

Facility Name & ID Number CRESTWOOD TERRACE

0048363 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	44,677	818		45,495	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,677	818		45,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.92%

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 11/01/2006

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

YES Date 11/01/2006 NO

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

YES NO If YES, enter number

of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number

CRESTWOOD TERRACE

0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	155,349	14,535	11,880	181,764		181,764		181,764		1
2	Food Purchase		211,349		211,349		211,349	(341)	211,008		2
3	Housekeeping	154,830	25,506		180,336		180,336		180,336		3
4	Laundry	55,718	15,610		71,328		71,328	3,970	75,298		4
5	Heat and Other Utilities			84,864	84,864		84,864	321	85,185		5
6	Maintenance	85,060	23,041	29,091	137,192		137,192	4,917	142,109		6
7	Other (specify):*			8,951	8,951		8,951	61	9,012		7
8	TOTAL General Services	450,957	290,041	134,786	875,784		875,784	8,928	884,712		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	1,007,163	35,884	12,288	1,055,335		1,055,335		1,055,335		10
10a	Therapy	32,979			32,979		32,979		32,979		10a
11	Activities	82,510	6,240	4,395	93,145		93,145		93,145		11
12	Social Services	105,313		2,977	108,290		108,290		108,290		12
13	CNA Training										13
14	Program Transportation			134	134		134		134		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,227,965	42,124	25,194	1,295,283		1,295,283		1,295,283		16
	C. General Administration										
17	Administrative	69,439		66,497	135,936		135,936	40,287	176,223		17
18	Directors Fees										18
19	Professional Services			70,342	70,342		70,342	(25,170)	45,172		19
20	Dues, Fees, Subscriptions & Promotions			12,590	12,590		12,590	(3,400)	9,190		20
21	Clerical & General Office Expenses	71,199	14,555	75,896	161,650		161,650	(55,490)	106,160		21
22	Employee Benefits & Payroll Taxes			260,198	260,198		260,198		260,198		22
23	Inservice Training & Education			2,193	2,193		2,193	10	2,203		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,808	6,808		6,808	562	7,370		25
26	Insurance-Prop.Liab.Malpractice			76,796	76,796		76,796	903	77,699		26
27	Other (specify):*			78,000	78,000		78,000	(68,887)	9,113		27
28	TOTAL General Administration	140,638	14,555	649,320	804,513		804,513	(111,185)	693,328		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,819,560	346,720	809,300	2,975,580		2,975,580	(102,257)	2,873,323		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	11,880
	REPAIRS & MAINTENANCE	0
		0
		11,880
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	31,511
	ELECTRICITY	30,751
	WATER	21,476
	CABLE TV - LOBBY	1,126
		0
		84,864
6	MAINTENANCE	
	GROUNDS MAINTENANCE	7,570
	PAINTING & DECORATING	1,306
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	8,802
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,268
	FIRE SERVICE	9,145
		0
		0
		0
		0
		29,091
7	OTHER	
	SCAVENGER	8,501
	SECURITY SERVICE	450
		0
		0
		8,951
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	5,400
		5,400

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	5,678
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	3,010
	DENTAL CONSULTANT	3,600
		0
		12,288
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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,395
		0
		4,395
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,977
		0
		2,977
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	134
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	66,497
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	16,961
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	53,381
		0
		70,342
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	1,405
	EMPLOYEE WANT ADS XIX F	675
	CONTRIBUTIONS VI 20 XIX F	550
	DUES & SUBSCRIPTIONS XIX F	5,746
	LICENSES & PERMITS XIX F	418
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,756
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	40
	PATIENT BACKGROUND CHECKS XIX F	0
		12,590
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,146
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	66,000
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	8,750
	MESSENGER SERVICE	0
		0
		75,896

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	137,882
	UNEMPLOYMENT COMPENSATION XIX D	22,788
	WORKERS COMPENSATION INSURANCE XIX D	52,154
	HOSPITALIZATION INSURANCE XIX D	39,091
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	8,283
	CHICAGO HEAD TAX XIX D	0
		0
		260,198
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	2,193
		0
		2,193
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,808
		0
		6,808
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	76,796
		0
		76,796
27	OTHER	
	BAD DEBTS VI 24	78,000
		0
		78,000

GRAND TOTAL COLUMN 3 OTHER

809,300

**CRESTWOOD TERRACE
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	211,349
LESS SALES TAX	<u>(341)</u>
NET FOOD	211,008

TOTAL PATIENT CENSUS	45,495
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	136,485

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

PATIENT MEALS	136,485
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	136,485

NET FOOD	211,008
DIVIDE TOTAL MEALS/YEAR	<u>136,485</u>

COST PER MEAL	1.55
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

Facility Name & ID Number

CRESTWOOD TERRACE

#0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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			9,647	9,647		9,647	(5,508)	4,139			30
31	Amortization of Pre-Op. & Org.			500	500		500		500			31
32	Interest			12,040	12,040		12,040	(21,070)	(9,030)			32
33	Real Estate Taxes			288,169	288,169		288,169	1,256	289,425			33
34	Rent-Facility & Grounds			566,455	566,455		566,455		566,455			34
35	Rent-Equipment & Vehicles			39,512	39,512		39,512	186	39,698			35
36	Other (specify):* IME			9,828	9,828		9,828	(9,828)				36
37	TOTAL Ownership			926,151	926,151		926,151	(34,964)	891,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			68,985	68,985		68,985		68,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,819,560	346,720	1,804,436	3,970,716		3,970,716	(137,221)	3,833,495			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,554)	30		9
10	Interest and Other Investment Income	(22,689)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	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		21		18
19	Entertainment		20		19
20	Contributions	(4,306)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,000)	27		24
25	Fund Raising, Advertising and Promotional	(1,405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(44,610)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,905)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	20,684		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,684		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (137,221)		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

ID# 0048363
 Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING	\$ -12000	21	1
2	MARKETING VEHICLE RENTAL	(2,354)	35	2
3	NON ALLOWABLE PROFESSIONAL FEES	(30,256)	19	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				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	(44,610)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD TERRACE# 0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(341)	0	0	0	0	0	0	0	0	0	0	(341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	3,970	0	0	0	0	0	0	0	0	3,970	4
5	Heat and Other Utilities	0	0	0	321	0	0	0	0	0	0	0	321	5
6	Maintenance	0	0	1,394	1,479	2,044	0	0	0	0	0	0	4,917	6
7	Other (specify):*	0	0	45	16	0	0	0	0	0	0	0	61	7
8	TOTAL General Services	(341)	0	5,409	1,816	2,044	0	0	0	0	0	0	8,928	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	18,939	6,175	0	15,173	0	0	0	0	0	0	40,287	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(30,256)	0	4,671	47	368	0	0	0	0	0	0	(25,170)	19
20	Fees, Subscriptions & Promotions	(5,711)	0	2,286	25	0	0	0	0	0	0	0	(3,400)	20
21	Clerical & General Office Expenses	(12,000)	0	(48,563)	7	5,066	0	0	0	0	0	0	(55,490)	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	10	0	0	0	0	0	0	0	0	10	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	386	0	176	0	0	0	0	0	0	562	25
26	Insurance-Prop.Liab.Malpractice	0	0	154	85	664	0	0	0	0	0	0	903	26
27	Other (specify):*	(78,000)	0	3,332	0	5,781	0	0	0	0	0	0	(68,887)	27
28	TOTAL General Administration	(125,967)	18,939	(31,549)	164	27,228	0	0	0	0	0	0	(111,185)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(126,308)	18,939	(26,140)	1,980	29,272	0	0	0	0	0	0	(102,257)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD TERRACE# 0048363

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(6,554)	0	94	911	41	0	0	0	0	0	0	(5,508)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,689)	0	0	1,619	0	0	0	0	0	0	0	(21,070)	32
33	Real Estate Taxes	0	0	0	1,256	0	0	0	0	0	0	0	1,256	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(2,354)	0	1,803	401	336	0	0	0	0	0	0	186	35
36	Other (specify):*	0	0	0	(9,828)	0	0	0	0	0	0	0	(9,828)	36
37	TOTAL Ownership	(31,597)	0	1,897	(5,641)	377	0	0	0	0	0	0	(34,964)	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)	(157,905)	18,939	(24,243)	(3,661)	29,649	0	0	0	0	0	0	(137,221)	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
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				6865 FINANCIAL INC	LINCOLNWOOD	MGMT CONSLT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEE	\$ 66,497	6865 FINANCIAL INC	100.00%	\$	\$ (66,497)	1
2	V								2
3	V								3
4	V	17	SHELDON NEIDICH			33,438		33,438	4
5	V	17	EMI ENTERPRISES			39,517		39,517	5
6	V	17	PHILIP ESFORMES INC			2,533		2,533	6
7	V	17	DANIEL WEISS			9,889		9,889	7
8	V	17	AVRUM WEINFELD			59		59	8
9	V	19	ACCOUNTING FEES						9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 66,497			\$ 85,436	\$ *	18,939	14

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

Facility Name & ID Number CRESTWOOD TERRACE# 0048363Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	21 BOOKKEEPING	\$ 66,000	EKS MANAGEMENT	100.00%	\$	\$ (66,000)	15
16	V							16
17	V	4 HOUSEKEEPING SALARIES				3,970	3,970	17
18	V	6 PAINTERS SALARIES				1,394	1,394	18
19	V	7 SCAVENGER				45	45	19
20	V	17 CFO SALARY				6,175	6,175	20
21	V	19 PROFESSIONAL FEES				4,671	4,671	21
22	V	20 WANT ADS/BACKGR CKS				2,286	2,286	22
23	V	21 OFFICE EXPENSE				17,437	17,437	23
24	V	23 SEMINARS				10	10	24
25	V	25 TRANSPORTATION				386	386	25
26	V	26 INSURANCE				154	154	26
27	V	27 EMPLOYEE BENEFITS				3,332	3,332	27
28	V	30 DEPRECIATION				94	94	28
29	V	35 EQUIPMENT RENT				1,803	1,803	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		\$ 66,000			\$ 41,757	\$ * (24,243)	39

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

Facility Name & ID Number CRESTWOOD TERRACE# 0048363Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	36 OFFICE RENT	\$ 9,828	IME REALTY	100.00%	\$	\$ (9,828)	15
16	V							16
17	V							17
18	V	5 UTILITIES				321	321	18
19	V	6 PAINTERS FEES				646	646	19
20	V	6 REPAIRS/MAINT				833	833	20
21	V	7 ALARM SERVICE				16	16	21
22	V	19 PROFESSIONAL FEES				47	47	22
23	V	20 LICENSES & PERMITS				25	25	23
24	V	21 OFFICE EXPENSE				7	7	24
25	V	26 INSURANCE				85	85	25
26	V	30 DEPRECIATION				911	911	26
27	V	32 INTEREST				1,619	1,619	27
28	V	33 RE TAX				1,256	1,256	28
29	V	35 STORAGE FEES				401	401	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		\$ 9,828			\$ 6,167	\$ * (3,661)	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	17 MANAGEMENT FEES	\$	EMI ENTERPRISES	100.00%	\$	\$
16	V						
17	V	6 DRIVERS SALARIES				2,044	2,044
18	V	17 MESFORMES, OFFICER				10,473	10,473
19	V	17 REGIONAL DIRECTOR				4,700	4,700
20	V	19 ACCOUNTING FEES				368	368
21	V	21 OFFICE				5,066	5,066
22	V	25 TRANSPORTATION				176	176
23	V	26 INSURANCE				664	664
24	V	27 EMPLOYEE BENEFITS				5,781	5,781
25	V	30 DEPRECIATION				41	41
26	V	35 AUTO LEASE				336	336
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		\$			\$ 29,649	\$ * 29,649

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

Facility Name & ID Number

CRESTWOOD TERRACE

#

0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	MORRIS ESFORMES				SCHEDULE ATTACHED			SALARY	\$ 50020	17-7	1
2	AVRUM WEINFELD	CFO						SALARY	9889	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	6175	17-7	3
4	PHILIP ESFORMES							SALARY	39517	17-7	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 TERRACE

0048363

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 6865 FINANCIAL INC
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	17	SHELDON NEIDICH	PATIENT DAYS	538,796	10	\$ 22,500	\$ 22,500	\$ 0	1
2	17	EMI ENTERPRISES	PATIENT DAYS	538,796	10	396,000	45,495	33,438	2
3	17	PHILIP ESFORMES INC	PATIENT DAYS	538,796	10	468,000	45,495	39,517	3
4	17	DANIEL WEISS	PATIENT DAYS	538,796	10	30,000	45,495	2,533	4
5	17	AVRUM WEINFELD	PATIENT DAYS	538,796	10	117,111	45,495	9,889	5
6	19	ACCOUNTING FEES	PATIENT DAYS	538,796	10	700	45,495	59	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					\$ 1,034,311	\$ 637,611	\$ 85,436	25

Facility Name & ID Number **CRESTWOOD TERRACE**

0048363

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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 EKS MGMT
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	4	HOUSEKEEPING SALARIES	PATIENT DAYS	847,051	14	\$ 73,923	\$ 73,923	45,495	\$ 3,970	1
2	6	PAINTERS SALARIES	PATIENT DAYS	847,051	14	25,953	25,953	45,495	1,394	2
3	7	SCAVENGER	PATIENT DAYS	847,051	14	842		45,495	45	3
4	17	CFO SALARY	PATIENT DAYS	847,051	14	114,971	114,971	45,495	6,175	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	847,051	14	86,967	49,447	45,495	4,671	5
6	20	WANT ADS/BACKGR CKS	PATIENT DAYS	847,051	14	42,556		45,495	2,286	6
7	21	OFFICE EXPENSE	PATIENT DAYS	847,051	14	324,660	246,961	45,495	17,437	7
8	23	SEMINARS	PATIENT DAYS	847,051	14	190		45,495	10	8
9	25	TRANSPORTATION	PATIENT DAYS	847,051	14	7,194		45,495	386	9
10	26	INSURANCE	PATIENT DAYS	847,051	14	2,872		45,495	154	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	62,031		45,495	3,332	11
12	30	DEPRECIATION	PATIENT DAYS	847,051	14	1,757		45,495	94	12
13	35	EQUIPMENT RENT	PATIENT DAYS	847,051	14	33,562		45,495	1,803	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					\$ 777,478	\$ 511,255		\$ 41,757	25

Facility Name & ID Number **CRESTWOOD TERRACE**

0048363

Report Period Beginning:

01/01/2009

Ending: **2/31/2009**

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 IME REALTY CORP
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	5	UTILITIES	RENTAL INCOME	187,059	15	\$ 6,106	\$ 9,828	\$ 321	1
2	6	PAINTERS FEES	RENTAL INCOME	187,059	15	12,303	9,828	646	2
3	6	REPAIRS/MAINT	RENTAL INCOME	187,059	15	15,863	9,828	833	3
4	7	ALARM SERVICE	RENTAL INCOME	187,059	15	301	9,828	16	4
5	19	PROFESSIONAL FEES	RENTAL INCOME	187,059	15	897	9,828	47	5
6	20	LICENSES & PERMITS	RENTAL INCOME	187,059	15	468	9,828	25	6
7	21	OFFICE EXPENSE	RENTAL INCOME	187,059	15	136	9,828	7	7
8	26	INSURANCE	RENTAL INCOME	187,059	15	1,627	9,828	85	8
9	30	DEPRECIATION	RENTAL INCOME	187,059	15	17,336	9,828	911	9
10	32	INTEREST	RENTAL INCOME	187,059	15	30,806	9,828	1,619	10
11	33	RE TAX	RENTAL INCOME	187,059	15	23,914	9,828	1,256	11
12	35	STORAGE FEES	RENTAL INCOME	187,059	15	7,635	9,828	401	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					\$ 117,392	\$	\$ 6,167	25

Facility Name & ID Number CRESTWOOD TERRACE

0048363

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 EMI ENTERPRISES INC
 Street Address 6865 N LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674-1946
 Fax Number (847) 674-1962

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	6	DRIVERS SALARIES	PATIENT DAYS	847,051	14	\$ 38,060	\$ 38,060	45,495	\$ 2,044	1
2	17	M ESFORMES, OFFICER	PATIENT DAYS	847,051	14	195,000	195,000	45,495	10,473	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,051	14	87,500	87,500	45,495	4,700	3
4	19	ACCOUNTING FEES	PATIENT DAYS	847,051	14	6,850		45,495	368	4
5	21	OFFICE	PATIENT DAYS	847,051	14	94,319	58,251	45,495	5,066	5
6	25	TRANSPORTATION	PATIENT DAYS	847,051	14	3,276		45,495	176	6
7	26	INSURANCE	PATIENT DAYS	847,051	14	12,367		45,495	664	7
8	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,051	14	107,628		45,495	5,781	8
9	30	DEPRECIATION	PATIENT DAYS	847,051	14	765		45,495	41	9
10	35	AUTO LEASE	PATIENT DAYS	847,051	14	6,253		45,495	336	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					\$ 552,018	\$ 378,811		\$ 29,649	25

Facility Name & ID Number CRESTWOOD TERRACE

0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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																			
2																			
3																			
4																			
5																			
Working Capital																			
6	THE PRIVATE BANK	X	WORKING CAPITAL							12,040									
7																			
8	RELATED PARTY									1,619									
9	TOTAL Facility Related									13,659									
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related																		
15	TOTALS (line 9+line14)									13,659									

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

1. Real Estate Tax accrual used on 2008 report.		\$	246,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	264,169	2
3. Under or (over) accrual (line 2 minus line 1).		\$	18,169	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	270,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		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.		\$	288,169	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006	233,556	10
	2007	240,564	11
	2008	264,169	12

2009 REAL ESTATE TAX ACCRUAL IS BASED ON 102% OF THE 2008 REAL ESTATE TAX BILL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048363

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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-33-307-001-0000</u>	<u>NURSING HOME</u>	\$ <u>264,169.09</u>	\$ <u>264,169.09</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>264,169.09</u>	\$ <u>264,169.09</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

Facility Name & ID Number **CRESTWOOD TERRACE**

0048363

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,623 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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: 2,500 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 500 4. Dates Incurred: 11/06

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8	RELATED PARTY			28,992	875	39	875			8
Improvement Type**										
9	HANDRAILS		2008	6,814	248	27.5	248		424	9
10	CERAMIC TILE & BASE IN DINING ROOM		2009	30,602	510	27.5	510		510	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTWOOD TERRACE

0048363

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			66,408		1,633		934	

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

Facility Name & ID Number CRESTWOOD TERRACE

0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	\$ 12,242	\$ 2,223	\$ 1,224	\$ (999)	10 YRS	\$ 3,264	71
72	Current Year Purchases	11,110	6,666	1,111	(5,555)	10 YRS	1,111	72
73	Fully Depreciated Assets							73
74	<u>RELATED PARTY</u>		171	171		8-10 YRS		74
75	TOTALS	\$ 23,352	\$ 9,060	\$ 2,506	\$ (6,554)		\$ 4,375	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)	\$ 89,760	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,693	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,139	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,554)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,309	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number CRESTWOOD TERRACE

0048363

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE CRESTWOOD TERRACE OPERATOR LLC

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>1976</u>	<u>126</u>	<u>11/01/2006</u>	\$ <u>566,455</u>	<u>5.5 YEARS</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>126</u>		\$ <u>566,455</u>			7

10. Effective dates of current rental agreement:

Beginning 11/01/2006

Ending 04/01/2012

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

Fiscal Year Ending Annual Rent

12. 11/01/2010 \$ _____

13. 11/01/2011 \$ _____

14. 11/01/2012 \$ _____

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: \$ 15,070 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		<u>09FORD E350SD</u>	\$ <u>822.00</u>	\$ <u>8,540</u>	17
18		<u>08 CHRYSLER T/C</u>	<u>490.00</u>	<u>5,880</u>	18
19		<u>INFINITI</u>	<u>775.00</u>	<u>4,565</u>	19
20		<u>MISC</u>		<u>5,457</u>	20
21	TOTAL		\$ <u>#####</u>	\$ <u>24,442</u>	21

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

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

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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 TERRACE**# **0048363**Report Period Beginning: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 109,376	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>83,797</u>)	551,538		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,771		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	598,750		8
9	Other(specify): <u>RE TAX/INS ESCROWS</u>	117,052		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,460,487	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	37,416		15
16	Equipment, at Historical Cost	23,353		16
17	Accumulated Depreciation (book methods)	(16,507)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,500		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,584)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>ADV RENT/REPL RESV</u>	103,810		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 148,988	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,609,475	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 124,258	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,055		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,290		31
32	Accrued Real Estate Taxes(Sch.IX-B)	270,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	_____			36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 478,603	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 478,603	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,130,872	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,609,475	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,069,312	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,069,312	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	490,117	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	(428,557)	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)	\$ 61,560	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)	\$ 1,130,872	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	\$ 4,427,591	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,427,591	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***	22,689	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,689	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)	\$ 4,450,280	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	875,784	31
32	Health Care	1,295,283	32
33	General Administration	804,513	33
B. Capital Expense			
34	Ownership	926,151	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	68,985	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	(10,553)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,960,163	40
41	Income before Income Taxes (line 30 minus line 40)**	490,117	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 490,117	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 TERRACE**

0048363

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,944	2,080	\$ 49,440	\$ 23.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,600	1,854	46,344	25.00	3
4	Licensed Practical Nurses	12,227	13,485	313,522	23.25	4
5	CNAs & Orderlies	51,091	54,969	513,781	9.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,087	3,127	32,979	10.55	8
9	Activity Director					9
10	Activity Assistants	7,966	8,344	82,510	9.89	10
11	Social Service Workers	7,243	7,499	105,313	14.04	11
12	Dietician					12
13	Food Service Supervisor	1,848	1,896	26,453	13.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,718	14,694	128,896	8.77	15
16	Dishwashers					16
17	Maintenance Workers	5,657	9,465	85,060	8.99	17
18	Housekeepers	15,734	16,957	154,830	9.13	18
19	Laundry	5,850	6,614	55,718	8.42	19
20	Administrator	1,931	1,963	69,439	35.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,231	6,441	71,199	11.05	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	1,360	1,669	15,777	9.45	31
32	Other Health C: <u>QUALITY ASSUR</u>	1,968	2,080	47,840	23.00	32
33	Other(specify) <u>MDS/CARE PLAN</u>	788	796	20,459	25.70	33
34	TOTAL (lines 1 - 33)	140,243	153,933	\$ 1,819,560 *	\$ 11.82	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	M	\$ 11,880	1-3	35
36	Medical Director	O	5,400	9-3	36
37	Medical Records Consultant	N	5,678	10-3	37
38	Nurse Consultant	T	3,010	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,395	11-3	44
45	Social Service Consultant	E	2,977	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,340		49

C. CONTRACT NURSES

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

Facility Name & ID Number CRESTWOOD TERRACE

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. ICLTC \$5,656
- (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. \$ 0 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 _____ 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. \$ 68,985
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: _____
- (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.