FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 SOUTH CICERO AVENUE (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (708) 371-0400 **Fax #** (708 371-5871

HFS ID Number:

Date of Initial License for Current Owners: 08/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MICHAEL BRAUN **Telephone Number:** (847) 583-0100 X 126
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL C. BRAUN
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	303	Skilled (SNF)	303	110,595	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	303	TOTALS	303	110,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,361	2,120	14,555	34,036	8
9	SNF/PED					9
10	ICF	42,683	5,211	5,117	53,011	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,044	7,331	19,672	87,047	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.71%

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 [X]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 303 and days of care provided 12,474

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICE)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	566,200	45,011	36,537	647,748		647,748	2,365	650,113			1
2	Food Purchase		462,902		462,902		462,902	(4,163)	458,739			2
3	Housekeeping	361,183	79,482		440,665		440,665	3,559	444,224			3
4	Laundry	208,140	55,756	10,917	274,813		274,813	5,766	280,579			4
5	Heat and Other Utilities			229,580	229,580		229,580		229,580			5
6	Maintenance	81,851	56,460	80,204	218,515		218,515	1,368	219,883			6
7	Other (specify):*			150,288	150,288		150,288		150,288			7
8	TOTAL General Services	1,217,374	699,611	507,526	2,424,511		2,424,511	8,895	2,433,406			8
	B. Health Care and Programs											
9	Medical Director			81,000	81,000		81,000		81,000			9
10	Nursing and Medical Records	4,836,931	402,455	238,539	5,477,925		5,477,925	10,538	5,488,463			10
10a	Therapy	134,222		855	135,077		135,077		135,077			10a
11	Activities	194,790	5,612	11,419	211,821		211,821	2,720	214,541			11
12	Social Services	111,813		1,769	113,582		113,582		113,582			12
13	CNA Training											13
14	Program Transportation			1,230	1,230		1,230		1,230			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,277,756	408,067	334,812	6,020,635		6,020,635	13,258	6,033,893			16
	C. General Administration											
17	Administrative	516,294		724,640	1,240,934		1,240,934	(716,255)	524,679			17
18	Directors Fees											18
19	Professional Services			712,425	712,425		712,425	(241,741)	470,684			19
20	Dues, Fees, Subscriptions & Promotions			159,059	159,059		159,059	(108,636)	50,423			20
21	Clerical & General Office Expenses	303,747	49,644	93,096	446,487		446,487	364,821	811,308			21
22	Employee Benefits & Payroll Taxes			1,462,113	1,462,113		1,462,113		1,462,113			22
23	Inservice Training & Education			8,032	8,032		8,032		8,032			23
24	Travel and Seminar			67	67		67	21,555	21,622			24
25	Other Admin. Staff Transportation			10,565	10,565		10,565		10,565			25
26	Insurance-Prop.Liab.Malpractice			606,770	606,770		606,770	6,357	613,127			26
27	Other (specify):*			361,463	361,463		361,463	(361,463)				27
28	TOTAL General Administration	820,041	49,644	4,138,230	5,007,915		5,007,915	(1,035,362)	3,972,553			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,315,171	1,157,322	4,980,568	13,453,061		13,453,061	(1,013,209)	12,439,852			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.

Facility Name & ID#: CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	33,403	
	REPAIRS & MAINTENANCE		3,134	
			0	36,537
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		10,917	
			0	10,917
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		79,940	
	ELECTRICITY		118,767	
	WATER		30,873	
	CABLE TV - LOBBY		0	
			0	229,580
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,554	
	PAINTING & DECORATING		1,874	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		32,121	
	ELEVATOR MAINTENANCE & REPAIR		27,357	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,975	
	FIRE SERVICE		10,323	
			0	
			0	
			0	
			0	80,204
7	**OTHER**			
	SCAVENGER		45,498	
	SECURITY SERVICE		104,790	
			0	
			0	150,288
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	81,000	81,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	5,819	
	PHARMACY CONSULTANT	XVIII B 39-2	9,103	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	193,617	
	WOUND CARE CONSULTANT	XVIII B 46-2	30,000	
			0	238,539
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	855	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				855
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		8,340	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,079	
			0	11,419
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	348	
	SOCIAL WORKER	XVIII B 45-2	1,421	
			0	1,769
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,230	1,230
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	724,640	724,640
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	38,452	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	673,973	
			0	712,425
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	78,540	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,461	
	EMPLOYEE WANT ADS	XIX F	12,789	
	CONTRIBUTIONS	VI 20 XIX F	3,755	
	DUES & SUBSCRIPTIONS	XIX F	21,571	
	LICENSES & PERMITS	XIX F	2,938	
	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	8,900	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,520	
	PATIENT BACKGROUND CHECKS	XIX F	10,585	
				159,059
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,201	
	EQUIPMENT REPAIR & MAINTENANCE		4,362	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,201	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,581	
	TELEPHONE		63,251	
	MESSENGER SERVICE		7,500	
			0	93,096

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	542,712	
	UNEMPLOYMENT COMPENSATION	XIX D	97,367	
	WORKERS COMPENSATION INSURANC	XIX D	152,782	
	HOSPITALIZATION INSURANCE	XIX D	614,057	
	EMPLOYEE BENEFITS - OTHER	XIX D	25,625	
	EMPLOYEE PHYSICAL EXAMS	XIX D	6,082	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	23,488	
	CHICAGO HEAD TAX	XIX D	0	
			0	1,462,113
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		8,032	
				8,032
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	67	
				67
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,565	
				10,565
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		606,770	
				606,770
27	**OTHER**			
	BAD DEBTS	VI 24	361,463	
				361,463

GRAND TOTAL COLUMN 3 OTHER **4,980,568**

CRESTWOOD CARE CENTRE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	462,902
LESS SALES TAX	(4,163)
NET FOOD	458,739
TOTAL PATIENT CENSUS	87,047
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	261,141
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	261,141
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	261,141
NET FOOD	458,739
DIVIDE TOTAL MEALS/YEAR	261,141
COST PER MEAL	1.76
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			227,490	227,490		227,490	70,284	297,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179,526	179,526		179,526	206,786	386,312			32
33	Real Estate Taxes			525,679	525,679		525,679		525,679			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,102,316)	80,284			34
35	Rent-Equipment & Vehicles			102,993	102,993		102,993	17,745	120,738			35
36	Other (specify):* STORAGE/MTG INSURANCE			7,647	7,647		7,647	22,647	30,294			36
37	**TOTAL Ownership**			2,225,935	2,225,935		2,225,935	(784,854)	1,441,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,111,905	1,280,014	2,391,919		2,391,919		2,391,919			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,893	165,893		165,893		165,893			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,111,905	1,445,907	2,557,812		2,557,812		2,557,812			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,315,171	2,269,227	8,652,410	18,236,808		18,236,808	(1,798,063)	16,438,745			45

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 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	(90,040)	30		9
10	Interest and Other Investment Income	(37,015)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,163)	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	(10,201)	21		18
19	Entertainment	(78,540)	20		19
20	Contributions	(12,655)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(39,306)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(361,463)	27		24
25	Fund Raising, Advertising and Promotional	(18,461)	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	63,404			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (588,440)		$	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 Amount	2 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)	(1,209,623)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,209,623)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,798,063)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL	2,365	1	2
3	VACATION ACCRUAL	3,559	3	3
4	VACATION ACCRUAL	5,766	4	4
5	VACATION ACCRUAL	1,368	6	5
6	VACATION ACCRUAL	39,501	10	6
7	VACATION ACCRUAL	2,720	11	7
8	VACATION ACCRUAL	8,385	17	8
9	VACATION ACCRUAL	8,517	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(6,777)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	63,404		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	2,365	0	0	0	0	0	0	0	0	0	0	2,365	1
2	Food Purchase	(4,163)	0	0	0	0	0	0	0	0	0	0	(4,163)	2
3	Housekeeping	3,559	0	0	0	0	0	0	0	0	0	0	3,559	3
4	Laundry	5,766	0	0	0	0	0	0	0	0	0	0	5,766	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,368	0	0	0	0	0	0	0	0	0	0	1,368	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	8,895	0	0	0	0	0	0	0	0	0	0	8,895	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	39,501	0	0	(28,963)	0	0	0	0	0	0	0	10,538	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	2,720	0	0	0	0	0	0	0	0	0	0	2,720	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**	42,221	0	0	(28,963)	0	0	0	0	0	0	0	13,258	16
	C. General Administration													
17	Administrative	8,385	0	(362,320)	0	0	(362,320)	0	0	0	0	0	(716,255)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(48,083)	35,836	194,583	4,243	(428,320)	0	0	0	0	0	0	(241,741)	19
20	Fees, Subscriptions & Promotions	(109,656)	100	314	133	473	0	0	0	0	0	0	(108,636)	20
21	Clerical & General Office Expenses	(1,684)	0	21,400	9,549	335,556	0	0	0	0	0	0	364,821	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,218	7,341	9,996	0	0	0	0	0	0	21,555	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,234	3,080	2,043	0	0	0	0	0	0	6,357	26
27	Other (specify):*	(361,463)	0	0	0	0	0	0	0	0	0	0	(361,463)	27
28	**TOTAL General Administration**	(512,501)	35,936	(140,571)	24,346	(80,252)	(362,320)	0	0	0	0	0	(1,035,362)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(461,385)	35,936	(140,571)	(4,617)	(80,252)	(362,320)	0	0	0	0	0	(1,013,209)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(90,040)	150,825	2,860	1,427	5,212	0	0	0	0	0	0	70,284	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37,015)	243,801	0	0	0	0	0	0	0	0	0	206,786	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,182,600)	0	2,597	77,687	0	0	0	0	0	0	(1,102,316)	34
35	Rent-Equipment & Vehicles	0	0	8,256	7,204	2,285	0	0	0	0	0	0	17,745	35
36	Other (specify):*	0	22,647	0	0	0	0	0	0	0	0	0	22,647	36
37	TOTAL Ownership	(127,055)	(765,327)	11,116	11,228	85,184	0	0	0	0	0	0	(784,854)	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)	(588,440)	(729,391)	(129,455)	6,611	4,932	(362,320)	0	0	0	0	0	(1,798,063)	45

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ (1,182,600)	1
2	V	36	MORTGAGE INSURANCE		" "		22,647	22,647	2
3	V	30	DEPRECIATION - BLDG IMP		" "		150,825	150,825	3
4	V	30	DEPRECIATION - EQPT & FURN		" "				4
5	V	32	AMORTIZATION - MTG COST		" "		1,342	1,342	5
6	V	32	MORTGAGE INTEREST		" "		242,459	242,459	6
7	V	19	ACCOUNTING FEES		" "		23,086	23,086	7
8	V	19	DATA PROCESSING		" "		50	50	8
9	V	20	DUES & SUBSCRIPTIONS		" "		100	100	9
10	V	19	OTHER PROFESSIONAL		" "		12,700	12,700	10
11	V				" "				11
12	V								12
13	V								13
14	Total			$ 1,182,600			$ 453,209	$ * (729,391)	14

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 194,583	$ 194,583	15
16	V	20	DUES & SUBSCRIPTIONS		" "		314	314	16
17	V	21	CLERICAL		" "		21,400	21,400	17
18	V	24	TRAVEL		" "		4,218	4,218	18
19	V	26	INSURANCE		" "		1,234	1,234	19
20	V	35	RENT - EQPT & VEH		" "		8,256	8,256	20
21	V	17	ADMINISTRATIVE	362,320	" "			(362,320)	21
22	V	30	DEPRECIATION		" "		2,860	2,860	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 362,320			$ 232,865	$ * (129,455)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 174,764	CARLYLE NURSING ASSOCIATES, LLC		$ 145,801	$ (28,963)	15
16	V	19	PROFESSIONAL FEES		" "		4,243	4,243	16
17	V	20	DUES & SUBSCRIPTIONS		" "		133	133	17
18	V	21	CLERICAL		" "		9,549	9,549	18
19	V	24	TRAVEL		" "		7,341	7,341	19
20	V	26	INSURANCE		" "		3,080	3,080	20
21	V	30	DEPRECIATION		" "		1,427	1,427	21
22	V	34	RENT		" "		2,597	2,597	22
23	V	35	RENT - EQPT & VEH		" "		7,204	7,204	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 174,764			$ 181,375	$ * 6,611	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 431,262	THE KENSINGTON GROUP, LLC		$ 2,942	$ (428,320)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		473	473	16
17	V	21	CLERICAL		" "		335,556	335,556	17
18	V	24	TRAVEL		" "		9,996	9,996	18
19	V	26	INSURANCE		" "		2,043	2,043	19
20	V	30	DEPRECIATION		" "		5,212	5,212	20
21	V	34	RENT		" "		77,687	77,687	21
22	V	35	RENT - EQPT & VEH		" "		2,285	2,285	22
23	V				" "				23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 431,262			$ 436,194	$ * 4,932	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 362,320	CHESTERFIELD, LLC		$	$ (362,320)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 362,320			$ 0	$ * (362,320)	39

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	361,812	7	$ 808,776	$	87,047	$ 194,583	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	361,812	7	1,305		87,047	314	2
3	21	CLERICAL	PATIENT DAYS	361,812	7	88,950		87,047	21,400	3
4	24	TRAVEL	PATIENT DAYS	361,812	7	17,533		87,047	4,218	4
5	26	INSURANCE	PATIENT DAYS	361,812	7	5,130		87,047	1,234	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	361,812	7	34,314		87,047	8,256	6
7	30	DEPRECIATION	PATIENT DAYS	361,812	7	11,887		87,047	2,860	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					$ 967,895	$		$ 232,865	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 145,801	$ 145,801	1	$ 145,801	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	11	26,955		87,047	4,243	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	11	842		87,047	133	3
4	21	CLERICAL	PATIENT DAYS	552,974	11	60,665		87,047	9,549	4
5	24	TRAVEL	PATIENT DAYS	552,974	11	46,637		87,047	7,341	5
6	26	INSURANCE	PATIENT DAYS	552,974	11	19,567		87,047	3,080	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	11	9,065		87,047	1,427	7
8	34	RENT	PATIENT DAYS	552,974	11	16,500		87,047	2,597	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	552,974	11	45,767		87,047	7,204	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					$ 371,799	$ 145,801		$ 181,375	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	552,954	11	$ 18,688	$	87,047	$ 2,942	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004		87,047	473	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775		87,047	31,606	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497		87,047	9,996	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980		87,047	2,043	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106		87,047	5,212	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503		87,047	77,687	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	552,954	11	14,513		87,047	2,285	8
9	21	CLERICAL	DIRECT HOURS	1	1	303,950	303,950	1	303,950	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					$ 1,144,016	$ 303,950		$ 436,194	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	**RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	BERKADIA		X	MORTGAGE	$101,139.93	12/03	4,897,900	4,498,554	12/38	0.0535	242,459	2
3	BERKADIA		X	LOAN COST	AMORT - 35 YEARS		41,550	37,524			1,342	3
4												4
5												5
	Working Capital											
6												6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,291,428	6,213,169	DEMAND	VARIES	177,227	7
8	LETTER OF CREDIT FEE		X								2,299	8
9	TOTAL Facility Related				$101,139.93		$ 6,230,878	$ 10,749,247			$ 423,327	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,230,878	$ 10,749,247			$ 423,327	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** 36

*** 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.)**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 543,475	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.)		$ 532,779	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,696)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 536,375	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.		$ 525,679	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	477,629	8
	2006	483,822	9
	2007	492,056	10
	2008	519,666	11
	2009	532,779	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT MICHAEL C. BRAUN

TELEPHONE (847) 583-0100 X 126 FAX #: (847) 583-8873

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-03-303-011-0000	NURSING HOME	$ 186,778.65	$ 186,778.65
2.	28-03-303-012-0000	NURSING HOME	$ 338,361.50	$ 338,361.50
3.	28-03-303-038-000	NURSING HOME	$ 7,638.87	$ 7,638.87
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 532,779.02	$ 532,779.02

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	303		1974		$ 2,091,708	$	27.5	$	$	$ 2,091,708	4
5			1980		3,400		27.5			3,400	5
6	SEC 754 ADJ			1992	584,054	21,239	27.5	21,239		356,497	6
7	SEC 754 ADJ			2001	24,100	877	27.5	877		8,761	7
8											8
	Improvement Type**										
9	****RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466		20			38,466	12
13	IMPROVEMENTS			1985	18,271		10			18,271	13
14	IMPROVEMENTS			1985	1,200		20			1,200	14
15	IMPROVEMENTS			1985	32,506		15			32,506	15
16	IMPROVEMENTS			1986	76,557		20			76,557	16
17	IMPROVEMENTS			1986	16,943		19			16,943	17
18	IMPROVEMENTS			1986	1,559		19			1,559	18
19	IMPROVEMENTS			1987	23,951	854	27.5	854		17,620	19
20	IMPROVEMENTS			1987	22,863	831	27.5	831		17,873	20
21	IMPROVEMENTS			1988	20,627	750	27.5	750		17,350	21
22	IMPROVEMENTS			1989	35,057	1,264	27.5	1,264		25,213	22
23	IMPROVEMENTS			1990	50,320	1,828	27.5	1,828		33,688	23
24	IMPROVEMENTS			1991	53,090	1,930	27.5	1,930		34,034	24
25	IMPROVEMENTS			1992	53,668	1,953	27.5	1,953		33,042	25
26	IMPROVEMENTS			1992	51,711		15			51,711	26
27	IMPROVEMENTS			1993	42,479	1,545	27.5	1,545		21,559	27
28	IMPROVEMENTS			1993	78,601	2,858	27.5	2,858		46,509	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		111,421	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		11,032	30
31	ELEVATOR REHAB			1995	57,000	2,073	27.5	2,073		31,771	31
32	NURSES CALL STATION			1995	6,318	229	27.5	229		3,522	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		5,143	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 CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COOLING TOWER REPLACEMENT	1995	$ 15,650	$ 569	27.5	$ 569	$	$ 8,579	37
38	HANDRAILS/TILING ROOF	1996	103,547	3,766	27.5	3,766		54,897	38
39	HANDRAILS/TILING ROOF	1996	877	31	27.5	31		457	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		31,078	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		32,750	41
42	REMODELING - FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		201,884	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		21,741	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		37,168	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		15,082	45
46	ELECTRICAL - WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		2,073	46
47	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1,273		16,495	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		426	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		4,524	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		8,327	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		1,294	51
52	BOILER VALVE	1998	5,450	198	27.5	198		2,385	52
53	WALLCOVERING	1999	2,206	80	27.5	80		1,027	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		2,554	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		1,680	55
56	REMODEL - NURSES STATION	2000	25,135	914	27.5	914		9,635	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		10,636	57
58	ROOF WORK	2000	11,384	414	27.5	414		4,261	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAI	2000	23,240	845	27.5	845		8,626	59
60	REMODEL-NURSES STATION	2000	10,730	390	27.5	390		3,950	60
61	CLOSET DOORS - 2,3 AND 4TH FLOOR NURSES STATION	2001	1,900	69	27.5	69		687	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		376	62
63	RENOVATE - 3A, 4B AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		2,262	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		6,132	64
65	DRYWALL, AND PAINT ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		651	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		5,760	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	497	27.5	497		4,487	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,706,519	$ 84,613		$ 84,613	$	$ 3,655,786	70

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,706,519	$ 84,613		$ 84,613	$	$ 3,655,786	1
2	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		1,038	2
3	KITCHEN FLOOR-REMOVE OLD AND INSTALL NEW TILE	2002	3,086	112	27.5	112		995	3
4	REPLACE 49 DOORS AND 1ST AND 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		7,833	4
5	BUILD NEW SMOKING LOUNGE	2002	3,596	131	27.5	131		1,151	5
6	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	120	27.5	120		1,054	6
7	INSTALL WALLCOVERING - ROOM 223	2002	1,800	65	27.5	65		574	7
8	REBUILD AND PREP WALLS-RMS 234, 334, AND LOUNGE	2002	4,000	145	27.5	145		1,265	8
9	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	55	27.5	55		472	9
10	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	550	27.5	550		4,653	10
11	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		667	11
12	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	80	27.5	80		669	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,150	27.5	4,150		34,067	13
14	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	11,489	27.5	11,489		85,685	14
15	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	636	27.5	636		4,745	15
16	RESURFACE AND PAVE PARKING LOT	2003	3,697	247	15	247		1,850	16
17	ALUMINUM ROOF	2003	1,700	62	27.5	62		461	17
18	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	337	27.5	337		2,508	18
19	FIRE DAMPERS	2004	3,417	124	27.5	124		801	19
20	INSTALLED A SOFSTART	2004	2,670	97	27.5	97		626	20
21	AMEREX KP FIRE SUPPRESSION SYSTEM	2004	1,457	53	27.5	53		341	21
22	OAK FLUSH FIRE DOORS - DIETARY/BATH AND BED RMS	2004	7,632	278	27.5	278		1,792	22
23	REMOVE & INSTALL NEW SHAMPOO STATION & TOILET	2004	1,945	71	27.5	71		456	23
24	WATER SYSTEM	2004	16,254	591	27.5	591		3,816	24
25	REPLACE ENTRY WALK	2004	5,500	200	27.5	200		1,291	25
26	NEW PANASONIC TELEPHONE SYSTEM	2004	26,934	979	27.5	979		6,324	26
27	REMOVE & INSTALL WALLCOVERING - REHAB ROOM	2004	2,786	186	15	186		1,209	27
28	PATCH TO THE FIELD/WALL. FLASHING -ROOF	2004	1,500	55	27.5	55		352	28
29	REMOVE & INSTALL VINYL SHEET FLOORING & COVE								29
30	BASE	2005	28,921	1,051	27.5	1,051		6,266	30
31	REMOVE & INSTALL WALLPAPER IN PATIENT ROOM;								31
32	PAINT CEILINGS, BATHROOMS & DOOR FRAMES	2005	29,972	2,675	10	2,997	322	24,408	32
33	CUBICLE CURTAINS	2005	8,040	718	10	804	86	6,549	33
34	TOTAL (lines 1 thru 33)		$ 5,370,195	$ 110,955		$ 111,363	$ 408	$ 3,859,704	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,370,195	$ 110,955		$ 111,363	$ 408	$ 3,859,704	1
2	RE-FLOOR UPPER MAIN ROOF - APPROX, 23800	2005	67,950	2,471	27.5	2,471		14,517	2
3	2 FIRE DOORS FOR 2ND FLOOR	2005	1,702	61	27.5	61		348	3
4	PLUMBING WORK ON PIPES TO INCREASE HOT WATER	2005	10,923	397	27.5	397		2,234	4
5	NEW ANTENNA SYSTEM	2005	12,995	472	27.5	472		2,421	5
6	REMOVE & INSTL DRAIN LINES, SINK, LAUNDRY TUBS	2006	5,527	201	27.5	201		980	6
7	REMOVE & INSTALL. CEILING TILES - DOCTORS OFFICE	2006	980	36	27.5	36		174	7
8	REMOVE & INSTALL, DRYWALL, TILES, CEILING - 1ST FL	2006	1,985	72	27.5	72		352	8
9	PARTITIONS/WOVEN WIRE CUBICLES	2006	4,625	413	10	463	50	3,107	9
10	DIALYSIS RM - HAND DRYWALL/ PLYWOOD ENCLOSURE	2006	43,811	1,593	27.5	1,593		6,970	10
11	NURSES STATION - NEW WALLS, SUPPORTS & CABINETS	2006	19,905	723	27.5	723		3,106	11
12	RAISE & RESTORE WALKWAY	2006	1,500	54	27.5	54		234	12
13	TEAR OUT & INSTL. VCT & RUBBER BASE - ATRIUM LNGE	2006	2,380	87	27.5	87		357	13
14	INSTALL SPLASH GUARDS - DIALYSIS RM, SINK	2006	3,805	139	27.5	139		571	14
15	REMOVE & INSTALL VCT TILES - ROOM 238	2007	2,293	83	27.5	83		333	15
16	PAINT WALLS & CEILING, INSTALL TILE - 7-3 & 5-2 MAIN	2007	15,156	551	27.5	551		1,929	16
17	COVE BASE;HANDRAILS;WALLCOVERING-HALLWAY	2007	26,964	981	27.5	981		3,432	17
18	WALLCOVERING -DIALYSIS UNIT	2007	3,000	200	15	200		700	18
19	VINYL WOOD PANELS - HALLWAYS	2007	6,155	224	27.5	224		765	19
20	2 BARRIER FREE SHOWERS	2007	3,230	117	27.5	117		401	20
21	CEILING TILES & GRID FRAMEWORK - DIALYSIS RM	2007	2,141	78	27.5	78		266	21
22	BORDERS IN ROOMS & CORRIDORS - 3RD FLOOR	2007	4,659	310	15	310		1,061	22
23	PAINT DOOR FRAMES - FLOORS 2,3,&4	2007	1,145	77	15	77		242	23
24	35 CUBICLE CURTAINS	2007	3,594	240	15	240		759	24
25	HANDRAILS;BUMPER GUARDS & CORNER GUARDS	2007	6,540	238	27.5	238		733	25
26	CEMENT WORK - WALKWAY	2007	1,500	54	27.5	54		186	26
27	BEIGE WALLPAPER FOR 3RD FLR REMODELING	2008	19,543	3,753	10	1,955	(1,798)	4,886	27
28	WALLPAPER ROOM 326	2008	3,300	634	10	330	(304)	825	28
29	DEMOLITION AND REMODEL - ADMINISTRATIVE OFFICE	2008	6,115	222	27.5	222		630	29
30	REMOVE & INSTALL NEW CARPET IN 5 ROOMS	2008	3,500	672	10	350	(322)	875	30
31	SHADES & VALANCES FOR 3RD FLR. WOUND CARE UNIT	2008	21,138	4,058	10	2,113	(1,945)	5,284	31
32	LIGHT FIXTURES-WOUND CARE UNIT - 3RD FLOOR	2008	13,099	476	27.5	476		14,052	32
33	3RD FLOOR CEILING - REPAIR AND REPAINT	2008	6,912	251	27.5	251		7,414	33
34	TOTAL (lines 1 thru 33)		$ 5,698,267	$ 130,893		$ 126,982	$ (3,911)	$ 3,939,848	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,698,267	$ 130,893		$ 126,982	$ (3,911)	$ 3,939,848	1
2	ELECTRICAL WORK FOR 3RD FLR WOUND CARE UNIT	2008	1,988	73	27.5	73		193	2
3	FLOOR TILES - 3RD FLOOR WOUND CARE UNIT	2008	15,857	577	27.5	577		1,490	3
4	ELECTRICAL WORK - KITCHEN & BEAUTY SHOP AREA	2008	5,330	194	27.5	194		501	4
5	CURTAINS FOR DINING ROOM	2008	1,144	220	10	114	(106)	285	5
6	60 TON COMPRESSOR	2008	18,865	686	27.5	686		1,715	6
7	PLUMBING WORK IN KITCHEN AREA	2008	1,510	55	27.5	55		133	7
8	SERVICE & PASSENGER ELEVATOR - ALZHEIMERS UNIT	2008	3,185	116	27.5	116		270	8
9	TILE & COVE BASE - 3RD FLOOR	2008	1,780	65	27.5	65		151	9
10	SHOWER ROOMS RETILED - 4TH FLOOR	2008	1,815	66	27.5	66		149	10
11	3RD FLOOR CORRIDOR HANDRAILS	2008	9,267	337	27.5	337		758	11
12	3RD FLOOR WOUND CARE UNIT DEMOLITION &								12
13	REMODELING, CARPET, WALLPAPER, TILES & GUARD RA	2008	77,165	2,806	27.5	2,806		5,846	13
14	TILES, CARPETS, & OTHER SUPPLIES FOR 3RD FLR. REMO	2008	20,922	761	27.5	761		1,585	14
15	INSTALL WANDER MONITOR SYSTEM	2009	22,876	832	27.5	832		1,525	15
16	KNIGHT-TILE WOOD PLANKS - CORRIDOR	2009	5,782	210	27.5	210		350	16
17	BREAK CONCRETE, REPLACE NEW PIPE & LAY NEW								17
18	CONCRETE - COMPRESSOR ROOM	2009	4,300	157	27.5	157		261	18
19	COMPONENTS FOR ACOUSTICAL CEILING	2009	7,686	280	27.5	280		443	19
20	DEMOLITION & REMODEL OF RESIDENT ROOMS - 3RD FLR								20
21	& UTILITY ROOM, FIRE DOORS/DIALYSIS STORAGE RM	2009	115,017	4,183	27.5	4,183		6,274	21
22	WALLPAPER FOR RESIDENT ROOMS	2009	24,332	885	27.5	885		1,327	22
23	CORRIDOR HANDRAIL WITH CONTINUOUS ALUMINUM								23
24	RETAINER	2009	4,140	151	27.5	151		452	24
25	PAVE PARKING LOT AND RESET BUMPERS	2009	46,600	3,107	15	3,107		4,401	25
26	3RD FLR CORRIDOR HANDRAIL WITH ALMN RETAINER	2009	14,871	541	27.5	541		721	26
27	FLOOR TILES FOR 2ND FLR HALLS & RESIDENT RMS	2009	101,636	3,696	27.5	3,696		4,620	27
28	DRIVEWAY & PARKING LOT - INSTALL STONE & PAVE	2009	5,950	216	27.5	216		216	28
29	FIRE DOORS	2009	4,435	162	27.5	162		296	29
30	REPLACE CHILLER & HOT WATER PIPING FROM								30
31	CHECK VALVE TO GATE VALVE	2009	11,950	435	27.5	435		688	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,226,670	$ 151,704		$ 147,687	$ (4,017)	$ 3,974,498	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,226,670	$ 151,704		$ 147,687	$ (4,017)	$ 3,974,498	1
2	INSTALL TWIST LOCK ELECTRICAL RECEPTACLES AND								2
3	CIRCUITS FOR NEW RECEPTACLES FOR THE KITCHEN	2010	2,590	82	27.5	82		82	3
4	REMOVE & INSTALL DRYWALL, WALLPAPER, TILES,								4
5	ELECTRIC POWER STRIPS, SHADES & VALANCES FOR								5
6	ROOMS 307,313,315,316,317,331,334	2010	18,824	485	27.5	485		485	6
7	DEMOLISH & CONSTRUCT NEW SHOWER RM - INSTALL								7
8	NEW TILES, DRYWALL, LIGHT FIXTURES,& PLUMBING								8
9	ON THE SECOND FLOOR	2010	13,316	343	27.5	343		343	9
10	TWO SALON STATIONS FOR BEAUTY SHOP	2010	2,191	56	27.5	56		56	10
11	NEW SHOWER ROOM ON THE THIRD FLOOR - PLUMBING								11
12	WORK, INSTALL TILES, CONCRETE SHOWER BASES	2010	10,250	233	27.5	233		233	12
13	FIRST FLOOR REHAB ROOM - DEMOLISH COUNTERS,								13
14	FRAMES, CABINETS & SINK, REMOVE WALLPAPER,								14
15	REPAIR DRYWALL, SAND/PRIME WALLS, PAINT & INSTALL								15
16	VCT TILES	2010	7,371	145	27.5	145		145	16
17	BUILD & INSTALL WALL COVER, BOARD PANELS,								17
18	RAISE COUNTER AND LAMINATE COUNTERS & INSTALL								18
19	TWO DOORS	2010	6,450	127	27.5	127		127	19
20	REPLACE CEILING TILES ON 1ST FLR REHAB ROOM	2010	3,002	50	27.5	50		50	20
21	SECOND FLOOR RMS - 206-230 - REMOVE EXISTING								21
22	TOILETS, SINK, WALLPAPER/PATCH & TAPE DRYWALL,								22
23	INSTALL WALL PAPER, SHADES, & VALANCES AND TILES	2010	68,073	310	27.5	310		310	23
24	REPLACE CYLINDER ON NORTH CARE ELEVATOR	2010	37,514	1,307	27.5	1,307		1,307	24
25									25
26			ADJ. TO SL	(4,017)			4,017		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,396,251	$ 150,825		$ 150,825	$	$ 3,977,636	34

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 1,313,681	$ 114,667	$ 129,808	$ 15,141	3-15 YRS	$ 623,701	71
72	Current Year Purchases	152,838	112,823	7,642	(105,181)	3-15 YRS	7,642	72
73	Fully Depreciated Assets	667,031				3-15 YRS	667,031	73
74	RELATED PARTY		9,499	9,499				74
75	TOTALS	$ 2,133,550	$ 236,989	$ 146,949	$ (90,040)		$ 1,298,374	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)	$ 8,865,553	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 387,814	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 297,774	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (90,040)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,276,010	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	CONS. IN PROG	$ 8,200	92
93			93
94			94
95		$ 8,200	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 CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 57,846 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	FACILITY USE	2006 FORD 450-MINI BUS	$	$ 15,348	17
18	FACILITY USE	2009 FORD F250	780.31	9,364	18
19	FACILITY USE	FORD E350 BUS		16,860	19
20	ADMINISTRATIVE	2009 TOYOTA CORROLA	297.90	3,575	20
21	TOTAL		$	$ 45,147	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.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number CRESTWOOD CARE CENTRE

STATE OF ILLINOIS
0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 469,037	$		$ 469,037	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			109,492			109,492	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			701,485			701,485	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 prescrpts				513,541		513,541	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, RENTAL, I.V. TPY Other (specify): MEDICAL SUPPLY	39-2					598,364		598,364	13
14	TOTAL			$		$ 1,280,014	$ 1,111,905		$ 2,391,919	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.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 301,291	$ 1,377,559	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 262,555)	3,344,225	3,344,225	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,811	2,811	5
6	Prepaid Insurance	88,495	195,400	6
7	Other Prepaid Expenses	53,833	53,833	7
8	Accounts Receivable (owners or related parties)	1,339,999	1,362,464	8
9	Other(specify): ESCROW DEPOSITS		329,571	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,130,654	$ 6,665,863	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		2,174,399	11
12	Long-Term Investments			12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		3,692,989	15
16	Equipment, at Historical Cost	1,961,328	2,248,422	16
17	Accumulated Depreciation (book methods)	(1,769,139)	(5,388,654)	17
18	Deferred Charges		37,524	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		276,056	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONST. IN PROG		8,200	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 192,189	$ 5,621,531	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,322,843	$ 12,287,394	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,228,401	$ 1,264,374	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	213,511	213,511	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,090	225,090	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,378	32,378	31
32	Accrued Real Estate Taxes(Sch.IX-B)		536,375	32
33	Accrued Interest Payable	144,622	164,678	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO LESSOR/PRIOR OWNER	5,039,440		36
37	MANAGEMENT FEES	346,854	346,854	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,230,296	$ 2,783,260	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,213,169	6,213,169	39
40	Mortgage Payable		4,498,554	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)**	$ 6,213,169	$ 10,711,723	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,443,465	$ 13,494,983	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (8,120,622)	$ (1,207,589)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,322,843	$ 12,287,394	48

*(See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,883,393)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,883,397)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	178,314	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	(500,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PAID IN CAPITAL - 754 BASIS ADJ.	84,461	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (237,225)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (8,120,622)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,378,107	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 18,378,107	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***	37,015	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,015	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)**	$ 18,415,122	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,424,511	31
32	Health Care	6,020,635	32
33	General Administration	5,007,915	33
	B. Capital Expense		
34	Ownership	2,225,935	34
	C. Ancillary Expense		
35	Special Cost Centers	2,391,919	35
36	Provider Participation Fee	165,893	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,236,808	40
41	**Income before Income Taxes (line 30 minus line 40)****	178,314	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 178,314	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,222	2,574	$ 138,851	$ 53.94	1
2	Assistant Director of Nursing	6,830	7,643	284,822	37.27	2
3	Registered Nurses	34,426	37,117	1,118,600	30.14	3
4	Licensed Practical Nurses	64,605	69,409	1,692,963	24.39	4
5	CNAs & Orderlies	123,800	133,472	1,530,708	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,413	10,315	134,222	13.01	8
9	Activity Director	3,865	4,187	55,930	13.36	9
10	Activity Assistants	13,381	14,422	138,860	9.63	10
11	Social Service Workers	5,774	6,281	111,813	17.80	11
12	Dietician					12
13	Food Service Supervisor	4,756	5,209	131,520	25.25	13
14	Head Cook	10,024	10,965	130,089	11.86	14
15	Cook Helpers/Assistants	29,241	31,773	304,591	9.59	15
16	Dishwashers					16
17	Maintenance Workers	3,905	4,219	81,851	19.40	17
18	Housekeepers	27,723	30,777	361,183	11.74	18
19	Laundry	18,289	20,203	208,140	10.30	19
20	Administrator	2,695	2,949	289,740	98.25	20
21	Assistant Administrator	3,538	3,877	112,093	28.91	21
22	Other Administrative	3,327	3,658	114,461	31.29	22
23	Office Manager	1,837	2,166	64,971	30.00	23
24	Clerical	16,150	17,610	238,776	13.56	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	1,853	2,074	31,595	15.23	31
32	Other Health C: REHAB DIR.	22	22	705	32.05	32
33	Other(specify) WARD CLERK	1,970	2,099	38,687	18.43	33
34	TOTAL (lines 1 - 33)	389,646	423,021	$ 7,315,171 *	$ 17.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	472	$ 33,403	1-3	35
36	Medical Director	MONTHLY	81,000	9-3	36
37	Medical Records Consultant	58	5,819	10-3	37
38	Nurse Consultant	MONTHLY	193,617	10-3	38
39	Pharmacist Consultant	MONTHLY	9,103	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	MONTHLY	855	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	3,079	11-3	44
45	Social Service Consultant	31	1,769	12-3	45
46	Other(specify) WOUND CARE	150	30,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	759	$ 358,645		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LUCILLE HOFFMAN	ADMINISTRATOR		$ 225,174
LARRY BANK	ASST. ADMIN		64,566
CATRINA KAROUBAS	ASST. ADMIN		21,409
KATHY SMITH	ASST. ADMIN		68,557
DAYTRINA PARHAM	ASST. ADMIN		22,127
DAYTRINA PARHAM	MARKETING DIR.		57,230
SANIN WILLIAMS	MARKETING DIR.		57,231
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 516,294

B. Administrative - Other

Description	Amount
	$
WITTINGHAM MANAGEMENT ASSOC, LLC	362,320
CHESTERFIELD, LLC	362,320
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 724,640

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		712,425
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 712,425

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 152,782
Unemployment Compensation Insurance	97,367
FICA Taxes	542,712
Employee Health Insurance	614,057
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	25,625
EMPLOYEE PHYSICAL EXAMS	6,082
PENSION/PROFIT SHARING PLANS	23,488
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,462,113

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,789
Health Care Worker Background Check	1,520
(Indicate # of checks performed 152)	
Patient Background Checks 1058	10,585
TRUST/FRANCHISE/CONTRIB/ETC	12,655
MARKETING/ADV/PROMO	97,001
LICENSES/DUES/SUBSCRIPTIONS	24,509
MGMT CO ALLOC	1,020
TRUST/FRANCHISE/CONTRIB/ETC	(12,655)
Less: Public Relations Expense	(78,540)
Non-allowable advertising	(18,461)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,423

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	67
RELATED PARTY	21,555
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,622

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. COUNCIL ON LTC - $26864**

(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. $ **49,676** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **165,893**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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.