

Facility Name & ID Number Kenwood Healthcare Center

0033589 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,848	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	190	Intermediate/DD	190	69,540	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,388	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	6,813	454	3,235	10,502	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	72,244	732	129	73,105	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	79,057	1,186	3,364	83,607	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.83%

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

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 04/01/88

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

YES Date 04/01/88 NO

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

YES NO If YES, enter number of beds certified 64 and days of care provided 3,140

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Kenwood Healthcare Center # 0033589 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	454,010	31,512	25,436	510,958		510,958		510,958		1
2	Food Purchase		491,057		491,057		491,057	(13,731)	477,326		2
3	Housekeeping	466,476	148,820		615,296		615,296	255	615,551		3
4	Laundry	138,978	36,180		175,158		175,158		175,158		4
5	Heat and Other Utilities			351,694	351,694		351,694	14,453	366,147		5
6	Maintenance	167,407	139,953	27,143	334,503		334,503	5,490	339,993		6
7	Other (specify):*										7
8	TOTAL General Services	1,226,871	847,522	404,273	2,478,666		2,478,666	6,467	2,485,133		8
	B. Health Care and Programs										
9	Medical Director			23,551	23,551		23,551		23,551		9
10	Nursing and Medical Records	2,728,909	45,720	12,931	2,787,560		2,787,560	1,548	2,789,108		10
10a	Therapy			555,544	555,544		555,544		555,544		10a
11	Activities	128,768	5,118		133,886		133,886		133,886		11
12	Social Services	122,582			122,582		122,582		122,582		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,980,259	50,838	592,026	3,623,123		3,623,123	1,548	3,624,671		16
	C. General Administration										
17	Administrative	230,000		487,500	717,500		717,500	(556,028)	161,472		17
18	Directors Fees										18
19	Professional Services			150,925	150,925		150,925	9,355	160,280		19
20	Dues, Fees, Subscriptions & Promotions			17,639	17,639		17,639	(5,235)	12,404		20
21	Clerical & General Office Expenses	654,076		92,487	746,563		746,563	84,106	830,669		21
22	Employee Benefits & Payroll Taxes			652,457	652,457		652,457	8,659	661,116		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,195	2,195		2,195	(257)	1,938		24
25	Other Admin. Staff Transportation			52,772	52,772		52,772	2,520	55,292		25
26	Insurance-Prop.Liab.Malpractice			153,480	153,480		153,480	1,191	154,671		26
27	Other (specify):* Mgmt Alloc of Benefit							31,570	31,570		27
28	TOTAL General Administration	884,076		1,609,455	2,493,531		2,493,531	(424,119)	2,069,412		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,091,206	898,360	2,605,754	8,595,320		8,595,320	(416,104)	8,179,216		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 (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			69,857	69,857		69,857	435,167	505,024			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,504	32,504		32,504	442,537	475,041			32
33	Real Estate Taxes							356,638	356,638			33
34	Rent-Facility & Grounds			1,350,716	1,350,716		1,350,716	(1,350,716)				34
35	Rent-Equipment & Vehicles			1,963	1,963		1,963	2,207	4,170			35
36	Other (specify):*											36
37	TOTAL Ownership			1,455,040	1,455,040		1,455,040	(114,167)	1,340,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,890		87,890		87,890		87,890			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,582	174,582		174,582		174,582			42
43	Other (specify):* Non-allowable cost			315,967	315,967		315,967	(315,967)				43
44	TOTAL Special Cost Centers		87,890	490,549	578,439		578,439	(315,967)	262,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,091,206	986,250	4,551,343	10,628,799		10,628,799	(846,238)	9,782,561			45

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

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

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	69,582	30		9
10	Interest and Other Investment Income	(13,974)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(308)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,372)	43		18
19	Entertainment				19
20	Contributions	(928)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,163)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(266,665)	43		24
25	Fund Raising, Advertising and Promotional		43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(625)	43		28
29	Other-Attach Schedule See Pg. 5A	(33,357)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (271,810)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(574,428)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (574,428)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (846,238)		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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Kenwood Healthcare Center

ID# 0033589

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense	\$ (6,154)	43	1
2	Public Relations	(17,550)	43	2
3	Association Fees	(5,461)	20	3
4	Misc. Income	(542)	10	4
5	Trust Fees	(100)	43	5
6	Travel and Seminar	(285)	24	6
7	Theft and Damage Loss	(3,265)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(33,357)		49

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 Schedule 6A		See Schedule 6B		See Schedule 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Services	\$	KTNC Associates	100.00%	\$ 6,325	\$ 6,325	1
2	V	21 Clerical & General Office Expense		KTNC Associates	100.00%	151	151	2
3	V	32 Interest		KTNC Associates	100.00%	35,145	35,145	3
4	V	32 Amortization		KTNC Associates	100.00%	7,338	7,338	4
5	V	34 Rent-Facility & Grounds	408,428	KTNC Associates	100.00%		(408,428)	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 408,428			\$ 48,959	\$ * (359,469)	14

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

Kenwood Healthcare Center, Inc.
Provider #: 0033589
12/31/2008

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

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

Out-of-State:

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

Other Related Business Entities

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 <u>Food</u>	\$	<u>SW Management Co.</u>	100.00%	\$ 17	\$	17	15
16	V	3 <u>Housekeeping</u>		<u>SW Management Co.</u>	100.00%	255		255	16
17	V	5 <u>Heat and Other Utilities</u>		<u>SW Management Co.</u>	100.00%	2,489		2,489	17
18	V	6 <u>Maintenance</u>		<u>SW Management Co.</u>	100.00%	5,490		5,490	18
19	V	17 <u>Administrative</u>	717,500	<u>SW Management Co.</u>	100.00%	161,472		(556,028)	19
20	V	19 <u>Professional Services</u>		<u>SW Management Co.</u>	100.00%	8,193		8,193	20
21	V	20 <u>Dues, Fees, Subs & Promotions</u>		<u>SW Management Co.</u>	100.00%	226		226	21
22	V	21 <u>Clerical & General Office Expense</u>		<u>SW Management Co.</u>	100.00%	84,497		84,497	22
23	V	24 <u>Travel and Seminar</u>		<u>SW Management Co.</u>	100.00%	28		28	23
24	V	25 <u>Other Admin. Staff Transport</u>		<u>SW Management Co.</u>	100.00%	2,520		2,520	24
25	V	26 <u>Insurance-Prop.Liab.Malpractice</u>		<u>SW Management Co.</u>	100.00%	1,191		1,191	25
26	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>SW Management Co.</u>	100.00%	31,570		31,570	26
27	V	30 <u>Depreciation</u>		<u>SW Management Co.</u>	100.00%	6,043		6,043	27
28	V	33 <u>Real Estate Taxes</u>		<u>SW Management Co.</u>	100.00%	7,418		7,418	28
29	V	35 <u>Rent-Equipment & Vehicles</u>		<u>SW Management Co.</u>	100.00%	2,207		2,207	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		\$ 717,500			\$ 313,616	\$ *	(403,884)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 22,465	S & E Medical Supply Co.	100.00%	\$ 17,376	\$ (5,089)
16	V	10 Medical Supplies	8,993	S & E Medical Supply Co.	100.00%	10,541	1,548
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		\$ 31,458			\$ 27,917	\$ * (3,541)

* 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	<u>5</u> Utilities	\$	<u>Kenwood Property LLC</u>	100.00%	\$ <u>11,964</u>	\$	<u>11,964</u>	15
16	V	<u>30</u> Depreciation		<u>Kenwood Property LLC</u>	100.00%	<u>359,542</u>		<u>359,542</u>	16
17	V	<u>32</u> Interest Income	<u>18,530</u>	<u>Kenwood Property LLC</u>	100.00%			<u>(18,530)</u>	17
18	V	<u>32</u> Interest Expense		<u>Kenwood Property LLC</u>	100.00%	<u>413,257</u>		<u>413,257</u>	18
19	V	<u>32</u> Amortization		<u>Kenwood Property LLC</u>	100.00%	<u>19,301</u>		<u>19,301</u>	19
20	V	<u>33</u> Real Estate Taxes		<u>Kenwood Property LLC</u>	100.00%	<u>363,300</u>		<u>363,300</u>	20
21	V	<u>34</u> Rent	<u>956,368</u>	<u>Kenwood Property LLC</u>	100.00%			<u>(956,368)</u>	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		\$ <u>974,898</u>			\$ <u>1,167,364</u>	\$ *	<u>192,466</u>	39

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

Facility Name & ID Number

Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008

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	Sheldon Wolfe	President	Administrative	29.88	See Schedule 7A	7	17.50	Salary	\$ 32,480	L17, C7	1
2	Ronnie Klein	Administrator	Administrative	6.92	See Schedule 7B	26	52.00	Salary & Fees	96,512	17,3&17,7	2
3	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	7	17.50	Salary	32,480	L17, C7	3
4											4
5											5
6											6
7			Note: All individuals work in excess of 40 hours per week.								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 161,472		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	657,492	12	\$ 98	116,388	\$ 17	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	116,388	255	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	116,388	2,489	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	116,388	5,490	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	116,388	8,193	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	116,388	226	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	84,497	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	116,388	28	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	116,388	2,520	9	
10	26	Insurance-Prop.,Liab. & Malp.	Bed Days Available	657,492	12	6,729	116,388	1,191	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	116,388	31,570	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	116,388	7,418	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	116,388	2,207	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	7	64,960	17
18	17	Administrative	Avg. Hours Worked	50	6	185,600	185,600	26	96,512	18
19									19	
20	30	Depreciation	Direct Cost					6,043	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 313,616	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 17,376	1
2	10	Medical Supplies	Direct Cost					10,541	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 27,917	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kenwood Healthcare Center

0033589

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	Bank of America		X	Mortgage		9/23/99	\$ 4,000,000	\$	9/1/08	0.0800	\$ 35,145	1						
2	The Private Bank		X	Mortgage	\$16,200.00	6/4/08	12,670,000	12,556,600	05/01/2013	0.0321	413,257	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank One		X	Line of Credit			500,000	1,600,000	12/31/08	0.0525	32,504	6						
7												7						
8												8						
9	TOTAL Facility Related				\$16,200.00		\$ 17,170,000	\$ 14,156,600			\$ 480,906	9						
B. Non-Facility Related*																		
10											(27,019)	10						
11											26,639	11						
12											(5,485)	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (5,865)	14						
15	TOTALS (line 9+line14)						\$ 17,170,000	\$ 14,156,600			\$ 475,041	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 Kenwood Healthcare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033589

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>20-14-408-017-0000</u>	<u>Long-Term Care Property</u>	\$ <u>1,270.42</u>	\$ <u>1,270.42</u>
2. <u>20-14-408-015-0000</u>	<u>Long-Term Care Property</u>	\$ <u>2,639.53</u>	\$ <u>2,639.53</u>
3. <u>20-14-409-005-0000</u>	<u>Long-Term Care Property</u>	\$ <u>258,447.44</u>	\$ <u>258,447.44</u>
4. <u>20-14-408-016-0000</u>	<u>Long-Term Care Property</u>	\$ <u>2,517.68</u>	\$ <u>2,517.68</u>
5. <u>20-14-409-004-0000</u>	<u>Long-Term Care Property</u>	\$ <u>86,045.32</u>	\$ <u>86,045.32</u>
6. <u>10-28-412-049-0000</u>	<u>Allocated from SW Management</u>	\$ <u>43,500.34</u>	\$ <u>7,418.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>394,420.73</u>	\$ <u>358,338.39</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? X YES 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>		<u>1991</u>	\$ <u>70,784</u>	<u>1</u>
2	<u>Resident Care</u>		<u>1997</u>	<u>267,880</u>	<u>2</u>
3	TOTALS			\$ 338,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

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	318	2008		\$ 3,998,986	\$	35	\$ 55,541	\$ 55,541	\$ 55,541	4
5										5
6	Allocation From Management Co.	1995		76,620		39	2,189	2,189	27,703	6
7										7
8										8
Improvement Type**										
9	Various		1987	641		20			643	9
10	Various		1989	5,500		20			4,606	10
11	Various		1990	46,719	185	20	291	106	46,339	11
12	Various		1991	7,602	242	20	380	138	6,567	12
13	Various		1992	80,208	2,546	20	3,913	1,367	64,236	13
14	Various		1993	325,411	8,211	20	15,879	7,668	250,945	14
15	Various		1994	35,487	667	20	645	(22)	32,263	15
16	Various		1995	66,379	951	20	3,319	2,368	45,766	16
17	Various		1996	72,786	1,359	20	3,639	2,280	46,290	17
18	Various		1997	200,247	10,441	20	10,012	(429)	118,320	18
19	Various		1998	65,468	636	20	3,273	2,637	36,987	19
20	Various		1999	54,327	517	20	2,991	2,474	27,653	20
21	Wall Guard		2000	1,498		20	75	75	644	21
22	Elevator Repair		2000	1,800		20	90	90	788	22
23	Window Treatment		2000	1,020		20	51	51	425	23
24	Wallpaper		2000	883		20	44	44	385	24
25	Wallpaper		2000	1,196		20	60	60	525	25
26	Wallpaper		2000	1,470		20	74	74	646	26
27	Wallpaper		2000	3,324		20	166	166	1,453	27
28	Wallpaper		2000	21,712		20	1,086	1,086	9,502	28
29	Wallpaper		2000	825		20	41	41	360	29
30	Mini-Blinds		2000	65		20	3	3	27	30
31	Wallpaper		2000	2,081		20	104	104	910	31
32	Wallpaper		2000	4,663		20	233	233	2,039	32
33	Wallpaper		2000	1,099		20	55	55	477	33
34	Wallpaper		2000	3,146		20	157	157	1,362	34
35	Wallpaper		2000	1,451		20	73	73	632	35
36	Wallpaper		2000	826		20	41	41	356	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008 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	Wallpaper	2000	\$ 3,115	\$	20	\$ 156	\$ 156	\$ 1,313	37
38	Window Treatment	2000	18,430		20	922	922	7,758	38
39	Wallpaper Install	2000	63,355		20	3,168	3,168	26,400	39
40	Radiator	2000	5,900		20	295	295	2,483	40
41	Boilers	2000	4,514		20	226	226	1,901	41
42	Dishwasher Exhaust	2000	5,907		20	295	295	2,509	42
43	Elevator	2001	84,968	2,179	20	4,248	2,069	31,153	43
44	Wood Doors	2001	5,867		20	293	293	2,296	44
45	Carpeting	2001	4,657		20	233	233	1,728	45
46	Doors	2001	2,200		20	110	110	880	46
47	Door Locks	2001	1,115		20	56	56	434	47
48	Door Handles	2001	2,158		20	108	108	864	48
49	Valve	2001	2,657		20	133	133	1,020	49
50	Door Locks	2001	1,261		20	63	63	462	50
51	Door Locks	2001	1,960		20	98	98	694	51
52	Mechanical Equipment	2001	7,255		20	363	363	2,813	52
53	Electrical Breakers	2001	9,294		20	465	465	3,603	53
54	Sewage Pump	2001	8,495		20	425	425	3,223	54
55	Steamer	2001	14,992		20	750	750	5,437	55
56	3 Circuit Breaker	2001	2,400		20	120	120	860	56
57	Doors & Frames	2002	2,687		5			2,687	57
58	Drapes & Blinds	2002	1,022		10	102	102	680	58
59	Fire Alarm	2002	8,775		7	1,254	1,254	7,837	59
60	Fire Alarm	2002	4,100		7	586	586	3,809	60
61	Kitchen Plumbing	2002	3,150		5			3,150	61
62	Hot Water Heater	2002	6,300		12	525	525	3,456	62
63	Fire Protection	2002	3,333		7	476	476	3,174	63
64	Fire Stopping	2002	18,015		10	1,802	1,802	12,012	64
65	Sprinkler Hydraulic	2002	3,200		7	457	457	3,047	65
66	Elevator	2002	20,538	527	10	2,054	1,527	14,378	66
67	Plumbing	2002	2,617		10	262	262	1,746	67
68	Locks	2002	4,838		10	484	484	3,388	68
69	Elevator	2002	16,471		20	824	824	5,217	69
70	TOTAL (lines 4 thru 69)		\$ 5,428,986	\$ 28,461		\$ 125,776	\$ 97,315	\$ 946,802	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

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		\$ 5,428,986	\$ 28,461		\$ 125,776	\$ 97,315	\$ 946,802	1
2	<u>Carpeting</u>	2003	4,606		20	230	230	1,381	2
3	<u>Elevator</u>	2003	50,950	1,306	20	2,548	1,242	16,560	3
4	<u>Elevator</u>	2003	15,286	392	20	764	372	4,585	4
5	<u>85 Gal. Hot Water Heater</u>	2003	8,745		20	437	437	3,935	5
6	<u>Generator Repair</u>	2003	1,396		20	70	70	391	6
7	<u>Hot Water Heater Repair</u>	2003	1,649		20	82	82	466	7
8	<u>Roof Repair</u>	2003	1,821		20	91	91	485	8
9	<u>Telephone System Repair</u>	2003	1,271		20	64	64	340	9
10	<u>Door Locks</u>	2003	1,261		20	63	63	331	10
11	<u>Boiler Repair</u>	2003	1,013		20	51	51	262	11
12	<u>Tile</u>	2004	3,078	73	20	154	81	693	12
13	<u>Furnish and Install Doors</u>	2004	2,584	72	20	129	57	581	13
14	<u>Exit Devices, Pull Cylinders and Locks</u>	2004	6,030	155	20	302	147	1,358	14
15	<u>Wallpaper</u>	2004	29,363	753	20	1,468	715	6,606	15
16	<u>Generator</u>	2004	118,100	3,028	20	5,905	2,877	26,573	16
17	<u>Door</u>	2004	1,200	31	20	60	29	270	17
18	<u>Door</u>	2004	1,000	26	20	50	24	225	18
19	<u>Door</u>	2004	1,200	31	20	60	29	270	19
20	<u>Painting</u>	2004	40,374	1,035	20	2,019	984	9,085	20
21	<u>Painting</u>	2004	8,626	221	20	431	210	1,940	21
22	<u>Boiler and Storage Tank</u>	2004	13,350	342	20	668	326	3,005	22
23	<u>Sprinkler</u>	2004	6,800	174	7	340	166	1,530	23
24	<u>Damper for Generator</u>	2004	2,580	66	20	129	63	581	24
25	<u>Boiler and Storage</u>	2004	13,350	342	20	668	326	3,005	25
26	<u>Cabinets and Countertops</u>	2005	245,929	8,943	20	12,296	3,353	43,037	26
27	<u>Inside Drain Line</u>	2005	3,431	125	20	172	47	601	27
28	<u>Floor Tiles</u>	2005	3,276	119	20	164	45	574	28
29	<u>Alarm System</u>	2005	1,578	57	20	79	22	276	29
30	<u>Boiler</u>	2005	14,900	542	20	745	203	2,608	30
31	<u>Parking Lot - Asphalt Surface</u>	2005	36,231	2,898	20	1,812	(1,086)	6,341	31
32									32
33	<u>Adjustment per Desk Review</u>	2002	(7,800)						33
34	TOTAL (lines 1 thru 33)		\$ 6,062,164	\$ 49,192		\$ 157,825	\$ 108,633	\$ 1,084,697	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008 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		\$ 6,062,164	\$ 49,192		\$ 157,825	\$ 108,633	\$ 1,084,697	1
2	Water Heater	2006	7,073	257	20	354	97	884	2
3	Asphalt Path/Concrete Replacement	2006	14,951	1,278	20	748	(530)	1,869	3
4	Roof Repairs	2006	4,218	153	20	211	58	527	4
5	Water Heater	2006	7,453	271	20	373	102	932	5
6	Fireproofing	2007	4,700	171	20	235	64	353	6
7	New Floor Drain & Water Supply for Ice Machine	2007	2,200	80	20	110	30	165	7
8	S. Johnson-Paint Entire Facility	2007	17,220		20	861	861	1,292	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18	Allocated From Management Co. - leasehold improvements	1995	8,174		20	410	410	6,157	18
19	Allocated From Management Co. - leasehold improvements	1996	1,428		20	71	71	897	19
20	Allocated From Management Co. - leasehold improvements	1997	2,056		20	103	103	1,436	20
21	Allocated From Management Co. - leasehold improvements	1998	1,415		20	71	71	761	21
22	Allocated From Management Co. - leasehold improvements	1999	3,930		20	196	196	1,785	22
23	Allocated From Management Co. - leasehold improvements	2005	8,130		20	406	406	1,423	23
24	Allocated From Management Co. - leasehold improvements	2007	4,602		20	230	230	345	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)		\$ 6,149,713	\$ 51,402		\$ 162,203	\$ 110,801	\$ 1,103,523	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

01/01/2008

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	\$ 361,888	\$ 2,911	\$ 33,315	\$ 30,404	10 Yrs	\$ 263,699	71
72	Current Year Purchases	2,300,402	12,584	305,021	292,437	10 Yrs	305,021	72
73	Fully Depreciated Assets	811,986					811,986	73
74	Allocated from Management Co.	24,193		315	315	10 Yrs	17,732	74
75	TOTALS	\$ 3,498,469	\$ 15,495	\$ 338,651	\$ 323,156		\$ 1,398,438	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	Facility	2004 Lexus	2008	\$ 21,181	\$ 2,960	\$ 2,118	\$ (842)	5 Years	\$ 2,118	76
77	Allocated from Management Co.		2004	10,260		2,052	2,052	5 Years	9,234	77
78										78
79										79
80	TOTALS			\$ 31,441	\$ 2,960	\$ 4,170	\$ 1,210		\$ 11,352	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)	\$ 10,018,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,857	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 505,024	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 435,167	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,513,313	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2005 Lexus</u>	\$ <u>654.36</u>	\$ <u>1,963</u>	17
18					18
19					19
20	<u>Allocated from Management Co.</u>			<u>2,207</u>	20
21	TOTAL		\$ <u>654.36</u>	\$ <u>4,170</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	4,467	\$ 250,128	\$	4,467	\$ 250,128	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		829	49,750		829	49,750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,913	255,501		4,913	255,501	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				81,523		81,523	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Veterans Expense</u>	L39, C2					6,367		6,367	13
14	TOTAL			\$	10,209	\$ 555,379	\$ 87,890	10,209	\$ 643,269	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning: 01/01/2008

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	\$ 102,081	\$ 132,339	1
2	Cash-Patient Deposits	16,320	16,320	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>14,757</u>)	4,987,917	4,987,917	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,968	93,968	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch. 17A</u>	223,108	1,651,638	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,423,394	\$ 6,882,182	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,784	338,664	13
14	Buildings, at Historical Cost		3,998,986	14
15	Leasehold Improvements, at Historical Cost	1,320,975	2,150,727	15
16	Equipment, at Historical Cost	1,801,052	3,529,910	16
17	Accumulated Depreciation (book methods)	(2,016,720)	(2,513,313)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>See Sch. 17A</u>		4,667,261	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,176,091	\$ 12,172,235	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,599,485	\$ 19,054,417	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 111,186	\$ 111,186	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,168	20,168	28
29	Short-Term Notes Payable	1,600,000	1,600,000	29
30	Accrued Salaries Payable	155,582	155,582	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,389	27,389	31
32	Accrued Real Estate Taxes(Sch.IX-B)	361,500	361,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Sch. 17A</u>	556,074	676,933	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,831,899	\$ 2,952,758	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		12,556,600	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,556,600	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,831,899	\$ 15,509,358	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,767,586	\$ 3,545,059	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,599,485	\$ 19,054,417	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Kenwood Healthcare Center, Inc.
Provider #: 0033589

12/31/2008

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Investment in CD	-	1,428,530
Due from State - Interest	47,661	47,661
Employee Loans	1,000	1,000
Short Term Loan Exchange	48,456	48,456
Real Estate Tax Escrow	-	-
State Withholding	4,833	4,833
Due to public aid	299	299
Due to/from Kenwood Property	120,859	120,859
Total Line 9-Other Current Assets (Specify)	<u>223,108</u>	<u>1,651,638</u>

Other Long-Term Assets (Specify)

Loan Costs	-	165,434
AA Loan Costs	-	(19,301)
Goodwill	-	4,704,064
AA Goodwill	-	(182,936)
Total Line 22-Other Long-Term Assets (specify)	<u>-</u>	<u>4,667,261</u>

Other Current Liabilities (Specify)

Due from State	213,716	213,716
Reimbursement Due / Bad Debt	11,597	11,597
Insurance Premiums Payable	5,647	5,647
Union Dues	9,040	9,040
Accrued Expenses	231,366	231,366
Accrued Expenses - Legal	80,000	80,000
Accrued Legal	-	-
Short Term Loan Exchange	4,708	4,708
Due to/from Kenwood Healthcare	-	120,859
Total Line 36-Other Current Liabilities (Specify)	<u>556,074</u>	<u>676,933</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,814,121	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(226,824)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,587,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,180,289	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,180,289	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)	\$ 3,767,586	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,135,556	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,135,556	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	662,844	6
7	Oxygen	1,657	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 664,501	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***	8,489	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,489	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	542	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 542	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,809,088	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,478,666	31
32	Health Care	3,623,123	32
33	General Administration	2,493,531	33
	B. Capital Expense		
34	Ownership	1,455,040	34
	C. Ancillary Expense		
35	Special Cost Centers	403,857	35
36	Provider Participation Fee	174,582	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,628,799	40
41	Income before Income Taxes (line 30 minus line 40)**	1,180,289	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,180,289	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning: 01/01/2008

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	2,072	2,152	\$ 94,845	\$ 44.07	1
2	Assistant Director of Nursing	6,137	6,489	215,751	33.25	2
3	Registered Nurses	2,717	2,755	70,578	25.62	3
4	Licensed Practical Nurses	39,224	40,353	988,173	24.49	4
5	CNAs & Orderlies	103,671	108,582	1,056,419	9.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,694	10,320	128,768	12.48	10
11	Social Service Workers	11,222	11,878	122,582	10.32	11
12	Dietician					12
13	Food Service Supervisor	5,805	6,261	95,272	15.22	13
14	Head Cook	4,367	4,700	47,525	10.11	14
15	Cook Helpers/Assistants	32,643	34,681	311,213	8.97	15
16	Dishwashers					16
17	Maintenance Workers	7,782	8,310	167,407	20.15	17
18	Housekeepers	49,659	51,785	466,476	9.01	18
19	Laundry	13,753	14,821	138,978	9.38	19
20	Administrator	2,080	2,080	230,000	110.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	40,868	43,523	654,076	15.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Psych Techs</u>	30,566	31,308	303,143	9.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	362,260	379,998	\$ 5,091,206 *	\$ 13.40	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 25,436	L1, C3	35
36	Medical Director	Monthly	23,551	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	259	12,931	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3	165	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 62,083		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Kenwood Healthcare Center, Inc.

Provider # : 0033589

12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3) 150,925

Allocated from Real Estate Entity - Accounting

KTNC Assoc 6,325

Kenwood Property -

Allocated from Real Estate Entity - Legal

KTNC Assoc -

Kenwood Property -

Allocated from Mangement Company - Accounting 6,424

Allocated from Mangement Company - Legal 1,769

Less : Non-Allowable Legal Costs (5,163)

Total (Agree to Schedule V, Line 19, Column 8) 160,280

SEE ACCOUNTANTS' COMPILATION REPORT

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	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										
2																						
3																						
4	N/A																					
5																						
6																						
7																						
8																						
9																						
10																						
11																						
12																						
13																						
14																						
15																						
16																						
17																						
18																						
19																						
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kenwood Healthcare Center**# **0033589**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. Illinois Council on Long Term Care \$11,416
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,327 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
KTNC Associates
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 174,582
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,659 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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