

Facility Name & ID Number Kenwood Healthcare Center

0033589 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	190	Intermediate (ICF)	190	69,350	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	3,698	34	3,328	7,060	8
9	SNF/PED					9
10	ICF	75,936	854	51	76,841	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	79,634	888	3,379	83,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.28%

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 04/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/1988 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 3,306

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Kenwood Healthcare Center # 0033589 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	489,124	35,557	30,804	555,485		555,485		555,485		1
2	Food Purchase		511,056		511,056		511,056	(12,433)	498,623		2
3	Housekeeping	465,196	167,654		632,850		632,850	530	633,380		3
4	Laundry	153,713	29,588		183,301		183,301		183,301		4
5	Heat and Other Utilities			294,065	294,065		294,065	3,086	297,151		5
6	Maintenance	147,466	148,677	45,558	341,701		341,701	1,535	343,236		6
7	Other (specify):*										7
8	TOTAL General Services	1,255,499	892,532	370,427	2,518,458		2,518,458	(7,282)	2,511,176		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,943,822	51,176	21,550	3,016,548		3,016,548	(1,253)	3,015,295		10
10a	Therapy			542,810	542,810		542,810		542,810		10a
11	Activities	144,745	5,963		150,708		150,708		150,708		11
12	Social Services	131,211			131,211		131,211		131,211		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,219,778	57,139	576,360	3,853,277		3,853,277	(1,253)	3,852,024		16
	C. General Administration										
17	Administrative	96,052		739,500	835,552		835,552	(573,156)	262,396		17
18	Directors Fees										18
19	Professional Services			272,126	272,126		272,126	(9,438)	262,688		19
20	Dues, Fees, Subscriptions & Promotions			48,609	48,609		48,609	285	48,894		20
21	Clerical & General Office Expenses	761,562		101,029	862,591		862,591	85,661	948,252		21
22	Employee Benefits & Payroll Taxes			674,306	674,306		674,306	9,540	683,846		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,245	3,245		3,245	33	3,278		24
25	Other Admin. Staff Transportation			48,264	48,264		48,264	2,595	50,859		25
26	Insurance-Prop.Liab.Malpractice			378,624	378,624		378,624	1,057	379,681		26
27	Other (specify):* Mgmt Alloc of Benefit							32,290	32,290		27
28	TOTAL General Administration	857,614		2,265,703	3,123,317		3,123,317	(451,133)	2,672,184		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,332,891	949,671	3,212,490	9,495,052		9,495,052	(459,668)	9,035,384		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			168,280	168,280		168,280	316,772	485,052			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,247	22,247		22,247	1,101,652	1,123,899			32
33	Real Estate Taxes			358,041	358,041		358,041	7,440	365,481			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)				34
35	Rent-Equipment & Vehicles							2,216	2,216			35
36	Other (specify):*											36
37	TOTAL Ownership			1,568,568	1,568,568		1,568,568	408,080	1,976,648			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,626		117,626		117,626		117,626			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,105	174,105		174,105		174,105			42
43	Other (specify):* Non-allowable cost			439,556	439,556		439,556	(439,556)				43
44	TOTAL Special Cost Centers		117,626	613,661	731,287		731,287	(439,556)	291,731			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,332,891	1,067,297	5,394,719	11,794,907		11,794,907	(491,144)	11,303,763			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	(581,585)	30		9
10	Interest and Other Investment Income	(21,120)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(535)	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	(6,424)	43		18
19	Entertainment				19
20	Contributions	(2,120)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,152)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(405,866)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(102)	43		28
29	Other-Attach Schedule See PG5A	(24,509)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,060,413)		\$	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)	569,269		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 569,269		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (491,144)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Med A	\$ (5,984)	43	1
2	X Ray-Med A	(200)	43	2
3	Public Relations	(17,450)	43	3
4	Theft and Damage Loss	(875)	43	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	(24,509)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

1/1/09

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12/31/09

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	30 Depreciation	\$	Kenwood Property LLC	100.00%	\$ 892,941	\$ 892,941	1
2	V	32 Interest Income	1,127	Kenwood Property LLC	100.00%		(1,127)	2
3	V	32 Interest Expense		Kenwood Property LLC	100.00%	777,208	777,208	3
4	V	32 Amortization		Kenwood Property LLC	100.00%	346,691	346,691	4
5	V	34 Rent	1,020,000	Kenwood Property LLC	100.00%		(1,020,000)	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		\$ 1,021,127			\$ 2,016,840	\$ * 995,713	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Kenwood Healthcare Center
Provider #: 0033589
12/31/2009

VII Related Parties - Page 6

Schedule 6A

Share Number	Shareholder Name	Beginning Shares	Ownership Percentage
1	Sheldon Wolfe	298.75	29.88
2	Albert Milstein	393.1	39.31
3	Ronnie Klein	69.2	6.92
4	Judy Rajchenbach	75.4	7.54
5	Amanda Bachrach	18.87	1.89
6	James Wolf Trust	18.87	1.89
7	Neil Wolfe Trust	18.87	1.89
8	Richard Wolf Trust	18.87	1.89
9	Yedida Wolfe	18.87	1.89
10	Kenneth Klein	69.2	6.92

SEE ACCOUNTANTS' COMPILATION REPORT

Kenwood Healthcare Center, Inc.

Provider #: 0033589

12/31/2009

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

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 31	\$	31	15
16	V	3 Housekeeping		SW Management Co.	100.00%	530		530	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	3,086		3,086	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,535		1,535	18
19	V	17 Administrative	739,500	SW Management Co.	100.00%	166,344		(573,156)	19
20	V	19 Professional Services		SW Management Co.	100.00%	8,714		8,714	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	285		285	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	85,661		85,661	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	33		33	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	2,595		2,595	24
25	V	26 Insurance-Prop.Liab.Malpractice		SW Management Co.	100.00%	1,057		1,057	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	32,290		32,290	26
27	V	30 Depreciation		SW Management Co.	100.00%	5,416		5,416	27
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	7,440		7,440	28
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	2,216		2,216	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		\$ 739,500			\$ 317,233	\$ *	(422,267)	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	\$ 22,696	S & E Medical Supply Co.	100.00%	\$ 19,772	\$ (2,924)
16	V	10 Medical Supplies	12,682	S & E Medical Supply Co.	100.00%	11,429	(1,253)
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		\$ 35,378			\$ 31,201	\$ * (4,177)

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

Facility Name & ID Number

Kenwood Healthcare Center

#

0033589

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 33,460	L17, C7	1
2	Ronnie Klein	Administrator	Administrative	6.92	See Schedule 7B	26	52.00	Salary & Fees	99,424	17,3&17,7	2
3	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	7	17.50	Salary	33,460	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	\$ 166,344		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

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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 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

1	2	3	4	5	6	7	8	9		
Schedule V	Unit of Allocation	(i.e.,Days, Direct Cost,	Total Units	Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line	Item	Square Feet)		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference				Allocated Among	Allocated	in Column 6				
1	2	Food	Bed Days Available	657,730	11	\$ 177	\$ 116,070	\$ 31	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	116,070	530	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	116,070	3,086	3	
4	6	Maintenance	Bed Days Available	657,730	11	8,697	116,070	1,535	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	116,070	8,714	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,730	11	1,616	116,070	285	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	116,070	85,661	7
8	24	Travel and Seminar	Bed Days Available	657,730	11	186	116,070	33	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	116,070	2,595	9	
10	26	Insurance-Prop.,Liab. & Malp.	Bed Days Available	657,730	11	5,991	116,070	1,057	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	116,070	32,290	11	
12	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	116,070	7,440	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,730	11	12,559	116,070	2,216	13	
14									14	
15									15	
16									16	
17	17	Administrative	Avg. Hours Worked	40	11	382,400	382,400	7	66,920	17
18	17	Administrative	Avg. Hours Worked	50	6	191,200	191,200	26	99,424	18
19									19	
20	30	Depreciation	Direct Cost						5,416	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 1,005,656	\$ 317,233	25	

SEE ACCOUNTANTS' COMPILATION REPORT

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VIII. ALLOCATION OF INDIRECT COSTS

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 ()

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.

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		\$	\$		\$ 19,772	1
2	10	Medical Supplies	Direct Cost					11,429	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				\$	\$		\$ 31,201	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kenwood Healthcare Center

0033589

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	The Private Bank		X	Mortgage	\$17,300.00	6/4/08	\$ 12,670,000	\$ 12,354,500	5/1/13	0.0266	\$ 777,208	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Bank One		X	Line of Credit			500,000			0.0525	22,247	6							
7												7							
8												8							
9	TOTAL Facility Related				\$17,300.00		\$ 13,170,000	\$ 12,354,500			\$ 799,455	9							
B. Non-Facility Related*																			
10												10							
11											(22,247)	11							
12											346,691	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 324,444	14							
15	TOTALS (line 9+line14)						\$ 13,170,000	\$ 12,354,500			\$ 1,123,899	15							

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

Facility Name & ID Number Kenwood Healthcare Center

0033589

Report Period Beginning:

1/1/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,520 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories Six

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

1/1/09

Ending:

12/31/09

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	\$ 114,257	\$ 114,257	\$ 171,385	4
5											5
6	Allocation From Management Co.		1995		76,383		39	2,182	2,182	31,982	6
7											7
8											8
	Improvement Type**										
9	Various		1987		641		20			642	9
10	Various		1989		5,500		20			4,606	10
11	Various		1990		46,719	185	20	286	101	46,636	11
12	Various		1991		7,602	242	20	380	138	6,949	12
13	Various		1992		80,208	2,546	20	3,913	1,367	68,148	13
14	Various		1993		325,411	8,211	20	15,879	7,668	267,618	14
15	Various		1994		35,487	667	20	645	(22)	32,909	15
16	Various		1995		66,379	951	20	3,319	2,368	49,087	16
17	Various		1996		72,786	1,358	20	3,639	2,281	49,928	17
18	Various		1997		200,247	10,457	20	10,012	(445)	128,440	18
19	Various		1998		65,468	636	20	3,273	2,637	40,260	19
20	Various		1999		54,328	517	20	2,785	2,268	29,545	20
21	Wall Guard		2000		1,498		20	75	75	718	21
22	Elevator Repair		2000		1,800		20	90	90	878	22
23	Window Treatment		2000		1,020		20	51	51	476	23
24	Wallpaper		2000		883		20	44	44	430	24
25	Wallpaper		2000		1,196		20	60	60	586	25
26	Wallpaper		2000		1,470		20	74	74	718	26
27	Wallpaper		2000		3,324		20	166	166	1,620	27
28	Wallpaper		2000		21,712		20	1,086	1,086	10,586	28
29	Wallpaper		2000		825		20	41	41	403	29
30	Mini-Blinds		2000		65		20	3	3	32	30
31	Wallpaper		2000		2,081		20	104	104	1,014	31
32	Wallpaper		2000		4,663		20	233	233	2,273	32
33	Wallpaper		2000		1,099		20	55	55	532	33
34	Wallpaper		2000		3,146		20	157	157	1,521	34
35	Wallpaper		2000		1,451		20	73	73	702	35
36	Wallpaper		2000		826		20	41	41	399	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:

1/1/09

Ending:

12/31/09

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	\$ 1,468	37
38	Window Treatment	2000	18,430		20	922	922	8,678	38
39	Wallpaper Install	2000	63,355		20	3,168	3,168	29,567	39
40	Radiator	2000	5,900		20	295	295	2,778	40
41	Boilers	2000	4,514		20	226	226	2,125	41
42	Dishwasher Exhaust	2000	5,907		20	295	295	2,806	42
43	Elevator	2001	84,968	2,179	20	4,248	2,069	35,403	43
44	Wood Doors	2001	5,867		20	293	293	2,591	44
45	Carpeting	2001	4,657		20	233	233	1,960	45
46	Doors	2001	2,200		20	110	110	990	46
47	Door Locks	2001	1,115		20	56	56	489	47
48	Door Handles	2001	2,158		20	108	108	971	48
49	Valve	2001	2,657		20	133	133	1,152	49
50	Door Locks	2001	1,261		20	63	63	525	50
51	Door Locks	2001	1,960		20	98	98	792	51
52	Mechanical Equipment	2001	7,255		20	363	363	3,175	52
53	Electrical Breakers	2001	9,294		20	465	465	4,066	53
54	Sewage Pump	2001	8,495		20	425	425	3,647	54
55	Steamer	2001	14,992		20	750	750	6,185	55
56	3 Circuit Breaker	2001	2,400		20	120	120	980	56
57	Doors & Frames	2002	2,687		5			2,687	57
58	Drapes & Blinds	2002	1,022		10	102	102	783	58
59	Fire Alarm	2002	8,775		7	940	940	8,775	59
60	Fire Alarm	2002	4,100		7	292	292	4,100	60
61	Kitchen Plumbing	2002	3,150		5			3,150	61
62	Hot Water Heater	2002	6,300		12	525	525	3,981	62
63	Fire Protection	2002	3,333		7	159	159	3,333	63
64	Fire Stopping	2002	18,015		10	1,802	1,802	13,812	64
65	Sprinkler Hydraulic	2002	3,200		7	152	152	3,200	65
66	Elevator	2002	20,538	527	10	2,054	1,527	16,431	66
67	Plumbing	2002	2,617		10	262	262	2,006	67
68	Locks	2002	4,838		10	484	484	3,871	68
69	Elevator	2002	16,471		20	824	824	6,039	69
70	TOTAL (lines 4 thru 69)		\$ 5,428,750	\$ 28,476		\$ 183,045	\$ 154,569	\$ 1,133,538	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:

1/1/09

Ending:

12/31/09

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		\$ 5,428,750	\$ 28,476		\$ 183,045	\$ 154,569	\$ 1,133,538	1
2	<u>Carpeting</u>	2003	4,606		20	230	230	1,612	2
3	<u>Elevator</u>	2003	50,950	1,306	20	2,548	1,242	19,106	3
4	<u>Elevator</u>	2003	15,286	392	20	764	372	5,350	4
5	<u>85 Gal. Hot Water Heater</u>	2003	8,745		20	437	437	4,373	5
6	<u>Generator Repair</u>	2003	1,396		20	70	70	460	6
7	<u>Hot Water Heater Repair</u>	2003	1,649		20	82	82	550	7
8	<u>Roof Repair</u>	2003	1,821		20	91	91	576	8
9	<u>Telephone System Repair</u>	2003	1,271		20	64	64	402	9
10	<u>Door Locks</u>	2003	1,261		20	63	63	394	10
11	<u>Boiler Repair</u>	2003	1,013		20	51	51	312	11
12	<u>Tile</u>	2004	3,078	73	20	154	81	846	12
13	<u>Furnish and Install Doors</u>	2004	2,584	72	20	129	57	711	13
14	<u>Exit Devices, Pull Cylinders and Locks</u>	2004	6,030	155	20	302	147	1,658	14
15	<u>Wallpaper</u>	2004	29,363	753	20	1,468	715	8,075	15
16	<u>Generator</u>	2004	118,100	3,028	20	5,905	2,877	32,478	16
17	<u>Door</u>	2004	1,200	31	20	60	29	330	17
18	<u>Door</u>	2004	1,000	26	20	50	24	275	18
19	<u>Door</u>	2004	1,200	31	20	60	29	330	19
20	<u>Painting</u>	2004	40,374	1,035	20	2,019	984	11,103	20
21	<u>Painting</u>	2004	8,626	221	20	431	210	2,372	21
22	<u>Boiler and Storage Tank</u>	2004	13,350	342	20	668	326	3,671	22
23	<u>Sprinkler</u>	2004	6,800	174	7	340	166	1,870	23
24	<u>Damper for Generator</u>	2004	2,580	66	20	129	63	710	24
25	<u>Boiler and Storage</u>	2004	13,350	342	20	668	326	3,671	25
26	<u>Cabinets and Countertops</u>	2005	245,929	8,943	20	12,296	3,353	55,334	26
27	<u>Inside Drain Line</u>	2005	3,431	125	20	172	47	772	27
28	<u>Floor Tiles</u>	2005	3,276	119	20	164	45	737	28
29	<u>Alarm System</u>	2005	1,578	57	20	79	22	355	29
30	<u>Boiler</u>	2005	14,900	542	20	745	203	3,353	30
31	<u>Parking Lot - Asphalt Surface</u>	2005	36,231	2,609	20	1,812	(797)	8,152	31
32									32
33	<u>Adjustment per Desk Review</u>	2002	(7,800)						33
34	TOTAL (lines 1 thru 33)		\$ 6,061,928	\$ 48,918		\$ 215,094	\$ 166,176	\$ 1,303,476	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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,061,928	\$ 48,918		\$ 215,094	\$ 166,176	\$ 1,303,476	1
2	Water Heater	2006	7,073	257	20	354	97	1,238	2
3	Asphalt Path/Concrete Replacement	2006	14,951	1,151	20	748	(403)	2,616	3
4	Roof Repairs	2006	4,218	153	20	211	58	738	4
5	Water Heater	2006	7,453	271	20	373	102	1,305	5
6	Fireproofing	2007	4,700	171	20	235	64	588	6
7	New Floor Drain & Water Supply for Ice Machine	2007	2,200	80	20	110	30	275	7
8	S. Johnson-Paint Entire Facility	2007	17,220		20	861	861	2,153	8
9	Railings	2009	3,900	101	20	98	(3)	98	9
10	New Elevator Buttons	2009	2,810	55	20	70	15	70	10
11	Front Door	2009	4,050	55	20	101	46	101	11
12	Air Conditioner	2009	67,288	918	20	1,682	764	1,682	12
13	Sewage Pump	2009	6,810	72	20	170	98	170	13
14	Transformer	2009	3,950	30	20	99	69	99	14
15	Replace Piping-Mechanical Room	2009	18,932	143	20	473	330	473	15
16	Smoke Detectors	2009	3,094	14	20	77	63	77	16
17	Controller for Chiller	2009	3,672	6	20	92	86	92	17
18									18
19									19
20	Allocated From Management Co. - leasehold improvements	1995	8,149		20	407	407	6,546	20
21	Allocated From Management Co. - leasehold improvements	1996	1,423		20	71	71	965	21
22	Allocated From Management Co. - leasehold improvements	1997	2,049		20	103	103	1,534	22
23	Allocated From Management Co. - leasehold improvements	1998	1,411		20	71	71	829	23
24	Allocated From Management Co. - leasehold improvements	1999	3,918		20	196	196	1,975	24
25	Allocated From Management Co. - leasehold improvements	2005	8,104		20	405	405	1,823	25
26	Allocated From Management Co. - leasehold improvements	2007	4,588		20	229	229	574	26
27	Allocated From Management Co. - leasehold improvements	2009	9,579		20	239	239	239	27
28									28
29									29
30	To agree to financial statement depreciation			20,889			(20,889)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,273,469	\$ 73,284		\$ 222,568	\$ 149,284	\$ 1,329,736	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:

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Ending:

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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	\$ 2,953,712	\$ 4,890	\$ 252,470	\$ 247,580		\$ 922,610	71
72	Current Year Purchases	85,306	85,306	4,266	(81,040)		4,266	72
73	Fully Depreciated Assets	520,564					520,564	73
74	Allocated from Management Co.	24,118		489	489	10 Years	18,166	74
75	TOTALS	\$ 3,583,700	\$ 90,196	\$ 257,225	\$ 167,029		\$ 1,465,606	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	\$ 4,800	\$ 4,236	\$ (564)	5 Years	\$ 6,354	76
77	Allocated from Management Co.		2004	10,228		1,023	1,023	5 Years	10,228	77
78										78
79										79
80	TOTALS			\$ 31,409	\$ 4,800	\$ 5,259	\$ 459		\$ 16,582	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)	\$ 10,227,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 168,280	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 485,052	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 316,772	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,811,924	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>Allocated from Management Co.</u>		\$ _____	\$ <u>2,216</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>2,216</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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

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	Ln 10A, C3	hrs	\$	2,135	\$ 239,144	\$	2,135	\$ 239,144	1
2	Licensed Speech and Language Development Therapist	Ln 10A, C3	hrs		829	49,759		829	49,759	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10A, C3	hrs		2,395	249,122		2,395	249,122	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, C 2	# of prescrpts				116,942		116,942	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Veterans Expense</u>	Ln 39, C 2					684		684	12
13	Other (specify):									13
14	TOTAL			\$	5,359	\$ 538,025	\$ 117,626	5,359	\$ 655,651	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: **1/1/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(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	\$ 1,500	\$ 1,500	1
2	Cash-Patient Deposits	24,688	24,688	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>150,000</u>)	2,777,927	2,843,480	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,860	90,860	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	277,283	277,283	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,172,258	\$ 3,237,811	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		4,075,369	14
15	Leasehold Improvements, at Historical Cost	1,632,023	2,198,100	15
16	Equipment, at Historical Cost	1,689,815	3,615,109	16
17	Accumulated Depreciation (book methods)	(2,193,000)	(2,811,924)	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 (spe <u>See Sch 17A</u>)		4,320,570	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,199,622	\$ 11,735,888	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,371,880	\$ 14,973,699	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 132,562	\$ 132,562	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,793	43,793	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,501	189,501	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,095	27,095	31
32	Accrued Real Estate Taxes(Sch.IX-B)	365,100	365,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	319,559	445,218	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,077,610	\$ 1,203,269	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		12,354,500	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Interest Rate Collar</u>		946,705	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 13,301,205	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,077,610	\$ 14,504,474	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,294,270	\$ 469,225	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,371,880	\$ 14,973,699	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Kenwood Healthcare Center, Inc.
Provider #: 0033589
12/31/2009

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
Due from State - Interest	117,038	117,038
Employee Loans	849	849
Employee Payroll Advance	500	500
Short Term Loan Exchange	33,237	33,237
Due to/from Kenwood Property	125,659	125,659
Total Line 9-Other Current Assets (Specify)	277,283	277,283

Other Long-Term Assets (Specify)

Loan Costs	-	165,434
AA Loan Costs	-	(52,388)
Goodwill	-	4,704,064
AA Goodwill	-	(496,540)
Total Line 22-Other Long-Term Assets (specify)	-	4,320,570

Other Current Liabilities (Specify)

Due To State	(181,481)	(181,481)
Reimbursement Due / Bad Debt	(10,645)	(10,645)
Insurance Premiums Payable	(2,763)	(2,763)
Union Dues	(10,838)	(10,838)
Accrued Expenses	(93,806)	(93,806)
Accrued Expenses - Legal	(16,726)	(16,726)
Short Term Loan Exchange	(3,300)	(3,300)
Due to/from Kenwood Healthcare	-	(125,659)
Total Line 36-Other Current Liabilities (Specify)	(319,559)	(445,218)

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,767,586	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(8,003)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,759,583	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	806,681	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	(1,271,994)	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)	\$ (465,313)	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)	\$ 3,294,270	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kenwood Healthcare Center**# **0033589**Report Period Beginning: **1/1/09**Ending: **12/31/09**

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	\$ 11,944,759	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,944,759	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	505,312	6
7	Oxygen	5,236	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 510,548	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***	146,281	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 146,281	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)	\$ 12,601,588	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,518,458	31
32	Health Care	3,853,277	32
33	General Administration	3,123,317	33
B. Capital Expense			
34	Ownership	1,568,568	34
C. Ancillary Expense			
35	Special Cost Centers	557,182	35
36	Provider Participation Fee	174,105	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,794,907	40
41	Income before Income Taxes (line 30 minus line 40)**	806,681	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 806,681	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:

1/1/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 73,288	\$ 35.23	1
2	Assistant Director of Nursing	4,616	4,824	92,290	19.13	2
3	Registered Nurses	3,143	3,233	91,142	28.19	3
4	Licensed Practical Nurses	44,950	47,037	1,208,277	25.69	4
5	CNAs & Orderlies	104,077	109,202	1,056,813	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,050	11,734	144,745	12.34	10
11	Social Service Workers	11,222	12,159	131,211	10.79	11
12	Dietician					12
13	Food Service Supervisor	5,969	6,433	104,906	16.31	13
14	Head Cook	4,642	5,139	53,874	10.48	14
15	Cook Helpers/Assistants	35,145	37,279	330,344	8.86	15
16	Dishwashers					16
17	Maintenance Workers	6,923	7,380	147,466	19.98	17
18	Housekeepers	49,004	51,026	465,196	9.12	18
19	Laundry	15,612	16,813	153,713	9.14	19
20	Administrator	2,080	2,080	96,052	46.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	42,724	45,654	761,562	16.68	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: Psych Techs	39,804	41,220	422,012	10.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	383,041	403,293	\$ 5,332,891 *	\$ 13.22	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	\$ 30,804	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	431	21,550	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	96	4,785	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)	527	\$ 69,139		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	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Deborah Missal	Administrator	0	\$ 96,052	Workers' Compensation Insurance	\$ 87,774	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	87,677	Advertising: Employee Recruitment		
				FICA Taxes	407,980	Health Care Worker Background Check		
				Employee Health Insurance	66,987	(Indicate # of checks performed _____)		
				Employee Meals	9,540	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	34,996	
				Life Insurance	6,612	Miscellaneous Dues & Permits	605	
				Other Employee Benefits	17,276	Miscellaneous Inspections & Licenses	12,013	
						Allocated from Management Co.	285	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 96,052					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Central Bookkeeping Office			\$ 229,500				Less: Public Relations Expense ()	
SW Management Fees			260,000				Non-allowable advertising ()	
Ronnie Klein-Management Fees-Special			250,000				Yellow page advertising ()	
(Eliminated on Schedule V, Column 7)								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 739,500					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Ashman & Stein	Legal		\$ 176,194	N/A			Out-of-State Travel	\$
Helper Broom LLC	Legal		20,150					
Frederick S Frankel	Legal		1,550					
Jensen Reporting	Legal		1,947				In-State Travel	
Record Copy Services	Legal		239					
Trialvision	Legal		818					
Wichmann-Klawitter Reporting	Legal		2,958					
US Legal Support	Legal		86				Seminar Expense	3,245
Mary Koopman	Legal		655					
The Private Bank	Legal		825					
Gallop Johnson & Heuman	Legal		1,769				Allocated from Management Co.	33
See Attached Schedule 21A			64,935				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 272,126				TOTAL \$ 3,278	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Kenwood Healthcare Center, Inc.

Provider # : 0033589

12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total on Page 21 Section C		207,191
Add Additional :		
Allen Lefkowitz	Legal	158
Dr. Kuo	Legal	1,050
Dr. Brem	Legal	10,000
Wellspring Valuation LTD	Legal	1,500
Personnel Planners Inc.	U/E Consultant	4,023
McGladrey & Pullen, LLP	Accounting	33,421
Honkamp Krueger & Co	Accounting	14,783
		<u>64,935</u>
Total (Agree to Schedule V, Line 19, Column 3)		272,126
Allocated from Mangement Company - Accounting		3,196
Allocated from Mangement Company - Legal		5,518
Less : Non-Allowable Legal Costs		(18,152)
Total (Agree to Schedule V, Line 19, Column 8)		<u><u>262,688</u></u>

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	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kenwood Healthcare Center# 0033589Report Period Beginning: 1/1/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care - \$34,996
- (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. \$ 3,608 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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 174,105
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 9,540 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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT