FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0046151

Facility Name: Applewood Nursing & Rehab Center

Address: 21020 Kostner (Number) Matteson (City) 60443 (Zip Code)

County: Cook

Telephone Number: (708) 747-1300 **Fax #** (708) 747-6282

HFS ID Number:

Date of Initial License for Current Owners: 02/01/2003

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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	115	Skilled (SNF)	115	41,975	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	115	TOTALS	115	41,975	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	22,338	1,914	8,315	32,567	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,338	1,914	8,315	32,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.59%

D. How many bed-hold days during this year were paid by the Department?
1,356 (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 02/01/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 02/01/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 115 and days of care provided 7,898

Medicare Intermediary National Government Services

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	225,053	25,079	14,090	264,222		264,222	(563)	263,659			1
2	Food Purchase		183,261		183,261		183,261	128	183,389			2
3	Housekeeping	139,622	26,794		166,416		166,416	(1,626)	164,790			3
4	Laundry	62,590	18,572		81,162		81,162	(584)	80,578			4
5	Heat and Other Utilities			98,855	98,855		98,855	757	99,612			5
6	Maintenance	85,219		68,559	153,778		153,778	6,262	160,040			6
7	Other (specify):*							1,431	1,431			7
8	TOTAL General Services	512,484	253,706	181,504	947,694		947,694	5,806	953,500			8
	B. Health Care and Programs											
9	Medical Director			26,500	26,500		26,500		26,500			9
10	Nursing and Medical Records	1,952,628	162,152	12,631	2,127,411		2,127,411	10,159	2,137,570			10
10a	Therapy	156,054			156,054		156,054	2,329	158,383			10a
11	Activities	86,260	19,667		105,927		105,927		105,927			11
12	Social Services	102,460		22,129	124,589		124,589	1,666	126,255			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,873	6,873			15
16	TOTAL Health Care and Programs	2,297,402	181,819	61,260	2,540,481		2,540,481	21,027	2,561,508			16
	C. General Administration											
17	Administrative	106,155			106,155		106,155	29,887	136,042			17
18	Directors Fees											18
19	Professional Services			374,638	374,638	(5,500)	369,138	(261,565)	107,573			19
20	Dues, Fees, Subscriptions & Promotions			13,416	13,416		13,416	(6,193)	7,223			20
21	Clerical & General Office Expenses	126,625	24,707	245,725	397,057		397,057	(109,121)	287,936			21
22	Employee Benefits & Payroll Taxes			459,703	459,703		459,703	(12,771)	446,932			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,031	5,031		5,031	884	5,915			24
25	Other Admin. Staff Transportation			2,307	2,307		2,307	430	2,737			25
26	Insurance-Prop.Liab.Malpractice			201,107	201,107		201,107	563	201,670			26
27	Other (specify):*							16,942	16,942			27
28	TOTAL General Administration	232,780	24,707	1,301,927	1,559,414	(5,500)	1,553,914	(340,944)	1,212,970			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,042,666	460,232	1,544,691	5,047,589	(5,500)	5,042,089	(314,111)	4,727,978			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.

Facility Name & ID Number Applewood Nursing & Rehab Center #0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			69,413	69,413		69,413	33,429	102,842			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,615	46,615		46,615	64,080	110,695			32
33	Real Estate Taxes			334,167	334,167	5,500	339,667	1,098	340,765			33
34	Rent-Facility & Grounds			377,775	377,775		377,775	(377,095)	680			34
35	Rent-Equipment & Vehicles			11,690	11,690		11,690	(4,435)	7,255			35
36	Other (specify):*											36
37	**TOTAL Ownership**			839,660	839,660	5,500	845,160	(282,923)	562,237			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		638,047	713,269	1,351,316		1,351,316	(57,154)	1,294,162			39
40	Barber and Beauty Shops			385	385		385	(385)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*			97,734	97,734		97,734	(97,734)				43
44	**TOTAL Special Cost Centers**		638,047	874,351	1,512,398		1,512,398	(155,273)	1,357,125			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,042,666	1,098,279	3,258,702	7,399,647		7,399,647	(752,307)	6,647,340			45

***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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Refer-ence	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	(41,032)	30		9
10	Interest and Other Investment Income	(7,860)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	02		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	(13,229)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,783)	21		24
25	Fund Raising, Advertising and Promotional	(7,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(50)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(201,423)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (358,302)		$	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)	(394,005)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (394,005)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (752,307)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Applewood Nursing & Rehab Center

ID# 0046151

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (34)	10	1
2	Collection Expense	(408)	21	2
3	Barber & Beauty Income	(385)	40	3
4	Annual Report	(250)	20	4
5	Building Co. - Bank Charges	(616)	21	5
6	Building Co. - Filing Fees	(250)	21	6
7	Building Co. - Amortization	(1,084)	36	7
8	Prior Period Adjustment - Computer Expense	(77,299)	21	8
9	Out of Period Legal Fees	(13,590)	19	9
10	Non- Allowable Expense	(97,734)	43	10
11	Settlement Expense	(9,773)	21	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**	(201,423)		49

Applewood Nursing & Rehab Center

ID# 0046151

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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			85		2,503		(3,151)					(563)	1
2	Food Purchase	(108)		236									128	2
3	Housekeeping			303		33					(1,962)		(1,626)	3
4	Laundry										(584)		(584)	4
5	Heat and Other Utilities			687		70							757	5
6	Maintenance			1,976	4,238	70					(22)		6,262	6
7	Other (specify):*				708	351	372						1,431	7
8	**TOTAL General Services**	(108)		3,287	4,946	3,027	372	(3,151)			(2,567)		5,806	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)				16,105					(5,912)		10,159	10
10a	Therapy					2,329							2,329	10a
11	Activities													11
12	Social Services					1,666							1,666	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					2,817	4,056						6,873	15
16	**TOTAL Health Care and Programs**	(34)				22,917	4,056				(5,912)		21,027	16
	C. General Administration													
17	Administrative			1,400	5,437	23,050							29,887	17
18	Directors Fees													18
19	Professional Services	(13,590)		(188,403)		(59,572)							(261,565)	19
20	Fees, Subscriptions & Promotions	(8,068)		1,775		100							(6,193)	20
21	Clerical & General Office Expenses	(188,408)	866	8,293	65,895	4,233							(109,121)	21
22	Employee Benefits & Payroll Taxes				(8,162)		(4,429)				(180)		(12,771)	22
23	Inservice Training & Education													23
24	Travel and Seminar			87		797							884	24
25	Other Admin. Staff Transportation			430									430	25
26	Insurance-Prop.Liab.Malpractice			472		91							563	26
27	Other (specify):*				13,249	3,693							16,942	27
28	**TOTAL General Administration**	(210,066)	866	(175,946)	76,419	(27,608)	(4,429)				(180)		(340,944)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(210,208)	866	(172,659)	81,365	(1,664)	(1)	(3,151)			(8,660)		(314,111)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Applewood Nursing & Rehab Center** **#** **0046151** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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	(41,032)	71,427	2,552		482							33,429	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,860)	57,871	4,870		9,199							64,080	32
33	Real Estate Taxes			989		109							1,098	33
34	Rent-Facility & Grounds		(377,775)	680									(377,095)	34
35	Rent-Equipment & Vehicles			1,218								(5,653)	(4,435)	35
36	Other (specify):*	(1,084)	1,084											36
37	**TOTAL Ownership**	(49,976)	(247,393)	10,309		9,790						(5,653)	(282,923)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(4,575)	(27,920)	(2,361)	(9,249)	(13,049)	(57,154)	39
40	Barber and Beauty Shops	(385)											(385)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(97,734)											(97,734)	43
44	**TOTAL Special Cost Centers**	(98,119)						(4,575)	(27,920)	(2,361)	(9,249)	(13,049)	(155,273)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(358,302)	(246,527)	(162,350)	81,365	8,126	(1)	(7,726)	(27,920)	(2,361)	(17,909)	(18,702)	(752,307)	45

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		See Attached		See Attached		
				Applewood Property LLC		Building Co.

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	$ 377,775	Applewood Property LLC	100.00%	$	$ (377,775)	1
2	V	33	Real Estate Taxes	347,397	Applewood Property LLC	100.00%	347,397		2
3	V	32	Interest Income	97,949	Applewood Property LLC	100.00%	155,820	57,871	3
4	V	21	Bank Charges		Applewood Property LLC	100.00%	616	616	4
5	V	21	Filing Fees		Applewood Property LLC	100.00%	250	250	5
6	V	30	Depreciation		Applewood Property LLC	100.00%	71,427	71,427	6
7	V	36	Amortization		Applewood Property LLC	100.00%	1,084	1,084	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 823,121			$ 576,594	$ * (246,527)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 85	$ 85	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	236	236	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	303	303	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	687	687	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,976	1,976	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,400	1,400	20
21	V	19	Professional Fees	194,239	Extended Care Consulting, LLC	100.00%	5,836	(188,403)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,775	1,775	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	8,293	8,293	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	87	87	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	430	430	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	472	472	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,552	2,552	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	4,870	4,870	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	989	989	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	680	680	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,218	1,218	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 194,239			$ 31,889	$ * (162,350)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	4,238	$ 4,238	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	708	708	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	5,437	5,437	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	65,895	65,895	22
23	V	21	Office and Clerical (Direct)	12,977	Extended Care Consulting, LLC	100.00%	12,977		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	11,920	11,920	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,329	1,329	25
26	V	22	Employee Benefits	8,162	Extended Care Consulting, LLC	100.00%		(8,162)	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			$ 21,139			$ 102,504	$ * 81,365	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 33	$ 33	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	70	70	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	70	70	17
18	V	19	Professional Fees	63,483	Extended Care Clinical, LLC	100.00%	3,911	(59,572)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	100	100	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	934	934	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	797	797	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	91	91	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	482	482	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	9,199	9,199	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	109	109	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	2,503	2,503	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	351	351	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	16,105	16,105	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	2,329	2,329	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	1,666	1,666	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	2,817	2,817	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	23,050	23,050	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,299	3,299	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	3,693	3,693	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 63,483			$ 71,609	$ * 8,126	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	01	Dietary Salary	$ 2,665	Extended Care Clinical, LLC	100.00%	$ 2,665	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%	372	372	16
17	V	10	Nursing Salary	7,896	Extended Care Clinical, LLC	100.00%	7,896		17
18	V	12	Social Service Salary	20,872	Extended Care Clinical, LLC	100.00%	20,872		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	4,056	4,056	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	4,429	Extended Care Clinical, LLC	100.00%		(4,429)	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			$ 35,862			$ 35,861	$ * (1)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1	Dietary Supplies, Supplements	$ 7,093	Care Centers Health Systems, Inc.	100.00%	$ 3,942	$ (3,151)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	10,299	Care Centers Health Systems, Inc.	100.00%	5,724	(4,575)	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			$ 17,392			$ 9,666	$ * (7,726)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	39	Therapy	$ 702,797	TriCare Rehab	100.00%	$ 674,877	$ (27,920)	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			$ 702,797			$ 674,877	$ * (27,920)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	30,115	Reliable Medical of the Midwest, LLC	100.00%	27,754	(2,361)	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			$ 30,115			$ 27,754	$ * (2,361)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	29,441	Xcel Supply, LLC	100.00%	27,479	(1,962)	16
17	V	4	Laundry	8,759	Xcel Supply, LLC	100.00%	8,176	(584)	17
18	V	6	Repairs & Maintenance	324	Xcel Supply, LLC	100.00%	303	(22)	18
19	V	10	Nursing	88,719	Xcel Supply, LLC	100.00%	82,806	(5,912)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	2,704	Xcel Supply, LLC	100.00%	2,524	(180)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	138,795	Xcel Supply, LLC	100.00%	129,546	(9,249)	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			$ 268,743			$ 250,834	$ * (17,909)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 202,785	$ 202,785	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	202,785	CCS Employee Benefits Group	100.00%		(202,785)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	35	Matrix Leasing	$ 10,519	Vent Lease LLC	100.00%	$ 4,866	(5,653)	27
28	V	39	Ventilator Equipment	24,280	Vent Lease LLC	100.00%	11,231	(13,049)	28
29	V	39	Other Ancillary		Vent Lease LLC	100.00%			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			$ 237,584			$ 218,882	$ * (18,702)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Eric Rothner	Shareholder	Administrative	1.00%	See Attached	0.81	1.74%		$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.18	2.15%	Alloc. Salary	3,443	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1.07	2.68%	Alloc. Salary	1,862	22-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.47	2.11%	Alloc. Salary	1,598	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,903		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 Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										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					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	32,567	$ 85	1
2	02	Food	Patient Days	1,512,273	34	10,940		32,567	236	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		32,567	303	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		32,567	687	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		32,567	1,976	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		32,567	1,400	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		32,567	5,836	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		32,567	1,775	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		32,567	8,293	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		32,567	87	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		32,567	430	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		32,567	472	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		32,567	2,552	13
14	32	Interest	Patient Days	1,512,273	34	226,162		32,567	4,870	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		32,567	989	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		32,567	680	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		32,567	1,218	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 31,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	32,567	4,238	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		32,567	708	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607				4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	32,567	5,437	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	32,567	65,895	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		12,977	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		32,567	11,920	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			1,329	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					$ 5,054,827	$ 4,364,695		$ 102,504	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	32,567	$ 33	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		32,567	70	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		32,567	70	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		32,567	3,911	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		32,567	100	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		32,567	934	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		32,567	797	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		32,567	91	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		32,567	482	9
10	32	Interest	Patient Days	1,512,273	34	427,165		32,567	9,199	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		32,567	109	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	32,567	2,503	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		32,567	351	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	32,567	16,105	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	32,567	2,329	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	32,567	1,666	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		32,567	2,817	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	32,567	23,050	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	32,567	3,299	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		32,567	3,693	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 71,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$ 2,665	1
2	07	Emp. Ben. - General	Direct Allocation			1,662			372	2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		7,896	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		20,872	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			4,056	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 35,861	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	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	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 3,942	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						5,724	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					$	$		$ 9,666	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	39	Therapy	Direct Allocation			$	$		$ 674,877	1
2										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					$	$		$ 674,877	25

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	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	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						27,754	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 27,754	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	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	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						27,479	2
3	4	Laundry	Direct Allocation						8,176	3
4	6	Repairs & Maintenance	Direct Allocation						303	4
5	10	Nursing	Direct Allocation						82,806	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						2,524	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						129,546	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					$	$		$ 250,834	25

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: CCS Emp. Ben. Group / Vent Lease LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000 / (847) 674-1180
Fax Number: (847)905-4040 / (847-673-7741

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 202,785	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	35	Matrix Leasing	Direct Allocation			$	$		$ 4,866	11
12	39	Ventilator Equipment	Direct Allocation						11,231	12
13	39	Other Ancillary	Direct Allocation							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					$	$		$ 218,882	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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**		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	Busines Partners (Net)		X	Mortgage			$	$ 4,041,972			$ 155,820	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				(9,442)			45,496	6
7	Xerox		X	Copier Purchase Financing				1,727			1,119	7
8	See Supplemental Schedule										14,069	8
9	TOTAL Facility Related						$	$ 4,034,256			$ 216,504	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,860)	10
11	Interest Income - Bldg Co.		X								(97,948)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (105,808)	14
15	TOTALS (line 9+line14)						$	$ 4,034,256			$ 110,696	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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**		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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from EC Consulting		X				$	$			$ 4,870	8
9	Allocated from EC Clinical		X								9,199	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										14,069	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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 Applewood Nursing & Rehab Center # 0046151 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	311,672	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.)	$	316,142	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,470	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	330,795	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.**	$	5,500	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.	$	340,765	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	332,939	8
	2006	276,710	9
	2007	287,569	10
	2008	296,831	11
	2009	315,044	12

2010 Accrual = $315,044 x 0.96 = $302,429

Allocated from Extended Care Consulting - $989

Allocated from Extended Care Clinical - $109

	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 Applewood Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046151

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.	31-22-114-023-0000	Long Term Care Property	$ 7,055.66	$ 7,055.66
2.	31-22-114-024-0000	Long Term Care Property	$ 292,519.28	$ 292,519.28
3.	31-22-114-025-0000	Long Term Care Property	$ 4,099.18	$ 4,099.18
4.	31-22-114-026-0000	Long Term Care Property	$ 11,369.50	$ 11,369.50
5.	See Attached	Allocation from 2201 Main	$ 116,500.56	$ 1,011.45
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,544.18	$ 316,055.07

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046151

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,449 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

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 [X] (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).

None

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	Facility	191,644	2003	$ 223,625	1
2	Allocated from EC Consulting			7,119	2
3	TOTALS	191,644		$ 230,744	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	17,643		20	1,384	1,384	11,945	9
10	Various			2004	30,750		20	1,936	1,936	12,435	10
11	Various			2005	51,157		20	2,558	2,558	13,568	11
12	Various			2006	390,382		20	14,935	14,935	162,111	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,977,860	71,427		50,714	(20,713)		67
68	Related Party Allocations (Pages 12H & 12I)		31,853	2,169		2,169		15,183	68
69	Financial Statement Depreciation			69,413			(69,413)		69
70	TOTAL (lines 4 thru 69)		$ 2,499,645	$ 143,009		$ 73,695	$ (69,314)	$ 215,243	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 2,499,645	$ 143,009		$ 73,695	$ (69,314)	$ 215,243	1
2	Remodel 6 Shower Rooms	2007	40,905		20	2,045	2,045	8,011	2
3	Painting (Transfer Expense From Home Office)	2007	4,104		20			4,104	3
4	Painting (Transfer Expense From Home Office)	2007	4,167		20			4,167	4
5	Cubicle Curtains	2007	12,871		20	2,574	2,574	9,868	5
6	Painting (Transfer Expense From Home Office)	2007	6,782		20			6,782	6
7	Painting (Transfer Expense From Home Office)	2007	3,483		20			3,483	7
8	Blinds For Facility	2007	2,625		20	263	263	963	8
9	Parking Lot	2007	33,420		20	3,342	3,342	12,254	9
10	Painting (Transfer Expense From Home Office)	2007	3,850		20			3,850	10
11	A/C System	2007	3,250		20	271	271	970	11
12	Painting (Transfer Expense From Home Office)	2007	3,028		20			3,028	12
13	Kickplates	2007	2,897		20	145	145	507	13
14	Painting (Transfer Expense From Home Office)	2007	4,408		20			4,408	14
15	Painting (Transfer Expense From Home Office)	2007	4,056		20			4,056	15
16	Painting (Transfer Expense From Home Office)	2007	3,505		20			3,505	16
17	Norstar Analog Station	2007	21,384		20	4,277	4,277	13,900	17
18	A/C Condensing Unit	2008	4,000		20	333	333	889	18
19	Valve Repair	2009	6,100		20	305	305	407	19
20	Painting	2009	5,494		20	275	275	458	20
21	Replacement Door And Frame	2009	3,900		20	195	195	276	21
22	New Door Frame And Window	2010	3,500		20	160	160	160	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	1
2									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
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	1
2									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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	1
2									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
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,677,374	$ 143,009		$ 87,880	$ (55,129)	$ 301,287	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Building Company Information								1
2	Buildings:								2
3	Applewood Property LLC - 115 Bed Facility	1967	1,977,860	71,427	39	50,714	(20,713)	=	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,977,860	$ 71,427		$ 50,714	$ (20,713)	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	9,811	252	39	252		2,086	3
4	Allocated from Extended Care Clinical 2201 Main	2002	1,081	28	39	28		230	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	99	5	20	5		20	9
10	Allocated from Extended Care Consulting	2009	59	3	20	3		6	10
11	Allocated from Extended Care Consulting	2010	581	29	20	29		29	11
12									12
13	Allocated from Extended Care Consulting 2201 Main	2002	8,104	741	20	741		5,192	13
14	Allocated from Extended Care Consulting 2201 Main	2003	9,551	873	20	873		6,118	14
15	Allocated from Extended Care Consulting 2201 Main	2005	475	50	20	50		222	15
16	Allocated from Extended Care Consulting 2201 Main	2009	86	4	20	4		9	16
17									17
18	Allocated from Extended Care Clinical 2201 Main	2002	893	82	20	82		572	18
19	Allocated from Extended Care Clinical 2201 Main	2003	1,052	96	20	96		674	19
20	Allocated from Extended Care Clinical 2201 Main	2005	52	6	20	6		24	20
21	Allocated from Extended Care Clinical 2201 Main	2009	9		20			1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 31,853	$ 2,169		$ 2,169	$	$ 15,183	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 91,904	$ 486	$ 14,583	$ 14,097	10	$ 74,907	71
72	Current Year Purchases	314	31	31		10	31	72
73	Fully Depreciated Assets	803,290				10	803,696	73
74								74
75	TOTALS	$ 895,508	$ 517	$ 14,614	$ 14,097		$ 878,635	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		Alloc. Extended Care Consult.	2010	$ 6,925	$ 108	$ 108	$	5	$ 108	76
77		Alloc. Extended Care Clinical	2010	1,204	241	241		5	241	77
78										78
79										79
80	TOTALS			$ 8,129	$ 349	$ 349	$		$ 349	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)	$ 3,811,755	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,875	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 102,843	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,032)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,180,271	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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:				$			3
4	Additions							4
5	Allocated from EC Consulting				680			5
6								6
7	TOTAL				$ 680 **			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: $ 7,256 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 - 03	hrs	$		$ 253,100	$		$ 253,100	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			136,943			136,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			312,754			312,754	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				435,497		435,497	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					10,472	202,550		213,022	13
14	TOTAL			$		$ 713,269	$ 638,047		$ 1,351,316	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

STATE OF ILLINOIS

Facility Name & ID Number Applewood Nursing & Rehab Center **#** 0046151 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(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	$ 550	$ 81,765	1
2	Cash-Patient Deposits	36,605	36,605	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	612,680	613,276	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	227,669	227,669	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	651,621	3,310,815	8
9	Other(specify): See Attached Schedule	325,509	387,419	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,854,634	$ 4,657,549	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		223,625	13
14	Buildings, at Historical Cost		3,036,861	14
15	Leasehold Improvements, at Historical Cost	613,287	613,287	15
16	Equipment, at Historical Cost	163,303	163,303	16
17	Accumulated Depreciation (book methods)	(478,603)	(1,781,533)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 297,987	$ 2,255,543	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,152,621	$ 6,913,092	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 612,150	$ 612,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,657	21,657	28
29	Short-Term Notes Payable	(12,853)	(12,853)	29
30	Accrued Salaries Payable	124,536	124,536	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,527	3,527	31
32	Accrued Real Estate Taxes(Sch.IX-B)	359,162	330,795	32
33	Accrued Interest Payable		19,368	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	706	296,383	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,108,885	$ 1,395,564	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,138	5,138	39
40	Mortgage Payable		4,041,972	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,138	$ 4,047,110	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,114,023	$ 5,442,674	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,038,598	$ 1,470,418	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,152,621	$ 6,913,092	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (846,943)	1
2	Restatements (describe):		2
3	**Dividends**	112,021	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (734,922)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(404,602)	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	2,178,122	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,773,520	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,038,598	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 6,880,079	1
2	Discounts and Allowances for all Levels	(2,766,497)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,113,582	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,302,415	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,302,415	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	672	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	439,304	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,791	19
20	Radiology and X-Ray	4,780	20
21	Other Medical Services	84,565	21
22	Laundry	2,042	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 571,154	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,860	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,860	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	34	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,995,045	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	947,694	31
32	Health Care	2,540,481	32
33	General Administration	1,559,414	33
	B. Capital Expense		
34	Ownership	839,660	34
	C. Ancillary Expense		
35	Special Cost Centers	1,449,435	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,399,647	40
41	**Income before Income Taxes (line 30 minus line 40)****	(404,602)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (404,602)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **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 Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,049	1,162	$ 43,378	$ 37.33	1
2	Assistant Director of Nursing	2,347	2,584	83,024	32.13	2
3	Registered Nurses	15,543	17,975	521,177	28.99	3
4	Licensed Practical Nurses	18,589	20,903	519,491	24.85	4
5	CNAs & Orderlies	62,677	69,990	752,439	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,059	9,837	156,054	15.86	8
9	Activity Director	1,861	2,151	30,351	14.11	9
10	Activity Assistants	5,787	6,627	55,909	8.44	10
11	Social Service Workers	5,473	5,933	102,460	17.27	11
12	Dietician	192	203	3,012	14.84	12
13	Food Service Supervisor	1,971	2,263	40,889	18.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,763	6,489	76,762	11.83	15
16	Dishwashers	9,944	11,504	104,390	9.07	16
17	Maintenance Workers	3,785	4,298	85,219	19.83	17
18	Housekeepers	11,106	12,843	139,622	10.87	18
19	Laundry	2,524	2,719	62,590	23.02	19
20	Administrator	1,850	2,144	106,155	49.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,749	8,704	126,625	14.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,046	2,383	33,119	13.90	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	169,315	190,712	$ 3,042,666 *	$ 15.95	34

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	233	$ 11,425	01-03	35
36	Medical Director	Monthly	26,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,735	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	17	1,001	12-03	45
46	Other(specify)				46
47	See Attached - Extended Care Allocation		31,689		47
48					48
49	TOTAL (lines 35 - 48)	250	$ 75,350		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dianne O'Connor	Administrator	0	$ 106,155
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,155

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,407
Personnel Planners	Unemployment Tax Consult.	2,625
Extended Care Consulting	Home Office Expense	194,239
Extended Care Clinical	Home Office Expense	63,483
See Attached	Legal	47,107
Paycor	Payroll Processing	9,083
Ehealth Data Solutions	MDS Softare	3,180
AIS Assesment & Intelligence	Computer Services	1,059
Vision Share	Computer Services	1,756
National Datacare Corporation	Data Processing	1,072
Pinnacle Consulting	Customer Satisfaction	2,539
See Supplemetal Schedule		23,090
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 374,638

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,201
Unemployment Compensation Insurance	29,654
FICA Taxes	215,589
Employee Health Insurance	100,100
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	7,513
Other Employee Welfare	176
Holiday Expense	2,700
TOTAL (agree to Schedule V, line 22, col.8)	$ 446,932

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	385
Health Care Worker Background Check	
(Indicate # of checks performed)	3,566
Patient Background Checks 263	
Licenses & Fees	521
Dues & Subscriptions	876
Allocated from EC Consulting	1,775
Allocated from EC Clinical	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,223

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,032
Allocated from EC Consulting	87
Allocated from EC Clinical	797
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,916

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
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 Applewood Nursing & Rehab Center **#** 0046151 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,461** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **62,963**
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. $ 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? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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.