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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: [redacted]

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: slavenda@frrcpas.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	42,090	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	42,090	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	26,184	3,211	7,201	36,596	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,184	3,211	7,201	36,596	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.95%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 5,115

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

* 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: 01/01/12 Ending: 12/31/12

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	231,938	61,306	23,028	316,272		316,272	(10,286)	305,986			1
2	Food Purchase		195,946		195,946		195,946	(171)	195,775			2
3	Housekeeping	176,389	36,466		212,855		212,855		212,855			3
4	Laundry	30,673	12,264	34,956	77,893		77,893		77,893			4
5	Heat and Other Utilities			162,402	162,402		162,402	(14,516)	147,886			5
6	Maintenance	51,566	30,720	89,756	172,042		172,042	3,319	175,361			6
7	Other (specify):*							3,441	3,441			7
8	TOTAL General Services	490,566	336,702	310,142	1,137,410		1,137,410	(18,213)	1,119,197			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,956,587	253,179	42,696	2,252,462		2,252,462	(20,322)	2,232,140			10
10a	Therapy	159,779	764	7,703	168,246		168,246	(5,728)	162,518			10a
11	Activities	99,973	5,736	816	106,525		106,525		106,525			11
12	Social Services	43,863		11,040	54,903		54,903		54,903			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,028	3,028			15
16	TOTAL Health Care and Programs	2,260,202	259,679	92,255	2,612,136		2,612,136	(23,022)	2,589,114			16
	C. General Administration											
17	Administrative	148,045		416,581	564,626		564,626	(358,843)	205,783			17
18	Directors Fees											18
19	Professional Services			163,222	163,222	(15,031)	148,191	(103,821)	44,370			19
20	Dues, Fees, Subscriptions & Promotions			48,168	48,168		48,168	(6,354)	41,814			20
21	Clerical & General Office Expenses	123,827	30,560	281,960	436,347		436,347	(157,426)	278,921			21
22	Employee Benefits & Payroll Taxes			505,051	505,051		505,051		505,051			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,001	3,001		3,001	351	3,352			24
25	Other Admin. Staff Transportation			1,877	1,877		1,877	5,283	7,160			25
26	Insurance-Prop.Liab.Malpractice			84,511	84,511		84,511	873	85,384			26
27	Other (specify):*							25,917	25,917			27
28	TOTAL General Administration	271,872	30,560	1,504,371	1,806,803	(15,031)	1,791,772	(594,021)	1,197,751			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,022,640	626,941	1,906,768	5,556,349	(15,031)	5,541,318	(635,256)	4,906,062			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: 01/01/12 Ending: 12/31/12

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			18,653	18,653		18,653	65,766	84,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,180	26,180		26,180	182,459	208,639			32
33	Real Estate Taxes			318,000	318,000	15,031	333,031	98,180	431,211			33
34	Rent-Facility & Grounds			592,897	592,897		592,897	(592,897)				34
35	Rent-Equipment & Vehicles			3,722	3,722		3,722	3,370	7,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			959,452	959,452	15,031	974,483	(243,122)	731,361			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,245	581,922	816,167		816,167	(583)	815,584			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,017	261,017		261,017		261,017			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		234,245	842,939	1,077,184		1,077,184	(583)	1,076,601			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,022,640	861,186	3,709,159	7,592,985		7,592,985	(878,961)	6,714,024			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: 01/01/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,818)	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	(10,634)	30		9
10	Interest and Other Investment Income	(554)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	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	(1,750)	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	(196,800)	21		24
25	Fund Raising, Advertising and Promotional	(4,861)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,346)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (262,934)		$	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)	(616,027)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (616,027)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (878,961)		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

STATE OF ILLINOIS

Applewood Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (4,974)	21	1
2	Collections	(3,696)	19	2
3	Bank Fees	(5,944)	21	3
4	Lobbying	(433)	19	4
5	Theft & Damage	(439)	21	5
6	State Replacement Tax	(3,700)	21	6
7	Additional R&M	11,194	06	7
8	Non-allowable Legal Fees	(5,936)	19	8
9	Management Fee - Bldg Co.	(5,750)	21	9
10	Accounting Fee - Bldg. Co.	(1,650)	19	10
11	Bank Fees - Bldg. Co.	(73)	21	11
12	Filing Fees - Bldg. Co.	(250)	20	12
13	Amortization - Bldg. Co.	(10,694)	36	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**	(32,346)		49

Applewood Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 01/01/12

Ending: 12/31/12

	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: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary				(9,948)			(338)					(10,286)	1
2	Food Purchase	(171)											(171)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(15,818)			1,302								(14,516)	5
6	Maintenance	11,194		(9,039)	1,164								3,319	6
7	Other (specify):*			373	3,068								3,441	7
8	**TOTAL General Services**	(4,795)		(8,666)	(4,414)			(338)					(18,213)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(24,579)	4,257								(20,322)	10
10a	Therapy				(5,728)								(5,728)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,437	1,591								3,028	15
16	**TOTAL Health Care and Programs**			(23,142)	120								(23,022)	16
	C. General Administration													
17	Administrative			(402,029)	43,186								(358,843)	17
18	Directors Fees													18
19	Professional Services	(11,715)	1,650	(102,044)	8,288								(103,821)	19
20	Fees, Subscriptions & Promotions	(6,861)	250	257									(6,354)	20
21	Clerical & General Office Expenses	(217,680)	5,823	54,391	40								(157,426)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			351									351	24
25	Other Admin. Staff Transportation			5,283									5,283	25
26	Insurance-Prop.Liab.Malpractice			804	69								873	26
27	Other (specify):*			16,500	9,417								25,917	27
28	**TOTAL General Administration**	(236,257)	7,723	(426,487)	61,000								(594,021)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(241,052)	7,723	(458,295)	56,706			(338)					(635,256)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,634)	71,427		4,973								65,766	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(554)	183,759	(4,419)	3,673								182,459	32
33	Real Estate Taxes		96,213		1,967								98,180	33
34	Rent-Facility & Grounds		(592,897)										(592,897)	34
35	Rent-Equipment & Vehicles			3,370									3,370	35
36	Other (specify):*	(10,694)	10,694											36
37	TOTAL Ownership	(21,882)	(230,804)	(1,049)	10,613								(243,122)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(583)					(583)	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							(583)					(583)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(262,934)	(223,081)	(459,344)	67,319			(921)					(878,961)	45

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

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	Rental Income	$ 592,897	Applewood Property, LLC	100.00%	$	$ (592,897)	1
2	V	33	Property Tax	318,000	Applewood Property, LLC	100.00%		(318,000)	2
3	V	32	CIK Investments	6,000	Applewood Property, LLC	100.00%		(6,000)	3
4	V	21	Management Fee		Applewood Property, LLC	100.00%	5,750	5,750	4
5	V	19	Accounting Fee		Applewood Property, LLC	100.00%	1,650	1,650	5
6	V	21	Bank Service Charge		Applewood Property, LLC	100.00%	73	73	6
7	V	20	Filing Fees		Applewood Property, LLC	100.00%	250	250	7
8	V	30	Depreciation Expense		Applewood Property, LLC	100.00%	71,427	71,427	8
9	V	36	Amortization Expense		Applewood Property, LLC	100.00%	10,694	10,694	9
10	V	33	Real Estate Tax Expense		Applewood Property, LLC	100.00%	414,213	414,213	10
11	V	32	Interest Expense		Applewood Property, LLC	100.00%	189,759	189,759	11
12	V								12
13	V								13
14	Total			$ 916,897			$ 693,816	$ * (223,081)	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: 01/01/12 Ending: 12/31/12

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.	$ 13,800	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,761	$ (9,039)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	373	373	16
17	V	10	NURSING	33,120	S.I.R. MANAGEMENT, INC.	100.00%	8,541	(24,579)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,437	1,437	18
19	V	19	PROFESSIONAL FEES	109,140	S.I.R. MANAGEMENT, INC.	100.00%	6,976	(102,164)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	257	257	20
21	V	21	CLERICAL & GENERAL	33,120	S.I.R. MANAGEMENT, INC.	100.00%	32,577	(543)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	351	351	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,283	5,283	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	804	804	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,764	5,764	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(4,419)	(4,419)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,370	3,370	27
28	V								28
29	V	17	ADMINISTRATIVE	416,581	S.I.R. MANAGEMENT, INC.	100.00%	14,552	(402,029)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	120	120	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	54,934	54,934	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,736	10,736	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 605,761			$ 146,417	$ * (459,344)	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: 01/01/12 Ending: 12/31/12

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	$ 13,800	S.I.R. MANAGEMENT, INC.	100.00%	$ 3,852	$ (9,948)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	653	653	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	4,257	4,257	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	716	716	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	43,186	43,186	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	8,257	8,257	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	9,417	9,417	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	11,040	S.I.R. MANAGEMENT, INC.	100.00%	5,312	(5,728)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	875	875	25
26	V								26
27	V	6	MAINTENANCE SALARIES	12,420	S.I.R. MANAGEMENT, INC.	100.00%	13,281	861	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,415	2,415	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,302	1,302	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	303	303	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	31	31	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	40	40	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	69	69	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,973	4,973	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,673	3,673	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,967	1,967	37
38	V								38
39	Total			$ 37,260			$ 104,579	$ * 67,319	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: 01/01/12 Ending: 12/31/12

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%	$ 68,218	$ 68,218	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	68,218	CCS Employee Benefits Group	100.00%		(68,218)	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			$ 68,218			$ 68,218	$ *	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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary	$ 2,754	Long Term Care Laboratory, LLC	100.00%	$ 2,754	$	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			$ 2,754			$ 2,754	$ *	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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 1,207	Care Centers Health Systems, Inc.	100.00%	$ 869	$ (338)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	2,080	Care Centers Health Systems, Inc.	100.00%	1,497	(583)	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			$ 3,287			$ 2,366	$ * (921)	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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY 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 CENTER HEALTH SYSTE	EVANSTON	DIETARY & FOOD SUPPI	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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	Elka Abramchick	Relative	Clerical	N/A	See Attached	1.37	4.28%	Alloc. Salary	$ 1,901	21-7	1
2	Joey Abramchik	Owner	Administrative	1.57	See Attached	1.93	4.29%	Alloc. Salary	8,257	17-7	2
3	Bryan Barrish	Relative	Administrative	N/A	See Attached	1.72	3.82%	Alloc. Salary	8,581	17-7	3
4	Kirsten Barrish	Relative	Clerical	N/A	See Attached	1.72	4.30%	Alloc. Salary	1,999	21-7	4
5	Sarah Barrish	Owner	Administrative	1.57	See Attached	2.15	4.30%	Alloc. Salary	5,189	17-7	5
6	Louise Bergthold	Owner	Administrative	1.57	See Attached	2.57	4.28%	Alloc. Salary	8,581	17-7	6
7	Michael Giannini	Relative	Administrative	N/A	See Attached	1.5	3.75%	Alloc. Salary	7,208	17-7	7
8	Nenita Guzman	Relative	Dietary	N/A	See Attached	2.15	4.30%	Alloc. Salary	3,852	1-7	8
9	Patricia Mcdiarmid	Owner	Administrative	1.57	See Attached	2.15	4.30%	Alloc. Salary	5,907	17-7	9
10	Ronald Nunziatio	Owner	Administrative	1.57	See Attached	1.72	4.30%	Alloc. Salary	7,163	17-7	10
11	Adam Vales	Relative	Clerical	N/A	See Attached	0.45	1.13%	Alloc. Salary	828	22-7	11
12	See second page 7 for the detail of the additional owner and related compensation								8,763		12
13								TOTAL	$ 68,229		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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	852,976	13	$ 110,978	$ 47,841	36,596	$ 4,761	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		36,596	373	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	36,596	8,541	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		36,596	1,437	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	36,596	6,976	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		36,596	257	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	36,596	32,577	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		36,596	351	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		36,596	5,283	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		36,596	804	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		36,596	5,764	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		36,596	(4,419)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		36,596	3,370	13
14									14	
15	17	ADMINISTRATIVE PATIENT	DAYS	852,976	13	339,187	339,187	36,596	14,552	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		36,596	120	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	36,596	54,934	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		36,596	10,736	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,412,714	$ 2,543,620		$ 146,417	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	852,976	13	$ 89,778	$ 89,778	36,596	$ 3,852	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		36,596	653	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	36,596	4,257	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		36,596	716	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	36,596	43,186	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		36,596	8,257	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		36,596	9,417	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	11,040	5,312	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		11,040	875	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	12,420	13,281	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		12,420	2,415	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		553	1,302	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		553	303	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		553	31	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		553	40	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		553	69	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		553	4,973	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		553	3,673	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		553	1,967	23
24										24
25	TOTALS					$ 2,596,289	$ 1,763,707		$ 104,579	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 68,218	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					$	$		$ 68,218	25

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

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: Long Term Care Laboratory, LLC
Street Address: 2458 Elmhurst Road
City / State / Zip Code: Elk Grove Village, IL 60007
Phone Number: (630)422-7800
Fax Number: (847)422-1360

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Direct Allocation			$	$		$ 2,754	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					$	$		$ 2,754	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 869	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						1,497	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					$	$		$ 2,366	25

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

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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			$	$ 3,226,982			$ 189,759	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				200,000			26,180	6
7	Alloc. S.I.R. Management	X									3,673	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 3,426,982			$ 219,612	9
	B. Non-Facility Related*											
10	Interest Income		X								(554)	10
11	Interest Income - Bldg. Co		X								(6,000)	11
12	Alloc. S.I.R. Management	X									(4,419)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (10,973)	14
15	TOTALS (line 9+line14)						$	$ 3,426,982			$ 208,639	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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 332,194	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.)		$ 366,067	2
3. Under or (over) accrual (line 2 minus line 1).		$ 33,873	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 382,306	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.		$ 15,031	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 431,210	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	287,569	8
	2008	296,831	9
	2009	315,044	10
	2010	316,375	11
	2011	364,100	12

2012 Accrual = $364,100 x 1.05 = $382,306

Allocated from S.I.R. Management = $1,967

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 10,702.92	$ 10,702.92
2.	31-22-114-024-0000	Long Term Care Property	$ 335,541.59	$ 335,541.59
3.	31-22-114-025-0000	Long Term Care Property	$ 4,731.97	$ 4,731.97
4.	31-22-114-026-0000	Long Term Care Property	$ 13,124.16	$ 13,124.16
5.	See Attached	Allocated from SIR Management	$ 101,165.17	$ 3,401.91
6.		$		$
7.		$		$
8.		$		$
9.		$		$
10.		$		$
		TOTALS	$ 465,265.81	$ 367,502.55

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	115		2003	1967	$ 1,977,860	$ 71,427	39	$ 50,714	$ (20,713)	$ 1,977,860	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	17,643		20	220	220	13,486	9
10	Various			2004	30,750		20	323	323	14,693	10
11	Various			2005	51,157		20	426	426	16,552	11
12	Various			2006	390,382		20	2,489	2,489	179,535	12
13	Various			2007	154,735		20	2,153	2,153	98,924	13
14	Various			2008	4,000		20	56	56	1,278	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: 01/01/12 Ending: 12/31/12

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
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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)		77,817	2,618		3,212	594	32,109	68
69	Financial Statement Depreciation			18,653			(18,653)		69
70	TOTAL (lines 4 thru 69)		$ 2,704,344	$ 92,698		$ 59,592	$ (33,106)	$ 2,334,437	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: 01/01/12 Ending: 12/31/12

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		$ 2,704,344	$ 92,698		$ 59,592	$ (33,106)	$ 2,334,437	1
2	Valve Repair	2009	6,100		20	51	51	763	2
3	Painting	2009	5,494		20	46	46	778	3
4	Replacement Door And Frame	2009	3,900		20	33	33	504	4
5	New Door Frame And Window	2010	3,500		20	29	29	365	5
6	Water Heater	2011	7,493		20	749	749	1,374	6
7	Window A/C/ Units And Sleeves	2011	39,931		20	3,993	3,993	6,322	7
8	Electric Upgrade	2011	59,662		20	2,983	2,983	4,723	8
9	Asphalt Work	2011	12,490		20	625	625	937	9
10	Masonry Cut-Out A/C Units	2011	32,962		20	1,648	1,648	2,609	10
11	Fire Doors	2011	22,680		20	1,134	1,134	1,229	11
12	Water Main Break	2012	16,650		20	208	208	208	12
13	Water Main Break	2012	34,140		20	285	285	285	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)		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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: 01/01/12 Ending: 12/31/12

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		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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: 01/01/12 Ending: 12/31/12

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		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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: 01/01/12 Ending: 12/31/12

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		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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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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)		$ 2,949,346	$ 92,698		$ 71,375	$ (21,323)	$ 2,354,533	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: 01/01/12 Ending: 12/31/12

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
19									19
20									20
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24									24
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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: 01/01/12 Ending: 12/31/12

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 - S.I.R. Management	2009	10,735		39	275	275	837	3
4	Allocated- S.I.R. Properties - S.I.R. Management	1993	19,437	617	35	555	(62)	10,829	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	4,928	137	20	244	107	4,886	9
10	Allocated - S.I.R. Management	1994	15		20			15	10
11	Allocated - S.I.R. Management	1995	113		20	6	6	98	11
12	Allocated - S.I.R. Management	1997	7,572	170	20	371	201	5,971	12
13	Allocated - S.I.R. Management	1999	595		20	30	30	394	13
14	Allocated - S.I.R. Management	2000	703		20	35	35	441	14
15	Allocated - S.I.R. Management	2007	2,259	154	20	113	(41)	587	15
16	Allocated - S.I.R. Management	2008	6,224	595	20	392	(203)	1,901	16
17	Allocated - S.I.R. Management	2009	15,467	141	20	773	632	2,509	17
18	Allocated - S.I.R. Management	2011	383	38	20	38		54	18
19	Allocated - S.I.R. Management	2012	1,225	26	20	26		26	19
20									20
21	Allocated- S.I.R. Properties - S.I.R. Management	2012	1,191	633	20	5	(628)	5	21
22	Allocated- S.I.R. Properties - S.I.R. Management	2010	1,173		20	59	59	137	22
23	Allocated- S.I.R. Properties - S.I.R. Management	2009	1,167	73	20	58	(15)	222	23
24	Allocated- S.I.R. Properties - S.I.R. Management	2007	340	27	20	17	(10)	102	24
25	Allocated- S.I.R. Properties - S.I.R. Management	2002	77		20	4	4	41	25
26	Allocated- S.I.R. Properties - S.I.R. Management	1999	2,463		20	123	123	1,662	26
27	Allocated- S.I.R. Properties - S.I.R. Management	1998	1,177		20	59	59	853	27
28	Allocated- S.I.R. Properties - S.I.R. Management	1997	73		20	4	4	60	28
29	Allocated- S.I.R. Properties - S.I.R. Management	1994	185	5	20	9	4	171	29
30	Allocated- S.I.R. Properties - S.I.R. Management	1993	315	2	20	16	14	308	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: 01/01/12 Ending: 12/31/12

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
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 77,817	$ 2,618		$ 3,212	$ 594	$ 32,109	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: 01/01/12 Ending: 12/31/12

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	$ 141,020	$ 2,055	$ 11,646	$ 9,591	10	$ 44,067	71
72	Current Year Purchases	18,066	87	1,170	1,083	10	1,170	72
73	Fully Depreciated Assets	814,533				10	814,533	73
74								74
75	TOTALS	$ 973,619	$ 2,142	$ 12,816	$ 10,674		$ 859,771	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 S.I.R. Management	2011	$ 1,509	$ 214	$ 229	$ 15	5	$ 528	76
77										77
78										78
79										79
80	TOTALS			$ 1,509	$ 214	$ 229	$ 15		$ 528	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)	$ 4,148,099	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,054	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,420	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,634)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,214,832	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	Legat Architect	$ 49,352	92
93			93
94			94
95		$ 49,352	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 7,092 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: 01/01/12 Ending: 12/31/12

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: 01/01/12 Ending: 12/31/12

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	$		$ 221,854	$		$ 221,854	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			89,781			89,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			270,287			270,287	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				174,282		174,282	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						59,963		59,963	13
14	TOTAL			$		$ 581,922	$ 234,245		$ 816,167	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: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 38,900	$ 136,257	1
2	Cash-Patient Deposits	29,829	29,829	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,108,292	2,491,194	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,053	36,053	6
7	Other Prepaid Expenses	4,462	4,462	7
8	Accounts Receivable (owners or related parties)		3,923,329	8
9	Other(specify): See Attached Schedule		(87,113)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,217,536	$ 6,534,011	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	186,077	186,077	15
16	Equipment, at Historical Cost	147,805	147,805	16
17	Accumulated Depreciation (book methods)	(25,211)	(1,471,030)	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	624,352	624,352	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 933,023	$ 2,747,690	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,150,559	$ 9,281,701	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 593,596	$ 593,596	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,829	29,829	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	211,110	211,110	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,421	23,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)		382,306	32
33	Accrued Interest Payable		15,463	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,200	8,200	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	102,322	1,171,280	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,168,478	$ 2,635,205	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,226,982	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)**	$	$ 3,226,982	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,168,478	$ 5,862,187	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,982,081	$ 3,419,514	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,150,559	$ 9,281,701	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,687,417	1
2	Restatements (describe):		2
3	Partners Capital	20,000	3
4	Rounding 2		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,707,419	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	401,662	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	(127,000)	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)**	$ 274,662	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)**	$ 1,982,081	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: 01/01/12 Ending: 12/31/12

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,625,304	1
2	Discounts and Allowances for all Levels	(2,014,267)	
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,611,037	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,918,370	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,918,370	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	173,574	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,354	19
20	Radiology and X-Ray	3,305	20
21	Other Medical Services	116,587	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 304,820	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	554	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 554	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	159,866	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 159,866	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,994,647	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,137,410	31
2	Health Care	2,612,136	32
33	General Administration	1,806,803	33
	B. Capital Expense		
34	Ownership	959,452	34
	C. Ancillary Expense		
35	Special Cost Centers	816,167	35
36	Provider Participation Fee	261,017	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,592,985	40
41	**Income before Income Taxes (line 30 minus line 40)****	401,662	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 401,662	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,005,654	44
45	Private Pay - Net Inpatient Revenue	565,049	45
46	Medicare - Net Inpatient Revenue	718,816	46
47	Other-(specify) Hospice 235,495		47
48	Other-(specify) HMO/Insurance	86,023	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,611,037	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,595	1,673	$ 66,193	$ 39.57	1
2	Assistant Director of Nursing	1,167	1,253	42,813	34.17	2
3	Registered Nurses	15,721	16,608	491,644	29.60	3
4	Licensed Practical Nurses	17,014	18,353	452,702	24.67	4
5	CNAs & Orderlies	65,591	69,033	732,316	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,240	9,693	159,779	16.48	8
9	Activity Director	1,948	2,091	31,225	14.93	9
10	Activity Assistants	7,701	8,100	68,748	8.49	10
11	Social Service Workers	3,099	3,261	43,863	13.45	11
12	Dietician					12
13	Food Service Supervisor	1,937	2,091	40,311	19.28	13
14	Head Cook	5,729	6,203	78,943	12.73	14
15	Cook Helpers/Assistants	11,550	12,577	112,684	8.96	15
16	Dishwashers					16
17	Maintenance Workers	1,942	2,121	51,566	24.31	17
18	Housekeepers	13,638	14,999	176,389	11.76	18
19	Laundry	3,104	3,282	30,673	9.35	19
20	Administrator	1,764	2,091	104,719	50.08	20
21	Assistant Administrator	1,961	2,261	43,326	19.16	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,152	7,569	123,827	16.36	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	5,067	5,617	142,570	25.38	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,488	2,617	28,349	10.83	33
34	TOTAL (lines 1 - 33)	179,408	191,493	$ 3,022,640 *	$ 15.78	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	$ 9,228	01-03	35
36	Medical Director	Monthly 30,000		09-03	36
37	Medical Records Consultant	Monthly 2,352		10-03	37
38	Nurse Consultant	Monthly 33,120		10-03	38
39	Pharmacist Consultant	Monthly 7,224		10-03	39
40	Physical Therapy Consultant	1,320	1,320	10a-03	40
41	Occupational Therapy Consultant	540	540	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5,843	5,843	10a-03	43
44	Activity Consultant	Monthly	816	11-03	44
45	Social Service Consultant				45
46	Other(specify)			12-03	46
47	Director of Food Service	Monthly	13,800	01-03	47
48	Specailized Rehab	Monthly	11,040	12-03	48
49	TOTAL (lines 35 - 48)	7,703	$ 115,283		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dianne O'Connor	Administrator	0	$ 104,719
Patricia Swick	Asst. Admin	0	43,325
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,044

B. Administrative - Other

Description	Amount
SIR Management -Consulting Fees	$ 350,461
SIR Management - Dir. Of Admin Services	33,120
SIR Management - Ancillary Admin Charges	33,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 416,581
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir. Of Regulatory Service	$ 16,560
SIR Management	Accounting Fees	36,000
SIR Management	Bookkeeping	56,580
Pinnacle Consulting	Customer Satisfaction	2,731
FR&R	Accounting 17,643	
Personnel Planners	Unemployement Consulting	2,690
Ehealth Data	MDS Software	3,600
The Compliance Team	WOTC Consulting	898
Allen A Lefkovitz	R/E Tax Assessment	12,526
Legat Architects	Consulting Services	1,473
Lobbying	ADJ PG5A	433
See Supplemetal Schedule		12,089
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 163,223

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,708
Unemployment Compensation Insurance	80,360
FICA Taxes	223,454
Employee Health Insurance	89,024
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Contributions	4,392
Other Employee Benefits	7,113
TOTAL (agree to Schedule V, line 22, col.8)	$ 505,051

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	$ 1,992
Advertising: Employee Recruitment	22,093
Health Care Worker Background Check	2,985
(Indicate # of checks performed 299)	
Patient Background Checks	
Advertising & Promotions	4,861
Dues & Subscriptions	4,894
ICLTC	8,718
License & Permits	875
See Supplemental Schedule	257
Less: Public Relations Expense	( )
Non-allowable advertising	(4,861)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,814

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,001
Allocated from S.I.R. Management	351
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,352

* Attach copy of IMRF notifications

**See instructions.

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

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: 01/01/12 Ending: 12/31/12

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 $8,718**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,054** 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. $ **261,017**
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. $ **None** 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 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.