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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0051359

Facility Name: Applewood Rehabilitation Center, Llc

Address: 21020 Kostner Avenue (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: 03/01/11

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 03/01/11 to 12/31/11 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) Cary Drazner, C.P.A.
(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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	35,190	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	35,190	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	22,475	2,116	6,942	31,533	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,475	2,116	6,942	31,533	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.61%

D. How many bed-hold days during this year were paid by the Department?
16 (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 3/1/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 5,007

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: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	197,291	26,412	20,890	244,593		244,593	(8,059)	236,534			1
2	Food Purchase		174,832		174,832		174,832	(117)	174,715			2
3	Housekeeping	149,076	32,602		181,678		181,678	(982)	180,696			3
4	Laundry	13,621	9,583	42,044	65,248		65,248		65,248			4
5	Heat and Other Utilities			87,064	87,064		87,064	(11,546)	75,518			5
6	Maintenance	42,028	19,978	61,827	123,833		123,833	(956)	122,877			6
7	Other (specify):*							1,743	1,743			7
8	TOTAL General Services	402,016	263,407	211,825	877,248		877,248	(19,917)	857,331			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	1,745,226	293,549	30,486	2,069,261		2,069,261	(32,409)	2,036,852			10
10a	Therapy	121,128		2,827	123,955		123,955	(7,016)	116,939			10a
11	Activities	81,935	3,770	1,020	86,725		86,725		86,725			11
12	Social Services	28,721		12,791	41,512		41,512		41,512			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,637	2,637			15
16	TOTAL Health Care and Programs	1,977,010	297,319	72,124	2,346,453		2,346,453	(36,788)	2,309,665			16
	C. General Administration											
17	Administrative	116,971		343,734	460,705		460,705	(294,605)	166,100			17
18	Directors Fees											18
19	Professional Services			124,066	124,066	(15,057)	109,009	(86,876)	22,133			19
20	Dues, Fees, Subscriptions & Promotions			17,529	17,529		17,529	(5,813)	11,716			20
21	Clerical & General Office Expenses	120,015	25,267	71,677	216,959		216,959	26,696	243,655			21
22	Employee Benefits & Payroll Taxes			398,196	398,196		398,196		398,196			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,547	1,547		1,547	327	1,874			24
25	Other Admin. Staff Transportation			1,195	1,195		1,195	4,509	5,704			25
26	Insurance-Prop.Liab.Malpractice			107,585	107,585		107,585	738	108,323			26
27	Other (specify):*							20,090	20,090			27
28	TOTAL General Administration	236,986	25,267	1,065,529	1,327,782	(15,057)	1,312,725	(334,934)	977,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,616,012	585,993	1,349,478	4,551,483	(15,057)	4,536,426	(391,640)	4,144,786			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 Rehabilitation Center, Llc #0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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			6,558	6,558		6,558	14,107	20,665			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,169	33,169		33,169	163,787	196,956			32
33	Real Estate Taxes			308,186	308,186	15,057	323,243	3,063	326,306			33
34	Rent-Facility & Grounds			472,219	472,219		472,219	(472,219)				34
35	Rent-Equipment & Vehicles			2,851	2,851		2,851	3,282	6,133			35
36	Other (specify):*											36
37	TOTAL Ownership			822,983	822,983	15,057	838,040	(287,980)	550,060			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		267,881	486,820	754,701		754,701		754,701			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,786	181,786		181,786		181,786			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		267,881	668,606	936,487		936,487		936,487			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,616,012	853,874	2,841,067	6,310,953		6,310,953	(679,619)	5,631,334			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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,765)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(49,016)	30		9
10	Interest and Other Investment Income	(366)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(117)	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				18
19	Entertainment				19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,425)	21		24
25	Fund Raising, Advertising and Promotional	(5,611)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,355)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,906)		$	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)	(560,713)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (560,713)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (679,619)		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 Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 03/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of Period Legal Fees	$ (2,369)	19	1
2	Collection Expense	(816)	21	2
3	Building Co. -State Tax	(100)	21	3
4	Building Co. - Filing Fees	(250)	21	4
5	Building Co. - Amortization	(8,021)	36	5
6	Misc Income	(17)	21	6
7	Bank Charges	(3,847)	21	7
8	Theft & Damage Loss	(249)	21	8
9	Patient Clothing	(70)	10	9
10	Non Allowable Legal	(14,042)	19	10
11	Additional R&M	5,289	06	11
12	Building Co. - Accounting Fee	(1,550)	19	12
13	Building Co.- Management Fee	(4,313)	21	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**	(30,355)		49

Applewood Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 03/01/11

Ending: 12/31/11

	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 Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 03/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(8,059)								(8,059)	1
2	Food Purchase	(117)											(117)	2
3	Housekeeping					(982)							(982)	3
4	Laundry													4
5	Heat and Other Utilities	(12,765)			1,219								(11,546)	5
6	Maintenance	5,289		(6,493)	248								(956)	6
7	Other (specify):*			398	1,345								1,743	7
8	**TOTAL General Services**	(7,593)		(6,095)	(5,247)	(982)							(19,917)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(70)		(15,669)	3,580	(13,995)		(6,255)					(32,409)	10
10a	Therapy				(7,016)								(7,016)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,260	1,377								2,637	15
16	**TOTAL Health Care and Programs**	(70)		(14,409)	(2,059)	(13,995)		(6,255)					(36,788)	16
	C. General Administration													
17	Administrative			(331,184)	36,579								(294,605)	17
18	Directors Fees													18
19	Professional Services	(17,961)	1,550	(78,050)	7,585								(86,876)	19
20	Fees, Subscriptions & Promotions	(6,361)		548									(5,813)	20
21	Clerical & General Office Expenses	(29,517)	8,163	48,016	34								26,696	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			327									327	24
25	Other Admin. Staff Transportation			4,509									4,509	25
26	Insurance-Prop.Liab.Malpractice			681	57								738	26
27	Other (specify):*			11,831	8,259								20,090	27
28	**TOTAL General Administration**	(53,839)	9,713	(343,322)	52,514								(334,934)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(61,503)	9,713	(363,826)	45,208	(14,977)		(6,255)					(391,640)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 03/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(49,016)	59,552		3,893	(321)							14,107	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(366)	164,916	(4,120)	3,357								163,787	32
33	Real Estate Taxes				3,063								3,063	33
34	Rent-Facility & Grounds		(472,219)										(472,219)	34
35	Rent-Equipment & Vehicles			3,282									3,282	35
36	Other (specify):*	(8,021)	8,021											36
37	**TOTAL Ownership**	(57,403)	(239,730)	(838)	10,313	(321)							(287,980)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(118,906)	(230,017)	(364,664)	55,521	(15,298)		(6,255)					(679,619)	45

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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	$ 472,219	Applewood Property LLC	100.00%	$	$ (472,219)	1
2	V	33	Real Estate Taxes	233,662	Applewood Property LLC	100.00%	233,662		2
3	V	21	Management Fee		Applewood Property LLC	100.00%	4,313	4,313	3
4	V	21	State Replacement Tax		Applewood Property LLC	100.00%	100	100	4
5	V	21	Filing Fees		Applewood Property LLC	100.00%	250	250	5
6	V	30	Depreciation		Applewood Property LLC	100.00%	59,552	59,552	6
7	V	36	Amortization		Applewood Property LLC	100.00%	8,021	8,021	7
8	V	32	Interest		Applewood Property LLC	100.00%	164,916	164,916	8
9	V	21	Loan Fee		Applewood Property LLC	100.00%	3,500	3,500	9
10	V	19	Accounting		Applewood Property LLC	100.00%	1,550	1,550	10
11	V								11
12	V								12
13	V								13
14	Total			$ 705,881			$ 475,864	$ * (230,017)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	REPAIRS AND MAINT.	$ 11,500	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,007	$ (6,493)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	398	398	16
17	V	10	NURSING	23,000	S.I.R. MANAGEMENT, INC.	100.00%	7,331	(15,669)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,260	1,260	18
19	V	19	PROFESSIONAL FEES	84,050	S.I.R. MANAGEMENT, INC.	100.00%	6,000	(78,050)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	548	548	20
21	V	21	CLERICAL & GENERAL	23,000	S.I.R. MANAGEMENT, INC.	100.00%	24,668	1,668	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	327	327	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,509	4,509	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	681	681	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,163	2,163	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(4,120)	(4,120)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,282	3,282	27
28	V								28
29	V	17	ADMINISTRATIVE	343,734	S.I.R. MANAGEMENT, INC.	100.00%	12,550	(331,184)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	901		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	46,348	46,348	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,668	9,668	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 485,284			$ 121,521	$ * (364,664)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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 SALARIES	$ 11,500	S.I.R. MANAGEMENT, INC.	100.00%	$ 3,441	$ (8,059)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	598	598	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	3,580	3,580	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	620	620	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	36,579	36,579	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	7,116	7,116	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,259	8,259	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	11,500	S.I.R. MANAGEMENT, INC.	100.00%	4,484	(7,016)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	757	757	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,979	S.I.R. MANAGEMENT, INC.	100.00%	3,728	(251)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	747	747	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,219	1,219	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	499	499	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	27	27	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	34	34	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	57	57	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,893	3,893	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,357	3,357	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,063	3,063	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	442	442	38
39	Total			$ 26,979			$ 82,500	$ * 55,521	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	16,199	Xcel Supply, LLC	100.00%	15,217	(982)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	230,849	Xcel Supply, LLC	100.00%	216,854	(13,995)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation	5,301	Xcel Supply, LLC	100.00%	4,980	(321)	23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 252,350			$ 237,051	$ * (15,298)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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%	$ 149,869	$ 149,869	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	149,869	CCS Employee Benefits Group	100.00%		(149,869)	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			$ 149,869			$ 149,869	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Supplies-Enterals	$ 14,082	Care Centers Health Systems, Inc.	100.00%	$ 7,827	$ (6,255)	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			$ 14,082			$ 7,827	$ * (6,255)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES	30.118%	ALBANY CARE INC	EVANSTON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	1
2	B.G. TRUST	3.937%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	2
3	BARRIS GROUP LIMITED PARTNERSHIP	11.171%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	11.171%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	JOSEPH ABRAMCHIK	1.575%	ELMWOOD CARE, INC.	ELMWOOD PARK	CARE CENTERS HEALTH SYST	DES PLAINES	ENTERAL SUPPLIES	5
6	L.G. TRUST	3.937%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	LOUISE BERGTHOLD	1.575%	GREENWOOD CARE, INC.	EVANSTON				7
8	PATRICIA MCDIARMID	1.575%	MAPLEWOOD CARE, INC.	ELGIN				8
9	RALPH GESUALDO	11.171%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO CHILDREN'S TRUST	11.171%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	RONALD NUNZIATO, JR.	1.575%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	SARAH BARRISH	1.575%	WILSON CARE, INC.	CHICAGO				12
13	THOMAS WINTER	1.575%						13
14	UNITED TRUST #1	3.937%						14
15	UNITED TRUST #2	3.937%						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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	Relative	Administrative	0.00%	See Attached	0.23	3.83%	Alloc. Salary	$ 5,131	17-7	1
2	Bryan Barrish	Relative	Administrative	0.00%	See Attached	1.51	3.78%	Alloc. Salary	7,530	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.89	2.23%	Alloc. Salary	1,585	22-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	3,164	17-7	4
5	Mike Giannini	Relative	Administrative	0.00%	See Attached	1.32	3.77%	Alloc. Salary	6,287	17-7	5
6	Sarah Barrish	Owner	Administrative	1.57%	See Attached	1.88	3.76%	Alloc. Salary	4,508	17-7	6
7	Nenita Guzman	Relative	Dietary	0.00%	See Attached	1.88	3.76%	Alloc. Salary	3,441	1-7	7
8	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	1.51	3.78%	Alloc. Salary	1,695	21-7	8
9	Tom Winter	Owner	Administrative	1.57%	See Attached	2.26	3.77%	Alloc. Salary	7,530	17-7	9
10	Louis Bergthold	Owner	Administrative	1.57%	See Attached	0.45	0.75%	Alloc. Salary	1,582	17-7	10
11	Ronald Nunzioto	Owner	Administrative	1.57%	See Attached	1.51	3.78%	Alloc. Salary	6,565	17-7	11
12	See Supplemental								17,895		12
13								TOTAL	$ 66,913		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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	$ 133,007	$ 59,965	31,533	$ 5,007	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		31,533	398	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	31,533	7,331	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		31,533	1,260	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	31,533	6,000	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		31,533	548	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	31,533	24,668	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		31,533	327	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		31,533	4,509	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		31,533	681	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		31,533	2,163	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		31,533	(4,120)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		31,533	3,282	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	31,533	12,550	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		31,533	901	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	31,533	46,348	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		31,533	9,668	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,227,764	$ 2,435,626		$ 121,521	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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 S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	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 SALARIES	PATIENT DAYS	837,569	13	$ 91,408	$ 91,408	31,533	$ 3,441	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		31,533	598	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	31,533	3,580	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		31,533	620	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	31,533	36,579	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		31,533	7,116	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		31,533	8,259	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	11,500	4,484	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		11,500	757	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	3,979	3,728	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		3,979	747	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		485	1,219	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		485	499	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		485	27	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		485	34	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		485	57	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		485	3,893	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		485	3,357	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		485	3,063	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		485	442	24
25	TOTALS					$ 2,490,426	$ 1,625,498		$ 82,500	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	$					$		1
2	3	Housekeeping							15,217	2
3	4	Laundry								3
4	6	Repairs & Maintenance								4
5	10	Nursing							216,854	5
6	11	Activities								6
7	21	Office And Clerical								7
8	22	Employee Benefits								8
9	30	Fixed Assets-Depreciation							4,980	9
10	39	Ancillary								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					$	$		$ 237,051	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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 Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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			$	$		$ 149,869	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					$	$		$ 149,869	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	10	Supplies-Enterals	Direct Allocation			$	$		$ 7,827	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					$	$		$ 7,827	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

Name of Related Organization
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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Business Partners (Net)		X	Mortgage			$	$ 3,385,011			$ 164,916	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				1,725,000			33,169	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 5,110,011			$ 198,085	9
	B. Non-Facility Related*											
10	Interest Income		X								(366)	10
11	Allocated from SIR Management										(763)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,129)	14
15	TOTALS (line 9+line14)						$	$ 5,110,011			$ 196,956	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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 Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 03/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 340,383	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.)		$ 319,438	2
3. Under or (over) accrual (line 2 minus line 1).		$ (20,945)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 332,194	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.**		$ 15,057	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** $ 43,186 **For** 2008 **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.		$ 326,306	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	276,710	8
	2007	287,569	9
	2008	296,831	10
	2009	315,044	11
	2010	316,375	12

Allocated from SIR Management- $3,063
Beginning Accrual Adjusted
2011 Accrual- $316,375 x 1.05%= $332,194

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051359

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 2010 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 2010.

	(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	$ 7,272.86	$ 7,272.86
2.	31-22-114-024-0000	Long Term Care Property	$ 293,182.07	$ 293,182.07
3.	31-22-114-025-0000	Long Term Care Property	$ 4,218.90	$ 4,218.90
4.	31-22-114-026-0000	Long Term Care Property	$ 11,701.13	$ 11,701.13
5.	See Attached	Allocated from SIR Management	$ 98,193.53	$ 2,895.72
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 414,568.49	$ 319,270.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051359

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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					2
3	TOTALS	191,644		$ 223,625	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	115			1967	1,977,860	59,552	39		(59,552)		5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	17,643		20	220	220	12,165	9
10	Various			2004	30,750		20	323	323	12,757	10
11	Various			2005	51,157		20	426	426	13,995	11
12	Various			2006	390,382		20	2,489	2,489	164,601	12
13	Various			2007	154,735		20	2,153	2,153	86,008	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)								67
68	Related Party Allocations (Pages 12H & 12I)		56,709	1,772		2,522	750	24,354	68
69	Financial Statement Depreciation			6,558			(6,558)		69
70	TOTAL (lines 4 thru 69)		$ 2,679,236	$ 67,882		$ 8,133	$ (59,749)	$ 313,879	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,679,236	$ 67,882		$ 8,133	$ (59,749)	$ 313,879	1
2	A/C Condensing Unit	2008	4,000		20	56	56	944	2
3	Valve Repair	2009	6,100		20	51	51	458	3
4	Painting	2009	5,494		20	46	46	504	4
5	Replacement Door And Frame	2009	3,900		20	33	33	309	5
6	New Door Frame And Window	2010	3,500		20	29	29	190	6
7	Water Heater	2011	7,493		20	624	624	624	7
8	Window A/C/ Units And Sleeves	2011	39,931		20	2,329	2,329	2,329	8
9	Electric Upgrade	2011	59,662		20	1,740	1,740	1,740	9
10	Asphalt Work	2011	12,490		20	312	312	312	10
11	Masonry Cut-Out A/C Units	2011	32,962		20	961	961	961	11
12	Fire Doors	2011	22,680		20	95	95	95	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	TOTAL (lines 1 thru 33)		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 (lines 1 thru 33)		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 (lines 1 thru 33)		$ 2,877,448	$ 67,882		$ 14,409	$ (53,473)	$ 322,345	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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									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
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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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 SIR Properties	1993	17,045	541	35	487	(54)	8,522	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management	1993	4,322	120	20	214	94	4,070	9
10	Allocated from SIR Management	1994	13		20			13	10
11	Allocated from SIR Management	1995	99		20	5	5	81	11
12	Allocated from SIR Management	1997	6,640	149	20	326	177	4,911	12
13	Allocated from SIR Management	1999	522		20	26	26	320	13
14	Allocated from SIR Management	2000	616		20	31	31	356	14
15	Allocated from SIR Management	2007	1,981	183	20	99	(84)	415	15
16	Allocated from SIR Management	2008	5,459	521	20	344	(177)	1,323	16
17	Allocated from SIR Management	2009	13,564	124	20	678	554	1,522	17
18	Allocated from SIR Management	2011	336	14	20	7	(7)	7	18
19									19
20	Allocated from SIR Properties	2010	1,029		20	51	51	69	20
21	Allocated from SIR Properties	2009	1,023	90	20	51	(39)	143	21
22	Allocated from SIR Properties	2007	298	25	20	15	(10)	75	22
23	Allocated from SIR Properties	2002	68		20	3	3	32	23
24	Allocated from SIR Properties	1999	2,160		20	108	108	1,350	24
25	Allocated from SIR Properties	1998	1,032		20	52	52	697	25
26	Allocated from SIR Properties	1997	64		20	3	3	50	26
27	Allocated from SIR Properties	1994	162	4	20	8	4	142	27
28	Allocated from SIR Properties	1993	276	1	20	14	13	256	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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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)		$ 56,709	$ 1,772		$ 2,522	$ 750	$ 24,354	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 83,944	$ 1,954	$ 4,469	$ 2,515	10	$ 47,054	71
72	Current Year Purchases	74,697	(317)	1,594	1,911	10	1,915	72
73	Fully Depreciated Assets	790,547		8	8	10	790,547	73
74								74
75	TOTALS	$ 949,188	$ 1,637	$ 6,070	$ 4,433		$ 839,516	75

D. Vehicle Costs. (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		Allocated from SIR Management	2011	$ 1,324	$ 163	$ 187	$ 24	5	$ 262	76
77										77
78										78
79										79
80	TOTALS			$ 1,324	$ 163	$ 187	$ 24		$ 262	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)	$ 4,051,585	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,682	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,666	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (49,016)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,162,123	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	Construction in Progress	$ 45,083	92
93			93
94			94
95		$ 45,083	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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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								5
6								6
7	TOTAL				$ **			7

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

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

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 6,133 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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	$		$ 189,756	$		$ 189,756	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			77,627			77,627	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			219,437			219,437	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				237,909		237,909	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						29,972		29,972	13
14	TOTAL			$		$ 486,820	$ 267,881		$ 754,701	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 Rehabilitation Center, Llc # 0051359 **Report Period Beginning:** 03/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 48,412	$ 79,825	1
2	Cash-Patient Deposits	33,183	33,183	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,393,070	3,405,494	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,360	30,360	6
7	Other Prepaid Expenses	3,154	3,154	7
8	Accounts Receivable (owners or related parties)		3,922,829	8
9	Other(specify): See Attached Schedule	155	175,958	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,508,334	$ 7,650,803	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	135,287	135,287	15
16	Equipment, at Historical Cost	119,748	119,748	16
17	Accumulated Depreciation (book methods)	(6,558)	(1,380,950)	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	620,083	620,083	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 868,560	$ 2,754,654	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,376,894	$ 10,405,457	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 728,386	$ 728,386	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,183	33,183	28
29	Short-Term Notes Payable	1,725,000	1,725,000	29
30	Accrued Salaries Payable	184,457	184,457	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,951	13,951	31
32	Accrued Real Estate Taxes(Sch.IX-B)		332,194	32
33	Accrued Interest Payable		16,220	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,500	4,500	35
	Other Current Liabilities(specify):			
36	See Attached Schedule		1,620,773	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,689,477	$ 4,658,664	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,385,011	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)**	$	$ 3,385,011	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,689,477	$ 8,043,675	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,687,417	$ 2,361,782	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,376,894	$ 10,405,457	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Applewood Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 03/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,230,000	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,230,000	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	457,417	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 457,417	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)**	$ 1,687,417	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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	$ 6,540,867	1
2	Discounts and Allowances for all Levels	(1,611,020)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,929,847	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,526,860	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,526,860	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,976	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,615	19
20	Radiology and X-Ray	403	20
21	Other Medical Services	45,100	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 268,094	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	366	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 366	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	43,203	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,203	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,768,370	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	877,248	31
32	Health Care	2,346,453	32
33	General Administration	1,327,782	33
	B. Capital Expense		
34	Ownership	822,983	34
	C. Ancillary Expense		
35	Special Cost Centers	754,701	35
36	Provider Participation Fee	181,786	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,310,953	40
41	**Income before Income Taxes (line 30 minus line 40)****	457,417	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 457,417	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.**

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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	1,600	1,748	$ 61,188	$ 35.00	1
2	Assistant Director of Nursing	1,611	1,755	57,062	32.51	2
3	Registered Nurses	12,045	12,807	386,061	30.15	3
4	Licensed Practical Nurses	17,415	18,249	456,963	25.04	4
5	CNAs & Orderlies	56,397	59,310	626,910	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,709	8,081	121,128	14.99	8
9	Activity Director	1,599	1,792	25,994	14.51	9
10	Activity Assistants	6,182	6,566	55,941	8.52	10
11	Social Service Workers	1,886	1,997	28,721	14.39	11
12	Dietician					12
13	Food Service Supervisor	1,654	1,822	34,105	18.72	13
14	Head Cook	4,652	4,985	63,039	12.65	14
15	Cook Helpers/Assistants	10,173	10,874	100,147	9.21	15
16	Dishwashers					16
17	Maintenance Workers	1,645	1,784	42,028	23.56	17
18	Housekeepers	11,385	12,612	149,076	11.82	18
19	Laundry	1,361	1,426	13,621	9.55	19
20	Administrator	1,621	1,757	88,194	50.21	20
21	Assistant Administrator	1,384	1,550	28,777	18.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,396	8,868	120,015	13.53	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	4,709	5,267	131,424	24.95	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,305	2,424	25,618	10.57	33
34	TOTAL (lines 1 - 33)	155,728	165,673	$ 2,616,012 *	$ 15.79	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	Monthly	$ 9,390	01-03	35
36	Medical Director	Monthly	25,000	09-03	36
37	Medical Records Consultant	Monthly	1,920	10-03	37
38	Nurse Consultant	Monthly	23,000	10-03	38
39	Pharmacist Consultant	Monthly	5,566	10-03	39
40	Physical Therapy Consultant	26	1,460	10a-03	40
41	Occupational Therapy Consultant	11	645	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	722	10a-03	43
44	Activity Consultant	Monthly	1,020	11-03	44
45	Social Service Consultant		1,291	12-03	45
46	Other(specify) Specialized Rehab	Monthly	11,500	12-03	46
47	Food Service Director	Monthly	11,500	01-03	47
48					48
49	TOTAL (lines 35 - 48)	51	$ 93,014		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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dianne O'Connor	Administrator	0	$ 88,194
Patricia Swick	Asst Admin	0	28,777
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,971

B. Administrative - Other

Description	Amount
Management Fees	$ 297,734
Dir of Admin Services	23,000
Ancillary Admin Charges	23,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 343,734
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 1,430
Personnel Planners	Unemployment Tax Consult.	2,390
Consulting Solutions	Engineering Services	2,100
See Attached	Legal	21,257
SIR Management	Admin. Legal Services	11,500
SIR Management	Accounting/ Bookkeeping	72,550
HDSI	Data Processing	2,795
Ehealth Data Solutions	MDS Softare	80
Bock & Clark	Property Survey	1,800
MDI Achieve	Data Processing	4,250
Pinnacle Consulting	Customer Satisfaction	2,504
See Supplemetal Schedule		1,410
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 124,066

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,541
Unemployment Compensation Insurance	32,383
FICA Taxes	192,724
Employee Health Insurance	79,876
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benfits-Other	8,672
TOTAL (agree to Schedule V, line 22, col.8)	$ 398,197

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	477
Health Care Worker Background Check	3,751
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	3,736
License & Permits	3,203
Allocated from SIR Management	548
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,715

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,548
Allocated from SIR Management	327
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,875

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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 Rehabilitation Center, Llc # 0051359 Report Period Beginning: 03/01/11 Ending: 12/31/11

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? **Yes**
If YES, give association name and amount. **ICLTC $2,458**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,700** 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. $ **181,786**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** 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? **100% line 14**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.