694)	68,906			34
35	Rent-Equipment & Vehicles			84,267	84,267		84,267	14,390	98,657			35
36	Other (specify):* STORAGE/MTG INS			6,142	6,142		6,142	23,582	29,724			36
37	TOTAL Ownership			2,102,885	2,102,885		2,102,885	(634,271)	1,468,614			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		358,580	1,892,096	2,250,676		2,250,676		2,250,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,893	165,893		165,893		165,893			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		358,580	2,057,989	2,416,569		2,416,569		2,416,569			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,836,198	1,160,369	9,340,335	17,336,902		17,336,902	(2,599,444)	14,737,458			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,478	30		9
10	Interest and Other Investment Income	(10,273)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,451)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,157)	21		18
19	Entertainment		20		19
20	Contributions	(4,769)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(31,714)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(340,376)	27		24
25	Fund Raising, Advertising and Promotional	(88,822)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,618)	20		28
29	Other-Attach Schedule	(31,484)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (511,186)		\$	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,088,258)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,088,258)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,599,444)		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				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (1,796)	6	1
2	VACATION ACCRUAL	(10,703)	1	2
3	VACATION ACCRUAL	2,644	3	3
4	VACATION ACCRUAL	(6,507)	4	4
5	VACATION ACCRUAL	(3,763)	6	5
6	VACATION ACCRUAL	(17,419)	10	6
7	VACATION ACCRUAL	(1,628)	11	7
8	VACATION ACCRUAL	2,235	17	8
9	VACATION ACCRUAL	11,836	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11				11
12	MEDICARE A BILLING	(318)	19	12
13	MARKETING CONSULTANT	(4,065)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(31,484)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE# 0044164

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(10,703)	0	0	0	0	0	0	0	0	0	0	(10,703)	1
2	Food Purchase	(1,451)	0	0	0	0	0	0	0	0	0	0	(1,451)	2
3	Housekeeping	2,644	0	0	0	0	0	0	0	0	0	0	2,644	3
4	Laundry	(6,507)	0	0	0	0	0	0	0	0	0	0	(6,507)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,559)	0	0	0	0	0	0	0	0	0	0	(5,559)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,576)	0	0	0	0	0	0	0	0	0	0	(21,576)	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	(17,419)	0	0	(113,463)	0	0	0	0	0	0	0	(130,882)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,628)	0	0	0	0	0	0	0	0	0	0	(1,628)	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	(19,047)	0	0	(113,463)	0	0	0	0	0	0	0	(132,510)	16
	C. General Administration													
17	Administrative	2,235	0	(997,620)	0	0	(332,540)	0	0	0	0	0	(1,327,925)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(38,097)	9,564	78,430	1,336	(429,647)	0	0	0	0	0	0	(378,414)	19
20	Fees, Subscriptions & Promotions	(95,209)	0	723	198	808	0	0	0	0	0	0	(93,480)	20
21	Clerical & General Office Expenses	4,679	0	16,364	2,239	275,754	0	0	0	0	0	0	299,036	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	7,462	5,362	5,963	0	0	0	0	0	0	18,787	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	3,049	3,537	4,699	0	0	0	0	0	0	11,285	26
27	Other (specify):*	(340,376)	0	0	0	0	0	0	0	0	0	0	(340,376)	27
28	TOTAL General Administration	(466,768)	9,564	(891,592)	12,672	(142,423)	(332,540)	0	0	0	0	0	(1,811,087)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(507,391)	9,564	(891,592)	(100,791)	(142,423)	(332,540)	0	0	0	0	0	(1,965,173)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	6,478	183,661	757	340	6,693	0	0	0	0	0	0	197,929	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,273)	253,795	0	0	0	0	0	0	0	0	0	243,522	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	2,728	66,178	0	0	0	0	0	0	(1,113,694)	34
35	Rent-Equipment & Vehicles	0	0	4,864	5,511	4,015	0	0	0	0	0	0	14,390	35
36	Other (specify):*	0	23,582	0	0	0	0	0	0	0	0	0	23,582	36
37	TOTAL Ownership	(3,795)	(721,562)	5,621	8,579	76,886	0	0	0	0	0	0	(634,271)	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)	(511,186)	(711,998)	(885,971)	(92,212)	(65,537)	(332,540)	0	0	0	0	0	(2,599,444)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		CRESTWOOD HEIGHTS NURSING HOME		
					MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		\$	(1,182,600)	1
2	V	36 MORTGAGE INSURANCE		"		23,582	23,582	2
3	V	30 DEPRECIATION - BLDG IMP		"		183,069	183,069	3
4	V	30 DEPRECIATION - EQPT & FURN		"		592	592	4
5	V	32 AMORTIZATION - MTG COST		"		1,343	1,343	5
6	V	32 MORTGAGE INTEREST		"		252,452	252,452	6
7	V	19 ACCOUNTING FEES		"		9,364	9,364	7
8	V	19 DATA PROCESSING		"		200	200	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,182,600			\$ 470,602	\$ * (711,998)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$ 78,430	\$ 78,430
16	V	20 DUES & SUBSCRIPTIONS				723	723
17	V	21 CLERICAL				16,364	16,364
18	V	24 TRAVEL				7,462	7,462
19	V	26 INSURANCE				3,049	3,049
20	V	35 RENT - EQPT & VEH				4,864	4,864
21	V	17 ADMINISTRATIVE	997,620				(997,620)
22	V	30 DEPRECIATION				757	757
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		\$ 997,620			\$ 111,649	\$ * (885,971)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 174,764	CARLYLE NURSING ASSOCIATES, LLC		\$ 61,301	\$ (113,463)
16	V	19 PROFESSIONAL FEES		"		1,336	1,336
17	V	20 DUES & SUBSCRIPTIONS		"		198	198
18	V	21 CLERICAL		"		2,239	2,239
19	V	24 TRAVEL		"		5,362	5,362
20	V	26 INSURANCE		"		3,537	3,537
21	V	30 DEPRECIATION		"		340	340
22	V	34 RENT		"		2,728	2,728
23	V	35 RENT - EQPT & VEH		"		5,511	5,511
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		\$ 174,764			\$ 82,552	\$ * (92,212)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 436,630	THE KENSINGTON GROUP, LLC		\$ 6,983	\$ (429,647)
16	V	20 DUES & SUBSCRIPTIONS		"		808	808
17	V	21 CLERICAL		"		275,754	275,754
18	V	24 TRAVEL		"		5,963	5,963
19	V	26 INSURANCE		"		4,699	4,699
20	V	30 DEPRECIATION		"		6,693	6,693
21	V	34 RENT		"		66,178	66,178
22	V	35 RENT - EQPT & VEH		"		4,015	4,015
23	V	17 ADMINISTRATIVE		"			
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		\$ 436,630			\$ 371,093	\$ * (65,537)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE	\$ 332,540	CHESTERFIELD, LLC		\$	\$	(332,540)	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		\$ 332,540			\$	0	\$ * (332,540)	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: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	368,840	7	\$ 316,248	\$ 91,443	\$ 78,430	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	368,840	7	2,914	91,443	723	2
3	21	CLERICAL	PATIENT DAYS	368,840	7	65,982	91,443	16,364	3
4	24	TRAVEL	PATIENT DAYS	368,840	7	30,090	91,443	7,462	4
5	26	INSURANCE	PATIENT DAYS	368,840	7	12,294	91,443	3,049	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	368,840	7	19,611	91,443	4,864	6
7	30	DEPRECIATION	PATIENT DAYS	368,840	7	3,051	91,443	757	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					\$ 450,190	\$	\$ 111,649	25

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 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

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	10	NURSING	DIRECT HOURS	1	\$ 61,301	\$ 61,301	1	\$ 61,301	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	8,078		91,443	1,336	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	1,197		91,443	198	3
4	21	CLERICAL	PATIENT DAYS	553,355	13,541		91,443	2,239	4
5	24	TRAVEL	PATIENT DAYS	553,355	32,426		91,443	5,362	5
6	26	INSURANCE	PATIENT DAYS	553,355	21,389		91,443	3,537	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	2,056		91,443	340	7
8	34	RENT	PATIENT DAYS	553,355	16,500		91,443	2,728	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	33,327		91,443	5,511	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				\$ 189,815	\$ 61,301		\$ 82,552	25

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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 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

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	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	\$ 42,255	\$ 91,443	\$ 6,983	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	91,443	808	2
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	91,443	33,693	3
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	91,443	5,963	4
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	91,443	4,699	5
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	91,443	6,693	6
7	34	RENT	PATIENT DAYS	553,355	11	400,473	91,443	66,178	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	24,297	91,443	4,015	8
9									9
10	21	CLERICAL	DIRECT HOURS	1	1	242,061	242,061	1	242,061
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					\$ 1,022,882	\$ 242,061	\$ 371,093	25

Facility Name & ID Number

CRESTWOOD CARE CENTRE

0044164

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						\$	\$			\$	1						
2	CAPMARK		X	MORTGAGE	\$101,139.93	12/03	4,897,900	4,689,968	12/38	0.0535	252,452	2						
3	CAPMARK		X	LOAN COST	AMORT - 35 YEARS			41,550			1,343	3						
4												4						
5												5						
	Working Capital																	
6	JP MORGAN - CHASE		X	WORKING CAPITAL	DEMAND	VARIES	323,671	1,293,000	DEMAND	PRIME +	104,968	6						
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,291,428	2,467,025	DEMAND	VARIES	144,768	7						
8	LETTER OF CREDIT FEE		X						DEMAND	8.2500	2,299	8						
9	TOTAL Facility Related				\$101,139.93		\$ 6,512,999	\$ 8,491,543			\$ 505,830	9						
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 6,512,999	\$ 8,491,543			\$ 505,830	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.	\$	480,655	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.)	\$	483,822	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3,167	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	486,975	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.	\$	490,142	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	471,212	8
	2003	467,330	9
	2004	488,444	10
	2005	477,629	11
	2006	483,822	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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 2006 TAX BILL.

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>28-03-303-011-0000</u>	<u>NURSING HOME</u>	\$ <u>167,392.13</u>	\$ <u>167,392.13</u>
2. <u>28-03-303-012-0000</u>	<u>NURSING HOME</u>	\$ <u>303,473.92</u>	\$ <u>303,473.92</u>
3. <u>28-03-303-038-0000</u>	<u>NURSING HOME</u>	\$ <u>12,955.64</u>	\$ <u>12,955.64</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>483,821.69</u>	\$ <u>483,821.69</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 CRESTWOOD CARE CENTRE

0044164

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

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

N/A

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	303	1974		\$ 2,091,708	\$ 116,395	35	\$ 59,673	\$ (56,722)	\$ 2,026,692	4
5		1980		3,400		35	97	97	2,744	5
6	SEC 754 ADJ		1992	584,054	21,239	27.5	21,238	(1)	292,782	6
7	SEC 754 ADJ		2001	24,100	877	27.5	876	(1)	6,132	7
8										8
	Improvement Type**									
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE									
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	246	20		(246)	76,557	16
17	IMPROVEMENTS		1986	16,943	47	19		(47)	16,943	17
18	IMPROVEMENTS		1986	1,559	3	19	82	79	1,373	18
19	IMPROVEMENTS		1987	23,951	853	20	599	(254)	23,951	19
20	IMPROVEMENTS		1987	22,863	832	27.5	832		22,497	20
21	IMPROVEMENTS		1988	20,627	751	27.5	751		15,101	21
22	IMPROVEMENTS		1989	35,057	1,263	27.5	1,263		21,422	22
23	IMPROVEMENTS		1990	50,320	1,829	27.5	1,829		28,199	23
24	IMPROVEMENTS		1991	53,090	1,930	27.5	1,930		28,242	24
25	IMPROVEMENTS		1992	53,668	1,951	27.5	1,951		27,187	25
26	IMPROVEMENTS		1992	51,711	2,160	15	2,160		51,711	26
27	IMPROVEMENTS		1993	42,479	1,544	27.5	1,544		16,924	27
28	IMPROVEMENTS		1993	78,601	2,859	27.5	2,859		37,935	28
29	IMPROVEMENTS		1994	193,211	7,026	27.5	7,026		90,343	29
30	FIRE ALARM SYSTEMS		1995	19,476	708	27.5	708		8,907	30
31	ELEVATOR REHAB		1995	57,000	2,073	27.5	2,073		25,551	31
32	NURSES CALL STATION		1995	6,318	230	27.5	230		2,835	32
33	DINING ROOM AIR CONDITIONING SYSTEM		1995	9,370	341	27.5	341		4,120	33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

**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:

01/01/2007 Ending: 12/31/2007

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	COOLING TOWER REPLACEMENT	1995	\$ 15,650	\$ 569	27.5	\$ 569	\$	\$ 6,873	37
38	HANDRAILS/TILING ROOF	1996	103,547	3,766	27.5	3,766		43,601	38
39	HANDRAILS/TILING ROOF	1996	877	32	27.5	32		362	39
40	OUR TOWN	1996	61,800	2,248	27.5	2,248		24,337	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		25,580	41
42	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		157,502	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		16,920	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		28,816	44
45	OUR TOWN	1998	32,000	1,163	27.5	1,163		11,590	45
46	ELECTRICAL - WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		1,593	46
47	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,272	27.5	1,272		12,676	47
48	REMOFELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	32	27.5	32		327	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		3,476	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		6,374	50
51	ROOF REPAIRS	1998	2,790	102	27.5	102		990	51
52	BOILER VALVE	1998	5,450	198	27.5	198		1,790	52
53	WALLCOVERING	1999	2,206	80	27.5	80		787	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		1,870	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		1,227	55
56	REMODEL - NURSES STATION	2000	25,135	914	27.5	914		6,893	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		7,585	57
58	ROOF WORK	2000	11,384	414	27.5	414		3,019	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAL	2000	23,240	845	27.5	845		6,091	59
60	REMODEL - NURSES STATION	2000	10,730	390	27.5	390		2,779	60
61	CLOSET DOORS -2,3, AND 4TH FLOOR NURSES STATION	2001	1,900	69	27.5	69		480	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		261	62
63	RENOVATE - 3A, 4B AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		1,563	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	638	27.5	638		4,221	64
65	DRYWALL AND PAINT ROOM 226 AND BATHROOM	2001	1,883	69	27.5	69		446	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		3,933	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	497	27.5	497		2,998	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,706,519	\$ 203,466		\$ 146,371	\$ (57,095)	\$ 3,352,097	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:

01/01/2007 Ending: 12/31/2007

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		\$ 4,706,519	\$ 203,466		\$ 146,371	\$ (57,095)	\$ 3,352,097	1
2	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	114	27.5	114		694	2
3	KITCHEN FLOOR-REMOVE OLD AND INSTALL NEW TILE	2002	3,086	112	27.5	112		658	3
4	REPLACE 49 DOORS AND 1ST AND 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		5,160	4
5	BUILD NEW SMOKING LOUNGE	2002	3,596	131	27.5	131		759	5
6	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	119	27.5	119		694	6
7	INSTALL WALL COVERING - ROOM 223	2002	1,800	66	27.5	66		378	7
8	REBUILD AND PREP WALLS - RMS 234, 334 AND LOUNGE	2002	4,000	146	27.5	146		829	8
9	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	54	27.5	54		308	9
10	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	551	27.5	551		3,003	10
11	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		431	11
12	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	80	27.5	80		430	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,151	27.5	4,151		21,616	13
14	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	11,489	27.5	11,489		51,219	14
15	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	637	27.5	637		2,837	15
16	RESURFACE AND PAVE PARKING LOT	2003	3,697	246	15	246		1,110	16
17	ALUMINUM ROOF	2003	1,700	62	27.5	62		276	17
18	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	337	27.5	337		1,499	18
19	FIRE DAMPERS	2004	3,417	125	27.5	125		429	19
20	INSTALLED A SOFSTART	2004	2,670	97	27.5	97		335	20
21	AMEREX KP FIRE SUPPRESSION SYSTEM	2004	1,457	53	27.5	53		182	21
22	OAK FLUSH FIRE DOORS - DIETARY/BATH AND BED RMS	2004	7,632	277	27.5	277		959	22
23	REMOVE & INSTALL NEW SHAMPOO STATION & TOILET	2004	1,945	70	27.5	70		243	23
24	WATER SYSTEM	2004	16,254	591	27.5	591		2,043	24
25	REPLACE ENTRY WALK	2004	5,500	200	27.5	200		691	25
26	NEW PANASONIC TELEPHONE SYSTEM	2004	26,934	980	27.5	980		3,386	26
27	REMOVE & INSTALL WALLCOVERING - REHAB ROOM	2004	2,786	185	15	186		651	27
28	PATCH TO THE FIELD/WALL FLASHING - ROOF	2004	1,500	54	27.5	54		188	28
29	REMOVE & INSTALL VINYL SHEET FLOORING & COVE								29
30	BASE	2005	28,921	1,051	27.5	1,051		3,111	30
31	REMOVE & INSTALL WALLPAPER IN PATIENT ROOM;								31
32	PAINT CEILINGS, BATHROOMS & DOOR FRAMES	2005	29,972	5,242	7	4,282	(960)	12,847	32
33	CUBICLE CURTAINS	2005	8,040	1,406	7	1,149	(257)	3,447	33
34	TOTAL (lines 1 thru 33)		\$ 5,370,195	\$ 233,062		\$ 174,751	\$ (58,312)	\$ 3,472,510	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:

01/01/2007 Ending: 12/31/2007

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		\$ 5,370,195	\$ 233,062		\$ 174,751	\$ (58,311)	\$ 3,472,510	1
2	RE-FLOOR UPPER MAIN ROOF - APPROX, 23800	2005	67,950	2,471	27.5	2,471		7,104	2
3	2 FIRE DOORS FOR 2ND FLOOR	2005	1,702	62	27.5	62		163	3
4	PLUMBING WORK ON PIPES TO INCREASE HOT WATER	2005	10,923	397	27.5	397		1,042	4
5	NEW ANTENNA SYSTEM	2005	12,995	473	27.5	473		1,004	5
6	REMOVE & INSTL. DRAIN LINES, SINK, LAUNDRY TUBS	2006	5,527	201	27.5	201		377	6
7	REMOVE & INSTAL. CEILING TILES - DOCTORS OFFICE	2006	980	36	27.5	36		67	7
8	REMOVE & INSTAL. DRYWALL, TILES, CEILING - 1ST FLR	2006	1,985	72	27.5	72		135	8
9	PARTITIONS/WOVEN WIRE CUBICLES	2006	4,625	1,132	7	661	(471)	1,322	9
10	DIALYSIS RM - HANG DRYWALL, PLYWOOD ENCLOSURE	2006	43,811	1,594	27.5	1,594		2,191	10
11	NURSES STATION - NEW WALLS, SUPPORTS & CABINETS	2006	19,905	724	27.5	724		935	11
12	RAISE & RESTORE WALKWAY	2006	1,500	54	27.5	54		70	12
13	TEAR OUT & INSTL VCT & RUBBER BASE - ATRIUM LNGE	2006	2,380	86	27.5	86		97	13
14	INSTALL SPLASH GUARDS - DIALYSIS RM, SINK	2006	3,805	139	27.5	139		156	14
15	REMOVE & INSTALL VCT TILES - ROOM 238	2007	2,293	83	27.5	83		83	15
16	PAINT WALLS & CEILING, INSTALL TILE - 7-3 & 5-2 MAN I	2007	15,156	276	27.5	276		276	16
17	COVE BASE;HANDRAILS; WALL COVERING - HALLWAY	2007	26,964	490	27.5	490		490	17
18	WALL COVERING - DIALYSIS UNIT	2007	3,000	100	15	100		100	18
19	VINYLASA WOOD PANELS - HALLWAYS	2007	6,155	93	27.5	93		93	19
20	2 BARRIER FREE SHOWERS	2007	3,230	49	27.5	49		49	20
21	CEILING TILES & GRID FRAMEWORK - DIALYSIS RM	2007	2,141	32	27.5	32		32	21
22	BORDERS IN ROOMS & CORRIDORS - 3RD FLOOR	2007	4,659	129	15	129		129	22
23	PAINT DOOR FRAMES - FLOORS 2, 3, & 4	2007	1,145	13	15	13		13	23
24	35 CUBICLE CURTAINS	2007	3,594	40	15	40		40	24
25	HANDRAILS; BUMPER GUARDS & CORNER GUARDS	2007	6,540	20	27.5	20		20	25
26	CEMENT WORK - WALKWAY	2007	1,500	23	27.5	23		23	26
27									27
28			ADJ. TO SL	(58,782)			58,782		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,624,660	\$ 183,069		\$ 183,069	\$	\$ 3,488,521	34

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

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	\$ 939,864	\$ 70,291	\$ 89,825	\$ 19,534	3-10 YRS	\$ 538,475	71
72	Current Year Purchases	87,036	17,408	4,352	(13,056)	3-10 YRS	4,352	72
73	Fully Depreciated Assets	340,858					340,858	73
74	RELATED PARTY	5,917	8,382	8,382			3,848	74
75	TOTALS	\$ 1,373,675	\$ 96,081	\$ 102,559	\$ 6,478		\$ 887,533	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,334,087	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 279,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 285,628	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,478	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,376,054	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED 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: _____ *

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: \$ 58,831 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	\$ 1,167	17
18	FACILITY USE	2006 FORD 450(MINI BUS)	#####	14,069	18
19	FACILITY USE	2006 FORD CLUB WAGON	850.00	10,200	19
20					20
21	TOTAL		\$ #####	\$ 25,436	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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.

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	39-3	hrs	\$		\$ 514,986	\$		\$ 514,986	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			76,499			76,499	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			836,003			836,003	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts			464,608			464,608	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					358,580		358,580	13
14	TOTAL			\$		\$ 1,892,096	\$ 358,580		\$ 2,250,676	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ (133,792)	\$ 215,083	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 54,211)	6,398,466	6,398,466	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,811	2,811	5
6	Prepaid Insurance	89,889	232,057	6
7	Other Prepaid Expenses	83,793	90,617	7
8	Accounts Receivable (owners or related parties)	667,655	669,155	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		713,535	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,108,822	\$ 8,321,724	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		1,489,330	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		3,274,837	15
16	Equipment, at Historical Cost	1,367,758	1,367,758	16
17	Accumulated Depreciation (book methods)	(1,209,599)	(4,361,091)	17
18	Deferred Charges		41,550	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)	\$ 158,159	\$ 4,384,979	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,266,981	\$ 12,706,703	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,427,984	\$ 3,430,209	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	987,875	987,875	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,963	141,963	30
31	Accrued Taxes Payable (excluding real estate taxes)	97,291	97,291	31
32	Accrued Real Estate Taxes(Sch.IX-B)		486,975	32
33	Accrued Interest Payable		20,909	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO LESSOR</u>	3,462,537		36
37	<u>MANAGEMENT FEES</u>	658,205	658,205	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,775,855	\$ 5,823,427	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,760,025	2,908,586	39
40	Mortgage Payable		4,689,968	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)	\$ 3,760,025	\$ 7,598,554	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,535,880	\$ 13,421,981	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,268,899)	\$ (715,278)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,266,981	\$ 12,706,703	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,718,593)	1
2	Restatements (describe):		2
3	1065 REFUND	1,078	3
4	ROUNDING ADJ.	8	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,717,507)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(551,392)	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)	\$ (551,392)	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)	\$ (5,268,899)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,775,237	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,775,237	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,273	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,273	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,785,510	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,115,893	31
32	Health Care	5,639,817	32
33	General Administration	5,061,738	33
	B. Capital Expense		
34	Ownership	2,102,885	34
	C. Ancillary Expense		
35	Special Cost Centers	2,250,676	35
36	Provider Participation Fee	165,893	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38	NET VENDING COSTS		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,336,902	40
41	Income before Income Taxes (line 30 minus line 40)**	(551,392)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (551,392)	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: 01/01/2007

Ending: 12/31/2007

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	2,593	2,934	\$ 133,479	\$ 45.49	1
2	Assistant Director of Nursing	4,954	5,555	199,369	35.89	2
3	Registered Nurses	26,199	29,283	813,124	27.77	3
4	Licensed Practical Nurses	63,474	69,090	1,626,490	23.54	4
5	CNAs & Orderlies	137,857	148,600	1,582,786	10.65	5
6	CNA Trainees					6
7	Licensed Therapist	1,714	1,956	35,860	18.33	7
8	Rehab/Therapy Aides	7,869	8,650	116,854	13.51	8
9	Activity Director	3,917	4,267	59,657	13.98	9
10	Activity Assistants	14,492	15,529	143,916	9.27	10
11	Social Service Workers	14,282	16,169	338,760	20.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,710	14,781	240,159	16.25	14
15	Cook Helpers/Assistants	29,964	31,582	286,920	9.08	15
16	Dishwashers					16
17	Maintenance Workers	5,917	6,523	121,897	18.69	17
18	Housekeepers	24,844	27,460	278,846	10.15	18
19	Laundry	17,490	18,775	169,473	9.03	19
20	Administrator	1,977	2,426	238,576	98.34	20
21	Assistant Administrator	1,821	2,126	65,315	30.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,765	16,851	271,200	16.09	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	8,724	9,307	113,517	12.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	396,563	431,864	\$ 6,836,198 *	\$ 15.83	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	316	\$ 17,981	1-3	35
36	Medical Director	370	25,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	716	187,733	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	49	2,744	11-3	44
45	Social Service Consultant	45	2,900	12-3	45
46	Other(specify) <u>WOUND CARE</u>	150	30,000	10-3	46
47				10-3	47
48				10-3	48
49	TOTAL (lines 35 - 48)	1,742	\$ 269,958		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

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	
JUDY DUMONT	ADMINISTRATOR		\$ 238,576	Workers' Compensation Insurance	\$ 124,278	IDPH License Fee	\$	
KATHY SMITH	ASST ADMIN		65,315	Unemployment Compensation Insurance	137,262	Advertising: Employee Recruitment	27,408	
			0	FICA Taxes	509,214	Health Care Worker Background Check	6,380	
				Employee Health Insurance	485,821	(Indicate # of checks performed <u>638</u>)		
				Employee Meals	0	Patient Background Checks	568	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,769	
				EMPLOYEE BENEFITS - OTHER	30,165	MARKETING/ADV/PROMO	90,440	
				EMPLOYEE PHYSICAL EXAMS	5,261	LICENSES/DUES/SUBSCRIPTIONS	17,626	
				PENSION/PROFIT SHARING PLANS	12,759	MGMT CO ALLOC	1,729	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(4,769)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(88,822)	
						Yellow page advertising	(1,618)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 303,891	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,304,760	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 58,823	
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
WITTINGHAM MANAGEMENT ASSOC. LLC			\$ 997,620			\$	Out-of-State Travel	\$
CHESTERFIELD LLC			332,540					
							In-State Travel	
							TRAVEL	1,120
							RELATED PARTY	18,787
							Seminar Expense	
								0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,330,160	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 19,907
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$			\$		
SEE SCHEDULE ATTACHED			818,401					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 818,401					

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2006	\$ 4,243		\$	\$	\$ 708	\$ 1,414	\$ 1,414	\$ 707	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
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11																				
12																				
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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: 01/01/2007

Ending: 12/31/2007

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 - \$15132
- (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. \$ 21,363 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 of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees