

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	110,898	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	110,898	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	14,710	1,948	16,029	32,687	8
9	SNF/PED					9
10	ICF	46,752	6,193	3,862	56,807	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,462	8,141	19,891	89,494	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.70%

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 14,819

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICE)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **CRESTWOOD CARE CENTRE** # **0044164** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	573,016	39,563	23,019	635,598		635,598	(2,307)	633,291		1
2	Food Purchase		421,575		421,575		421,575	(8,844)	412,731		2
3	Housekeeping	291,223	63,119		354,342		354,342	(3,566)	350,776		3
4	Laundry	189,582	51,552	10,509	251,643		251,643	(925)	250,718		4
5	Heat and Other Utilities			302,367	302,367		302,367		302,367		5
6	Maintenance	118,519	35,062	78,272	231,853		231,853	(2,105)	229,748		6
7	Other (specify):*			150,865	150,865		150,865		150,865		7
8	TOTAL General Services	1,172,340	610,871	565,032	2,348,243		2,348,243	(17,747)	2,330,496		8
	B. Health Care and Programs										
9	Medical Director			56,000	56,000		56,000		56,000		9
10	Nursing and Medical Records	4,455,792	453,052	212,943	5,121,787		5,121,787	(135,318)	4,986,469		10
10a	Therapy	154,597		32,179	186,776		186,776		186,776		10a
11	Activities	183,593	14,809	8,950	207,352		207,352	(940)	206,412		11
12	Social Services	153,725		3,458	157,183		157,183		157,183		12
13	CNA Training										13
14	Program Transportation			320	320		320		320		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,947,707	467,861	313,850	5,729,418		5,729,418	(136,258)	5,593,160		16
	C. General Administration										
17	Administrative	307,335		1,406,180	1,713,515		1,713,515	(1,409,608)	303,907		17
18	Directors Fees										18
19	Professional Services			860,014	860,014		860,014	(310,772)	549,242		19
20	Dues, Fees, Subscriptions & Promotions			148,024	148,024		148,024	(120,455)	27,569		20
21	Clerical & General Office Expenses	377,957	35,951	76,547	490,455		490,455	274,019	764,474		21
22	Employee Benefits & Payroll Taxes			1,318,433	1,318,433		1,318,433		1,318,433		22
23	Inservice Training & Education			9,064	9,064		9,064		9,064		23
24	Travel and Seminar							21,255	21,255		24
25	Other Admin. Staff Transportation			4,982	4,982		4,982		4,982		25
26	Insurance-Prop.Liab.Malpractice			399,514	399,514		399,514	29,092	428,606		26
27	Other (specify):*			2,890,475	2,890,475		2,890,475	(2,890,475)			27
28	TOTAL General Administration	685,292	35,951	7,113,233	7,834,476		7,834,476	(4,406,944)	3,427,532		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,805,339	1,114,683	7,992,115	15,912,137		15,912,137	(4,560,949)	11,351,188		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	22,250
	REPAIRS & MAINTENANCE	769
		0
		23,019
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	10,509
		0
		10,509
5	HEAT & OTHER UTILITIES	
	GAS HEAT	134,336
	ELECTRICITY	141,374
	WATER	26,657
	CABLE TV - LOBBY	0
		0
		302,367
6	MAINTENANCE	
	GROUNDS MAINTENANCE	13,030
	PAINTING & DECORATING	783
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	34,148
	ELEVATOR MAINTENANCE & REPAIR	15,953
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,925
	FIRE SERVICE	10,433
		0
		0
		0
		0
		78,272
7	OTHER	
	SCAVENGER	48,406
	SECURITY SERVICE	102,459
		0
		0
		150,865
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	56,000
		56,000

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	3,618
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	179,325
	WOUND CARE CONSULTANT XVIII B 46-2	30,000
		0
		212,943
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	32,179
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		32,179
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	7,186
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,764
		0
		8,950
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	1,468
	SOCIAL WORKER XVIII B 45-2	1,990
		0
		3,458
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	320
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	1,406,180
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	28,994
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	831,020
		0
		860,014
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	100,246
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,016
	EMPLOYEE WANT ADS XIX F	6,192
	CONTRIBUTIONS VI 20 XIX F	2,070
	DUES & SUBSCRIPTIONS XIX F	8,345
	LICENSES & PERMITS XIX F	2,495
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,426
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	13,524
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	3,280
	PATIENT BACKGROUND CHECKS XIX F	5,430
		148,024
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,040
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	18,630
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	51,927
	MESSENGER SERVICE	4,950
		0
		76,547

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	507,140
	UNEMPLOYMENT COMPENSATION XIX D	108,269
	WORKERS COMPENSATION INSURANC XIX D	150,138
	HOSPITALIZATION INSURANCE XIX D	507,043
	EMPLOYEE BENEFITS - OTHER XIX D	22,959
	EMPLOYEE PHYSICAL EXAMS XIX D	2,487
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	20,397
	CHICAGO HEAD TAX XIX D	0
		0
		1,318,433
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	9,064
		9,064
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	4,982
		4,982
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	399,514
		399,514
27	OTHER	
	BAD DEBTS VI 24	2,890,475
		2,890,475

GRAND TOTAL COLUMN 3 OTHER

7,992,115

**CRESTWOOD CARE CENTRE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	421,575
LESS SALES TAX	<u>(8,844)</u>
NET FOOD	412,731

TOTAL PATIENT CENSUS	89,494
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	268,482

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	268,482
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	268,482

NET FOOD	412,731
DIVIDE TOTAL MEALS/YEAR	<u>268,482</u>

COST PER MEAL	1.54
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:

01/01/2008

Ending:

12/31/2008

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			174,024	174,024		174,024	136,816	310,840			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,037	233,037		233,037	247,070	480,107			32
33	Real Estate Taxes			509,656	509,656		509,656		509,656			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,121,945)	60,655			34
35	Rent-Equipment & Vehicles			81,373	81,373		81,373	16,942	98,315			35
36	Other (specify):* STORAGE/MTG INSURANCE			5,984	5,984		5,984	23,286	29,270			36
37	TOTAL Ownership			2,186,674	2,186,674		2,186,674	(697,831)	1,488,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		819,425	1,402,525	2,221,950		2,221,950		2,221,950			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,348	166,348		166,348		166,348			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		819,425	1,568,873	2,388,298		2,388,298		2,388,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,805,339	1,934,108	11,747,662	20,487,109		20,487,109	(5,258,780)	15,228,329			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	(77,067)	30		9
10	Interest and Other Investment Income	(3,694)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,844)	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	(18,630)	21		18
19	Entertainment	(100,246)	20		19
20	Contributions	(15,594)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(13,208)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,890,475)	27		24
25	Fund Raising, Advertising and Promotional	(5,016)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,426)	20		28
29	Other-Attach Schedule	(79,903)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,214,103)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(2,044,677)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,044,677)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (5,258,780)		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,414	6	1
2	VACATION ACCRUAL	(2,307)	1	2
3	VACATION ACCRUAL	(3,566)	3	3
4	VACATION ACCRUAL	(925)	4	4
5	VACATION ACCRUAL	(3,519)	6	5
6	VACATION ACCRUAL	(48,755)	10	6
7	VACATION ACCRUAL	(940)	11	7
8	VACATION ACCRUAL	(3,428)	17	8
9	VACATION ACCRUAL	(7,958)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(1,549)	19	11
12	MARKETING CONSULTANT	(6,370)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(79,903)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE# 0044164

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(2,307)	0	0	0	0	0	0	0	0	0	0	(2,307)	1
2	Food Purchase	(8,844)	0	0	0	0	0	0	0	0	0	0	(8,844)	2
3	Housekeeping	(3,566)	0	0	0	0	0	0	0	0	0	0	(3,566)	3
4	Laundry	(925)	0	0	0	0	0	0	0	0	0	0	(925)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,105)	0	0	0	0	0	0	0	0	0	0	(2,105)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(17,747)	0	0	0	0	0	0	0	0	0	0	(17,747)	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	(48,755)	0	0	(86,563)	0	0	0	0	0	0	0	(135,318)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(940)	0	0	0	0	0	0	0	0	0	0	(940)	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	(49,695)	0	0	(86,563)	0	0	0	0	0	0	0	(136,258)	16
	C. General Administration													
17	Administrative	(3,428)	0	(1,051,277)	0	0	(354,903)	0	0	0	0	0	(1,409,608)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,127)	13,215	107,822	121	(408,803)	0	0	0	0	0	0	(310,772)	19
20	Fees, Subscriptions & Promotions	(122,282)	164	822	251	590	0	0	0	0	0	0	(120,455)	20
21	Clerical & General Office Expenses	(26,588)	0	25,103	4,411	271,093	0	0	0	0	0	0	274,019	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	7,376	6,428	7,451	0	0	0	0	0	0	21,255	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	2,605	3,342	23,145	0	0	0	0	0	0	29,092	26
27	Other (specify):*	(2,890,475)	0	0	0	0	0	0	0	0	0	0	(2,890,475)	27
28	TOTAL General Administration	(3,065,900)	13,379	(907,549)	14,553	(106,524)	(354,903)	0	0	0	0	0	(4,406,944)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,133,342)	13,379	(907,549)	(72,010)	(106,524)	(354,903)	0	0	0	0	0	(4,560,949)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE# 0044164

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(77,067)	206,278	756	310	6,539	0	0	0	0	0	0	136,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,694)	250,764	0	0	0	0	0	0	0	0	0	247,070	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	0	60,655	0	0	0	0	0	0	(1,121,945)	34
35	Rent-Equipment & Vehicles	0	0	8,966	5,357	2,619	0	0	0	0	0	0	16,942	35
36	Other (specify):*	0	23,286	0	0	0	0	0	0	0	0	0	23,286	36
37	TOTAL Ownership	(80,761)	(702,272)	9,722	5,667	69,813	0	0	0	0	0	0	(697,831)	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)	(3,214,103)	(688,893)	(897,827)	(66,343)	(36,711)	(354,903)	0	0	0	0	0	(5,258,780)	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		"		23,286	23,286	2
3	V	30 DEPRECIATION-BLDG IMP		"		205,686	205,686	3
4	V	30 DEPRECIATION - EQPT & FURN		"		592	592	4
5	V	32 AMORTIZATION - MTG COST		"		1,342	1,342	5
6	V	32 MORTGAGE INTEREST		"		249,422	249,422	6
7	V	19 ACCOUNTING FEES		"		12,029	12,029	7
8	V	19 DATA PROCESSING		"		194	194	8
9	V	20 DUES & SUBSCRIPTIONS		"		100	100	9
10	V	20 LICENSES & PERMITS		"		64	64	10
11	V	19 LEGAL FEES		"		992	992	11
12	V							12
13	V							13
14	Total		\$ 1,182,600			\$ 493,707	\$ * (688,893)	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		\$ 107,822	\$ 107,822
16	V	20 DUES & SUBSCRIPTIONS		"		822	822
17	V	21 CLERICAL		"		25,103	25,103
18	V	24 TRAVEL		"		7,376	7,376
19	V	26 INSURANCE		"		2,605	2,605
20	V	35 RENT - EQPT & VEH		"		8,966	8,966
21	V	17 ADMINISTRATIVE	1,051,277	"			(1,051,277)
22	V	30 DEPRECIATION		"		756	756
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		\$ 1,051,277			\$ 153,450	\$ * (897,827)

* 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	\$ 179,325	CARLYLE NURSING ASSOCIATES, LLC		\$ 92,762	\$ (86,563)
16	V	19 PROFESSIONAL FEES		"		121	121
17	V	20 DUES & SUBSCRIPTIONS		"		251	251
18	V	21 CLERICAL		"		4,411	4,411
19	V	24 TRAVEL		"		6,428	6,428
20	V	26 INSURANCE		"		3,342	3,342
21	V	30 DEPRECIATION		"		310	310
22	V	34 RENT		"			
23	V	35 RENT - EQPT & VEH		"		5,357	5,357
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		\$ 179,325			\$ 112,982	\$ * (66,343)

* 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	\$ 431,262	THE KENSINGTON GROUP, LLC		\$ 22,459	\$ (408,803)
16	V	20 DUES & SUBSCRIPTIONS		" "		590	590
17	V	21 CLERICAL		" "		271,093	271,093
18	V	24 TRAVEL		" "		7,451	7,451
19	V	26 INSURANCE		" "		23,145	23,145
20	V	30 DEPRECIATION		" "		6,539	6,539
21	V	34 RENT		" "		60,655	60,655
22	V	35 RENT - EQPT & VEH		" "		2,619	2,619
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		\$ 431,262			\$ 394,551	\$ * (36,711)

* 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	\$ 354,903	CHESTERFIELD, LLC		\$	\$ (354,903)
16	V						
17	V						
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		\$ 354,903			\$ 0	\$ * (354,903)

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

Facility Name & ID Number **CRESTWOOD CARE CENTRE** # **0044164** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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: 01/01/2008

Ending: 2/31/2008

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 AXXOC. LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,373	7	\$ 431,773	\$ 89,494	\$ 107,822	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	89,494	822	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	89,494	25,103	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	89,494	7,376	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	89,494	2,605	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	358,373	7	35,906	89,494	8,966	6
7	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	89,494	756	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					\$ 614,484	\$	\$ 153,450	25

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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	\$ 92,762	\$ 92,762	1	\$ 92,762	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	744		89,494	121	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	1,552		89,494	251	3
4	21	CLERICAL	PATIENT DAYS	554,294	27,317		89,494	4,411	4
5	24	TRAVEL	PATIENT DAYS	554,294	39,814		89,494	6,428	5
6	26	INSURANCE	PATIENT DAYS	554,294	20,700		89,494	3,342	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	1,923		89,494	310	7
8	34	RENT	PATIENT DAYS	554,294			89,494		8
9	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	33,179		89,494	5,357	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				\$ 217,991	\$ 92,762		\$ 112,982	25

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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 THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1	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	554,294	11	\$ 139,104	\$ 89,494	\$ 22,459	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	89,494	590	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	89,494	29,395	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	89,494	7,451	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	89,494	23,145	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	89,494	6,539	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	89,494	60,655	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	16,218	89,494	2,619	8
9	21	CLERICAL	DIRECT HOURS	1	1	241,698	241,698	1	241,698
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					\$ 1,188,403	\$ 241,698	\$ 394,551	25

Facility Name & ID Number

CRESTWOOD CARE CENTRE

0044164

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	4,629,538	12/38	0.0535	249,422	2						
3	CAPMARK		X	LOAN COST	AMORT - 35 YEARS		41,550	40,208			1,342	3						
4												4						
5												5						
Working Capital																		
6	PRIVATE BANK		X	WORKING - CAPITAL	DEMAND	VARIES	323,671	298,302	DEMAND	PRIME +	50,044	6						
7	RELATED PARTY	X		WORKING - CAPITAL	DEMAND	VARIES	1,291,428	2,817,685	DEMAND	VARIES	182,993	7						
8	LETTER OF CREDIT FEE		X									8						
9	TOTAL Facility Related				\$101,139.93		\$ 6,554,549	\$ 7,785,733			\$ 483,801	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)						\$ 6,554,549	\$ 7,785,733			\$ 483,801	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 2007 report.	\$	486,975	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.)	\$	492,056	2
3. Under or (over) accrual (line 2 minus line 1).	\$	5,081	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	504,575	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.	\$	509,656	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	467,330	8
	2004	488,444	9
	2005	477,629	10
	2006	483,822	11
	2007	492,056	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>170,240.98</u>	\$ <u>170,240.98</u>
2. <u>28-03-303-012-0000</u>	<u>NURSING HOME</u>	\$ <u>308,638.73</u>	\$ <u>308,638.73</u>
3. <u>28-03-303-038-0000</u>	<u>NURSING HOME</u>	\$ <u>13,176.08</u>	\$ <u>13,176.08</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>492,055.79</u>	\$ <u>492,055.79</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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:

01/01/2008 Ending: 12/31/2008

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	\$ 95,230	35	\$ 59,763	\$ (35,467)	\$ 2,086,455	4
5		1980		3,400		35	97	97	2,841	5
6	SEC 754 ADJ		1992	584,054	21,238	27.5	21,238		314,020	6
7	SEC 754 ADJ		2001	24,100	876	27.5	876		7,008	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		20			76,557	16
17	IMPROVEMENTS		1986	16,943		19			16,943	17
18	IMPROVEMENTS		1986	1,559		19	82	82	1,455	18
19	IMPROVEMENTS		1987	23,951	855	20		(855)	23,951	19
20	IMPROVEMENTS		1987	22,863	831	27.5	366	(465)	22,863	20
21	IMPROVEMENTS		1988	20,627	749	27.5	749		15,850	21
22	IMPROVEMENTS		1989	35,057	1,264	27.5	1,264		22,686	22
23	IMPROVEMENTS		1990	50,320	1,830	27.5	1,830		30,029	23
24	IMPROVEMENTS		1991	53,090	1,931	27.5	1,931		30,173	24
25	IMPROVEMENTS		1992	53,668	1,951	27.5	1,951		29,138	25
26	IMPROVEMENTS		1992	51,711		15			51,711	26
27	IMPROVEMENTS		1993	42,479	1,545	27.5	1,545		18,469	27
28	IMPROVEMENTS		1993	78,601	2,857	27.5	2,857		40,792	28
29	IMPROVEMENTS		1994	193,211	7,025	27.5	7,025		97,368	29
30	FIRE ALARM SYSTEMS		1995	19,476	709	27.5	709		9,616	30
31	ELEVATOR REHAB		1995	57,000	2,073	27.5	2,073		27,624	31
32	NURSES CALL STATION		1995	6,318	229	27.5	229		3,064	32
33	DINING ROOM AIR CONDITIONING SYSTEM		1995	9,370	341	27.5	341		4,461	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:

01/01/2008 Ending: 12/31/2008

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	\$ 568	27.5	\$ 568	\$	\$ 7,441	37
38	HANDRAILS/TILING ROOF	1996	103,547	3,765	27.5	3,765		47,366	38
39	HANDRAILS/TILING ROOF	1996	877	32	27.5	32		394	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		26,584	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		27,970	41
42	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		172,296	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		18,527	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		31,600	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		12,754	45
46	ELECTRICAL - WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		1,753	46
47	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		13,949	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		360	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	350	27.5	350		3,826	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		7,025	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		1,091	51
52	BOILER VALVE	1998	5,450	199	27.5	199		1,989	52
53	WALLCOVERING	1999	2,206	80	27.5	80		867	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		2,098	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		1,378	55
56	REMODEL- NURSES STATION	2000	25,135	914	27.5	914		7,807	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		8,602	57
58	ROOF WORK	2000	11,384	414	27.5	414		3,433	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAL	2000	23,240	845	27.5	845		6,936	59
60	REMODEL- NURSES STATION	2000	10,730	391	27.5	391		3,170	60
61	CLOSET DOORS-2,3, AND 4TH FLOOR NURSES STATION	2001	1,900	69	27.5	69		549	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	39	27.5	39		300	62
63	RENOVATE -3A, 4B AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		1,796	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		4,858	64
65	DRYWALL, AND PAINT ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		514	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		4,542	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	496	27.5	496		3,494	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,706,519	\$ 179,843		\$ 143,235	\$ (36,608)	\$ 3,495,332	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:

01/01/2008 Ending: 12/31/2008

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	\$ 179,843		\$ 143,235	\$ (36,608)	\$ 3,495,332	1
2	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		809	2
3	KITCHEN FLOOR-REMOVE OLD AND INSTALL NEW TILE	2002	3,086	113	27.5	113		771	3
4	REPLACE 49 DOORS AND 1ST AND 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		6,051	4
5	BUILD NEW SMOKING LOUNGE	2002	3,596	130	27.5	130		889	5
6	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	120	27.5	120		814	6
7	INSTALL WALL COVERING - ROOM 223	2002	1,800	65	27.5	65		443	7
8	REBUILD AND PREP WALLS-RMS 234, 334, AND LOUNGE	2002	4,000	145	27.5	145		974	8
9	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	55	27.5	55		363	9
10	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	550	27.5	550		3,553	10
11	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		510	11
12	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	79	27.5	79		509	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,150	27.5	4,150		25,766	13
14	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	11,489	27.5	11,489		62,708	14
15	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	636	27.5	636		3,473	15
16	RESURFACE AND PAVE PARKING LOT	2003	3,697	247	15	247		1,357	16
17	ALUMINUM ROOF	2003	1,700	61	27.5	61		337	17
18	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	336	27.5	336		1,835	18
19	FIRE DAMPERS	2004	3,417	124	27.5	124		553	19
20	INSTALLED A SOFSTART	2004	2,670	97	27.5	97		432	20
21	AMEREX KP FIRE SUPPRESION SYSTEM	2004	1,457	53	27.5	53		235	21
22	OAK FLUSH FIRE DOORS - DIETARY/BATH AND BED RMS	2004	7,632	278	27.5	278		1,237	22
23	REMOVE & INSTALL NEW SHAMPOO STATION & TOILET	2004	1,945	71	27.5	71		314	23
24	WATER SYSTEM	2004	16,254	591	27.5	591		2,634	24
25	REPLACE ENTRY WALK	2004	5,500	200	27.5	200		891	25
26	NEW PANASONIC TELEPHONE SYSTEM	2004	26,934	979	27.5	979		4,365	26
27	REMOVE & INSTALL WALLCOVERING - REHAB ROOM	2004	2,786	186	15	186		837	27
28	PATCH TO THE FIELD/WALL FLASHING - ROOF	2004	1,500	55	27.5	55		243	28
29	REMOVE & INSTALL VINYL SHEET FLOORING & COVE								29
30	BASE	2005	28,921	1,052	27.5	1,052		4,163	30
31	REMOVE & INSTALL WALLPAPER IN PATIENT ROOM;								31
32	PAINT CEILINGS, BATHROOMS & DOOR FRAMES	2005	29,972	3,745	7	4,282	537	17,129	32
33	CUBICLE CURTAINS	2005	8,040	1,005	7	1,149	144	4,596	33
34	TOTAL (lines 1 thru 33)		\$ 5,370,195	\$ 207,540		\$ 171,613	\$ (35,927)	\$ 3,644,123	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:

01/01/2008 Ending: 12/31/2008

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	\$ 207,540		\$ 171,613	\$ (35,927)	\$ 3,644,123	1
2	RE-FLOOR UPPER MAIN ROOF - APPROX, 23800	2005	67,950	2,471	27.5	2,471		9,575	2
3	2 FIRE DOORS FOR 2ND FLOOR	2005	1,702	62	27.5	62		225	3
4	PLUMBING WORK ON PIPES TO INCREASE HOT WATER	2005	10,923	398	27.5	398		1,440	4
5	NEW ANTENNA SYSTEM	2005	12,995	472	27.5	472		1,476	5
6	REMOVE & INSTL. DRAIN LINES, SINK, LAUNDRY TUBS	2006	5,527	201	27.5	201		578	6
7	REMOVE & INSTAL. CEILING TILES - DOCTORS OFFICE	2006	980	35	27.5	35		102	7
8	REMOVE & INSTAL. DRYWALL, TILES, CEILING - 1ST FLR	2006	1,985	73	27.5	73		208	8
9	PARTITIONS/WOVEN WIRE CUBICLES	2006	4,625	809	7	661	(148)	1,983	9
10	DIALYSIS RM - HANG DRYWALL, PLYWOOD ENCLOSURE	2006	43,811	1,593	27.5	1,593		3,784	10
11	NURSES STATION - NEW WALLS, SUPPORTS & CABINETS	2006	19,905	724	27.5	724		1,659	11
12	RAISE & RESTORE WALKWAY	2006	1,500	55	27.5	55		125	12
13	TEAR OUT & INSTL. VCT & RUBBER BASE - ATRIUM LNGL	2006	2,380	87	27.5	87		184	13
14	INSTALL SPLASH GUARDS-DIALYSIS RM, SINK	2006	3,805	138	27.5	138		294	14
15	REMOVE & INSTALL VCT TILES - ROOM 238	2007	2,293	84	27.5	84		167	15
16	PAINT WALLS & CEILING, INSTALL TILE - 7-3 & 5-2 MAIN	2007	15,156	551	27.5	551		827	16
17	COVE BASE;HANDRAILS;WALL COVERING - HALLWAY	2007	26,964	981	27.5	981		1,471	17
18	WALL COVERING - DIALYSIS UNIT	2007	3,000	200	15	200		300	18
19	VINYLASA WOOD PANELS - HALLWAYS	2007	6,155	224	27.5	224		317	19
20	2 BARRIER FREE SHOWERS	2007	3,230	117	27.5	117		166	20
21	CEILING TILES & GRID FRAMEWORK - DIALYSIS RM	2007	2,141	78	27.5	78		110	21
22	BORDERS IN ROOMS & CORRIDORS - 3RD FLOOR	2007	4,659	311	15	311		440	22
23	PAINT DOOR FRAMES - FLOORS 2, 3, & 4	2007	1,145	76	15	76		89	23
24	35 CUBICLE CURTAINS	2007	3,594	240	15	240		280	24
25	HANDRAILS; BUMPER GUARDS & CORNER GUARDS	2007	6,540	238	27.5	238		258	25
26	CEMENT WORK - WALKWAY	2007	1,500	54	27.5	54		77	26
27	BEIGE WALLPAPER FOR 3RD FLR REMODELING	2008	19,543	3,909	5	977	(2,932)	977	27
28	WALLPAPER ROOM 326	2008	3,300	660	5	165	(495)	165	28
29	DEMOLITION AND REMODEL - ADMINISTRATIVE OFFICE	2008	6,115	185	27.5	185		185	29
30	REMOVE & INSTALL NEW CARPET IN 5 ROOMS	2008	3,500	700	5	175	(525)	175	30
31	SHADES & VALANCES FOR 3RD FLR. WOUND CARE UNIT	2008	21,138	4,228	5	1,057	(3,171)	1,057	31
32	LIGHT FIXTURES - WOUND CARE UNIT - 3RD FLOOR	2008	13,099	357	27.5	13,099	12,742	13,099	32
33	3RD FLOOR CEILING - REPAIR AND REPAINT	2008	6,912	168	27.5	6,912	6,744	6,912	33
34	TOTAL (lines 1 thru 33)		\$ 5,698,267	\$ 228,019		\$ 204,307	\$ (23,712)	\$ 3,692,828	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:

01/01/2008 Ending: 12/31/2008

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 12C, Carried Forward		\$ 5,698,267	\$ 228,019		\$ 204,307	\$ (23,712)	\$ 3,692,828	1
2	ELECTRICAL WORK FOR 3RD FLR WOUND CARE UNIT	2008	1,988	48	27.5	48		48	2
3	FLOOR TILES - 3RD FLOOR WOUND CARE UNIT	2008	15,857	336	27.5	336		336	3
4	ELECTRICAL WORK - KITCHEN & BEAUTY SHOP AREA	2008	5,330	113	27.5	113		113	4
5	CURTAINS FOR DINING ROOM	2008	1,144	229	5	57	(172)	57	5
6	60 TON COMPRESSOR	2008	18,865	343	27.5	343		343	6
7	PLUMBING WORK IN KITCHEN AREA	2008	1,510	23	27.5	23		23	7
8	SERVICE & PASSENGER ELEVATOR-ALZHEIMERS UNIT	2008	3,185	39	27.5	39		39	8
9	TILE & COVE BASE - 3RD FLOOR	2008	1,780	22	27.5	22		22	9
10	SHOWER ROOMS RETILED-4TH FLOOR	2008	1,815	17	27.5	17		17	10
11	3RD FLOOR CORRIDOR HANDRAILS	2008	9,267	84	27.5	84		84	11
12	3RD FLOOR WOUND CARE UNIT DEMOLITION &								12
13	REMODELING, CARPET, WALLPAPER, TILES & GUARD RA	2008	77,165	234	27.5	234		234	13
14	TILES, CARPETS, & OTHER SUPPLIES FOR 3RD FLR. REMO	2008	20,922	63	27.5	63		63	14
15									15
16									16
17			ADJ. TO SL	(23,884)			23,884		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,857,095	\$ 205,686		\$ 205,686	\$	\$ 3,694,207	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:

01/01/2008

Ending:

12/31/2008

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	\$ 931,940	\$ 68,073	\$ 88,128	\$ 20,055		\$ 535,995	71
72	Current Year Purchases	176,585	105,951	8,829	(97,122)		8,829	72
73	Fully Depreciated Assets	482,754					482,754	73
74	RELATED PARTY		8,197	8,197				74
75	TOTALS	\$ 1,591,279	\$ 182,221	\$ 105,154	\$ (77,067)		\$ 1,027,578	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)	\$ 7,784,126	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 387,907	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 310,840	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (77,067)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,721,785	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: \$ 55,825 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	FACILITY USE	2006 FORD 450(MINI BUS)	#####	15,348	18
19	FACILITY USE	2006 FORD CLUB WAGON	850.00	10,200	19
20					20
21	TOTAL		\$ #####	\$ 25,548	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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	\$		\$ 470,935	\$		\$ 470,935	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			136,552			136,552	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			795,038			795,038	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				505,055		505,055	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify): MEDICAL SUPPLY	39-2					314,370		314,370	13
14	TOTAL			\$		\$ 1,402,525	\$ 819,425		\$ 2,221,950	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (114,248)	\$ 44,474	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>2,159,114</u>)	5,217,328	5,217,328	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79,129	241,873	6
7	Other Prepaid Expenses	47,478	58,427	7
8	Accounts Receivable (owners or related parties)	947,655	949,155	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		572,573	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,177,342	\$ 7,083,830	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,811	2,339,719	12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		3,153,832	15
16	Equipment, at Historical Cost	1,544,342	1,875,666	16
17	Accumulated Depreciation (book methods)	(1,383,623)	(4,742,571)	17
18	Deferred Charges		40,208	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)	\$ 163,530	\$ 5,239,449	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,340,872	\$ 12,323,279	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,516,490	\$ 4,528,510	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	688,547	688,547	28
29	Short-Term Notes Payable	355,322	355,322	29
30	Accrued Salaries Payable	175,417	175,417	30
31	Accrued Taxes Payable (excluding real estate taxes)	97,468	97,468	31
32	Accrued Real Estate Taxes(Sch.IX-B)		504,575	32
33	Accrued Interest Payable	7,361	28,001	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO LESSOR</u>	4,582,076		36
37	<u>MANAGEMENT FEES</u>	1,054,385	1,054,385	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,477,066	\$ 7,432,225	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,115,987	3,115,987	39
40	Mortgage Payable		4,629,538	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)	\$ 3,115,987	\$ 7,745,525	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,593,053	\$ 15,177,750	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,252,181)	\$ (2,854,471)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,340,872	\$ 12,323,279	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,268,899)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,268,895)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,908,286)	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	(75,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,983,286)	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)	\$ (8,252,181)	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	\$ 17,575,129	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,575,129	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***	3,694	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,694	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)	\$ 17,578,823	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,348,243	31
32	Health Care	5,729,418	32
33	General Administration	7,834,476	33
	B. Capital Expense		
34	Ownership	2,186,674	34
	C. Ancillary Expense		
35	Special Cost Centers	2,221,950	35
36	Provider Participation Fee	166,348	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)*	\$ 20,487,109	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,908,286)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,908,286)	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: 01/01/2008

Ending: 12/31/2008

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	3,511	3,873	\$ 175,815	\$ 45.40	1
2	Assistant Director of Nursing	5,788	6,202	225,361	36.34	2
3	Registered Nurses	25,803	29,142	828,453	28.43	3
4	Licensed Practical Nurses	65,833	70,938	1,705,056	24.04	4
5	CNAs & Orderlies	128,915	137,451	1,482,330	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,384	11,467	154,597	13.48	8
9	Activity Director	3,910	4,183	63,158	15.10	9
10	Activity Assistants	11,954	12,953	120,435	9.30	10
11	Social Service Workers	7,441	8,094	153,725	18.99	11
12	Dietician					12
13	Food Service Supervisor	3,641	4,152	118,854	28.63	13
14	Head Cook	9,543	10,203	129,683	12.71	14
15	Cook Helpers/Assistants	32,107	34,438	324,479	9.42	15
16	Dishwashers					16
17	Maintenance Workers	5,915	6,282	118,519	18.87	17
18	Housekeepers	25,484	27,725	291,223	10.50	18
19	Laundry	17,762	19,145	189,582	9.90	19
20	Administrator	2,041	2,391	235,294	98.41	20
21	Assistant Administrator	1,912	2,131	72,041	33.81	21
22	Other Administrative					22
23	Office Manager	1,898	2,251	69,543	30.89	23
24	Clerical	18,958	20,979	308,414	14.70	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	2,586	2,797	38,777	13.86	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	385,386	416,797	\$ 6,805,339 *	\$ 16.33	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	342	\$ 22,250	1-3	35
36	Medical Director	336	56,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	1,117	179,325	10-3	38
39	Pharmacist Consultant	96	3,618	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	496	32,179	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	32	1,764	11-3	44
45	Social Service Consultant	59	3,458	12-3	45
46	Other(specify) <u>WOUND CARE</u>	150	30,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,628	\$ 328,594		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	Amount	
JUDY DUMONT	ADMINISTRATOR		\$ 235,294	Workers' Compensation Insurance	\$ 150,138	IDPH License Fee	\$		
KATHY SMITH	ASST ADMIN		72,041	Unemployment Compensation Insurance	108,269	Advertising: Employee Recruitment		6,192	
			0	FICA Taxes	507,140	Health Care Worker Background Check		3,280	
				Employee Health Insurance	507,043	(Indicate # of checks performed <u>328</u>)			
				Employee Meals	0	Patient Background Checks	<u>543</u>	5,430	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC		15,594	
				EMPLOYEE BENEFITS - OTHER	22,959	MARKETING/ADV/PROMO		106,688	
				EMPLOYEE PHYSICAL EXAMS	2,487	LICENSES/DUES/SUBSCRIPTIONS		10,840	
				PENSION/PROFIT SHARING PLANS	20,397	MGMT CO ALLOC		1,827	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC		(15,594)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense		(100,246)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising		(5,016)	
						Yellow page advertising		(1,426)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 307,335	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,318,433	TOTAL (agree to Sch. V, line 20, col. 8)	\$	27,569	
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			\$ 1,051,277			\$	Out-of-State Travel	\$	
CHESTERFIELD, LLC			354,903						
							In-State Travel		
							TRAVEL	0	
							RELATED PARTY	21,255	
							Seminar Expense		
								0	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,406,180	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
C. Professional Services							TOTAL	\$ 21,255	
Vendor/Payee	Type		Amount						
			\$						
SEE SCHEDULE ATTACHED			860,014						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 860,014						

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

Facility Name & ID Number CRESTWOOD CARE CENTRE

0044164

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 - \$22885.20
- (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. \$ 22,658 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. \$ 166,348
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