

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>23,460</u>	<u>6,610</u>	<u>8,274</u>	<u>38,344</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,460</u>	<u>6,610</u>	<u>8,274</u>	<u>38,344</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.35%

D. How many bed-hold days during this year were paid by the Department?

55 (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)

NoneF. 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 2/1/2003

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2/1/2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter numberof beds certified 115 and days of care provided 8,001Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	221,067	35,280	9,804	266,151		266,151	(11,595)	254,556		1
2	Food Purchase		173,962		173,962		173,962	(97)	173,865		2
3	Housekeeping	141,000	25,541		166,541		166,541	(1,735)	164,806		3
4	Laundry	51,875	22,929		74,804		74,804	(170)	74,634		4
5	Heat and Other Utilities			99,478	99,478		99,478	2,051	101,529		5
6	Maintenance	78,490		88,956	167,446		167,446	43,576	211,022		6
7	Other (specify):*							5,064	5,064		7
8	TOTAL General Services	492,432	257,712	198,238	948,382		948,382	37,094	985,476		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	2,035,456	129,631	2,680	2,167,767		2,167,767	7,947	2,175,714		10
10a	Therapy	151,146		60	151,206		151,206	1,711	152,917		10a
11	Activities	85,306	16,620	342	102,268		102,268		102,268		11
12	Social Services	125,913		572	126,485		126,485	4,913	131,398		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,136	3,136		15
16	TOTAL Health Care and Programs	2,397,821	146,251	24,654	2,568,726		2,568,726	17,707	2,586,433		16
	C. General Administration										
17	Administrative	98,824		(2,194)	96,630		96,630	55,895	152,525		17
18	Directors Fees										18
19	Professional Services			310,877	310,877	(11,816)	299,061	(227,705)	71,356		19
20	Dues, Fees, Subscriptions & Promotions			21,153	21,153		21,153	(588)	20,565		20
21	Clerical & General Office Expenses	117,555	28,255	250,796	396,606		396,606	(103,115)	293,491		21
22	Employee Benefits & Payroll Taxes			493,059	493,059		493,059	(903)	492,156		22
23	Inservice Training & Education			3,817	3,817		3,817		3,817		23
24	Travel and Seminar			2,932	2,932		2,932	2,456	5,388		24
25	Other Admin. Staff Transportation			3,104	3,104		3,104	1,158	4,262		25
26	Insurance-Prop.Liab.Malpractice			117,844	117,844		117,844	2,810	120,654		26
27	Other (specify):*							22,979	22,979		27
28	TOTAL General Administration	216,379	28,255	1,201,388	1,446,022	(11,816)	1,434,206	(247,013)	1,187,193		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,106,632	432,218	1,424,280	4,963,130	(11,816)	4,951,314	(192,212)	4,759,102		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Applewood Nursing & Rehab Center #0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			146,534	146,534		146,534	153,501	300,035		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			79,698	79,698		79,698	176,676	256,374		32
33	Real Estate Taxes			217,656	217,656	11,816	229,472	1,904	231,376		33
34	Rent-Facility & Grounds			377,775	377,775		377,775	(375,426)	2,349		34
35	Rent-Equipment & Vehicles			4,365	4,365		4,365	1,980	6,345		35
36	Other (specify):*							14,115	14,115		36
37	TOTAL Ownership			826,028	826,028	11,816	837,844	(27,250)	810,594		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		524,323	408,976	933,299		933,299	(81,980)	851,319		39
40	Barber and Beauty Shops			2,151	2,151		2,151		2,151		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			62,963	62,963		62,963		62,963		42
43	Other (specify):*							48,898	48,898		43
44	TOTAL Special Cost Centers		524,323	474,090	998,413		998,413	(33,082)	965,331		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,106,632	956,541	2,724,398	6,787,571		6,787,571	(252,544)	6,535,027		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,066)	30		9
10	Interest and Other Investment Income	(301)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(295)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,271)	21		24
25	Fund Raising, Advertising and Promotional	(5,366)	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	(123,224)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (249,523)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(3,021)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,021)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (252,544)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Sch. V Line Reference
1	Miscellaneous Income	(7,648) 21
2	Bury Dues Income	(10) 2
3	Patient Clothing	(261) 10
4	Collection Expense	(389) 21
5	Three Year and Non-Allowable Legal Expense	(1,273) 49
6	Annual Report	(250) 20
7	Non-Allowable Expense	(113,300) 21
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101	Total	(123,224) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07**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			161	2,278	(14,034)							(11,595)	1
2	Food Purchase	(295)		198									(97)	2
3	Housekeeping			302	30	19			(2,086)				(1,735)	3
4	Laundry								(170)				(170)	4
5	Heat and Other Utilities			1,438	78	535							2,051	5
6	Maintenance			43,000	10	218		402	(54)				43,576	6
7	Other (specify):*			4,848	216								5,064	7
8	TOTAL General Services	(295)		49,947	2,612	(13,262)		402	(2,310)				37,094	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(364)			17,699				(9,388)				7,947	10
10a	Therapy				1,711								1,711	10a
11	Activities													11
12	Social Services				4,913								4,913	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,136								3,136	15
16	TOTAL Health Care and Programs	(364)			27,459				(9,388)				17,707	16
	C. General Administration													
17	Administrative			9,059	31,090	4,382	11,364						55,895	17
18	Directors Fees													18
19	Professional Services	(1,273)		(166,614)	(60,516)	58	640						(227,705)	19
20	Fees, Subscriptions & Promotions	(5,616)		4,146	19	331	532						(588)	20
21	Clerical & General Office Expenses	(221,608)		101,053	8,048	7,343	3,896	(1,846)	(0)				(103,115)	21
22	Employee Benefits & Payroll Taxes			(626)					(277)				(903)	22
23	Inservice Training & Education													23
24	Travel and Seminar			701	373		1,382						2,456	24
25	Other Admin. Staff Transportation			908		250							1,158	25
26	Insurance-Prop.Liab.Malpractice			920	10	482	1,398						2,810	26
27	Other (specify):*			14,564	5,285	1,749	1,381						22,979	27
28	TOTAL General Administration	(228,497)		(35,889)	(15,691)	14,595	20,593	(1,846)	(277)				(247,013)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(229,156)		14,058	14,380	1,333	20,593	(1,444)	(11,976)				(192,212)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(20,066)	156,594	11,728	493	377	743	3,632					153,501	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(301)	144,276	22,129	2,121	628	6,920	903					176,676	32
33	Real Estate Taxes			1,717	116	71							1,904	33
34	Rent-Facility & Grounds		(377,775)	1,854		495							(375,426)	34
35	Rent-Equipment & Vehicles			244	4	121	1,611						1,980	35
36	Other (specify):*		14,115										14,115	36
37	TOTAL Ownership	(20,367)	(62,790)	37,672	2,734	1,692	9,274	4,535					(27,250)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(17,414)	(48,631)	(10,095)	(5,840)				(81,980)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*						48,898						48,898	43
44	TOTAL Special Cost Centers					(17,414)	267	(10,095)	(5,840)				(33,082)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(249,523)	(62,790)	51,730	17,114	(14,389)	30,134	(7,004)	(17,816)				(252,544)	45

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Applewood Property LLC		Building Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 377,775	Applewood Property LLC	100.00%	\$	\$ (377,775)	1
2	V	33 Real Estate Tax	217,656			217,656		2
3	V	32 Interest	306,604			450,880	144,276	3
4	V	36 Amortization				14,115	14,115	4
5	V	30 Depreciation				156,594	156,594	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 902,035			\$ 839,245	\$ * (62,790)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/07Ending: 12/31/07

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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 161	\$ 161	15
16	V	02	Food		Care Centers, Inc.	100.00%	198	198	16
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	302	302	17
18	V	05	Utilities		Care Centers, Inc.	100.00%	1,438	1,438	18
19	V	06	Maintenance		Care Centers, Inc.	100.00%	2,372	2,372	19
20	V	17	Administrative	(2,194)	Care Centers, Inc.	100.00%	1,437	3,631	20
21	V	19	Professional Fees	174,198	Care Centers, Inc.	100.00%	7,584	(166,614)	21
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,146	4,146	22
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	12,014	12,014	23
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	701	701	24
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	908	908	25
26	V	26	Insurance		Care Centers, Inc.	100.00%	920	920	26
27	V	30	Depreciation		Care Centers, Inc.	100.00%	11,728	11,728	27
28	V	32	Interest		Care Centers, Inc.	100.00%	22,129	22,129	28
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,717	1,717	29
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	1,854	1,854	30
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	244	244	31
32	V	06	Maintenance	4	Care Centers, Inc.	100.00%	40,632	40,628	32
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	4,848	4,848	33
34	V	17	Administrative		Care Centers, Inc.	100.00%	5,428	5,428	34
35	V	21	Office and Clerical		Care Centers, Inc.	100.00%	89,039	89,039	35
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	14,564	14,564	36
37	V	22	Employee Benefits	626	Care Centers, Inc.	100.00%		(626)	37
38	V								38
39	Total			\$ 172,634			\$ 224,364	\$ * 51,730	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/07Ending: 12/31/07

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 30	\$ 30	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	78	78	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	10	10	17	
18	V	19	Professional Fees	61,813	Care Centers Clinical, Inc.	100.00%	1,297	(60,516)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	19	19	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	76	76	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	373	373	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	10	10	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	493	493	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	2,121	2,121	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	116	116	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	4	4	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	2,278	2,278	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	216	216	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	17,699	17,699	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,711	1,711	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	4,913	4,913	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	3,136	3,136	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	31,090	31,090	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	7,972	7,972	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	5,285	5,285	35	
36	V	22	Employee Benefits		Care Centers Clinical, Inc.	100.00%			36	
37	V								37	
38	V								38	
39	Total			\$ 61,813			\$ 78,927	\$ * 17,114	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/07Ending: 12/31/07

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary		Care Centers Health Systems, Inc.	100.00%	\$ 2,667	\$ 2,667	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	19	19	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	535	535	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	218	218	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	58	58	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	331	331	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,145	1,145	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	250	250	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	482	482	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	377	377	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	628	628	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	71	71	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	495	495	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	121	121	28	
29	V	01	Dietary	24,864	Care Centers Health Systems, Inc.	100.00%	8,163	(16,701)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing		Care Centers Health Systems, Inc.	100.00%			32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	25,925	Care Centers Health Systems, Inc.	100.00%	8,511	(17,414)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	4,382	4,382	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	6,198	6,198	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,749	1,749	38	
39	Total			\$ 50,789			\$ 36,400	\$ * (14,389)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Administration	\$	Therapy Works Rehabilitation Services, LLC	100.00%	\$ 795	\$ 795	15
16	V	19 Professional Fees		Therapy Works Rehabilitation Services, LLC	100.00%	640	640	16
17	V	20 Dues and Subscriptions		Therapy Works Rehabilitation Services, LLC	100.00%	532	532	17
18	V	21 Office & Clerical		Therapy Works Rehabilitation Services, LLC	100.00%	3,896	3,896	18
19	V	24 Travel and Seminar		Therapy Works Rehabilitation Services, LLC	100.00%	1,382	1,382	19
20	V	26 Insurance		Therapy Works Rehabilitation Services, LLC	100.00%	1,398	1,398	20
21	V	30 Depreciation		Therapy Works Rehabilitation Services, LLC	100.00%	743	743	21
22	V	32 Interest		Therapy Works Rehabilitation Services, LLC	100.00%	6,920	6,920	22
23	V	35 Rent - Equipment		Therapy Works Rehabilitation Services, LLC	100.00%	1,611	1,611	23
24	V	39 Ancillary		Therapy Works Rehabilitation Services, LLC	100.00%	18,661	18,661	24
25	V	17 Administrative		Therapy Works Rehabilitation Services, LLC	100.00%	10,569	10,569	25
26	V	27 Emp. Ben. - Gen. Admin.		Therapy Works Rehabilitation Services, LLC	100.00%	1,381	1,381	26
27	V	39 Ancillary	406,721	Therapy Works Rehabilitation Services, LLC	100.00%	339,429	(67,292)	27
28	V	43 Emp. Ben. - Other		Therapy Works Rehabilitation Services, LLC	100.00%	48,898	48,898	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		\$ 406,721			\$ 436,855	\$ * 30,134	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 402	\$ 402	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	3,168	3,168	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	265	265	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	464	464	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	638	638	20
21	V	21	Office and Clerical	1,846	Vent Lease, LLC.	100.00%		(1,846)	21
22	V	39	Ancillary	10,095	Vent Lease, LLC.	100.00%		(10,095)	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		\$ 11,941				\$ 4,937	\$ * (7,004)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	25,869	Xcel Supply, LLC	100.00%	23,782	(2,086)	16
17	V	4 Laundry	2,102	Xcel Supply, LLC	100.00%	1,932	(170)	17
18	V	6 Repairs & Maintenance	675	Xcel Supply, LLC	100.00%	621	(54)	18
19	V	10 Nursing	116,401	Xcel Supply, LLC	100.00%	107,013	(9,388)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical	4	Xcel Supply, LLC	100.00%	4	(0)	23
24	V	22 Employee Benefits	3,435	Xcel Supply, LLC	100.00%	3,158	(277)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	72,413	Xcel Supply, LLC	100.00%	66,572	(5,840)	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		\$ 220,899			\$ 203,083	\$ * (17,816)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 219,857	\$ 219,857	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	219,857	CCS Employee Benefits Group	100.00%		(219,857)	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			\$ 219,857			\$ 219,857	\$ *	39

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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 Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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 Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	1.00	See Attached	0.79	1.71%		\$		1
2	Mark Steinberg	Relative	Administrative		See Attached	1.3	2.36%	Salary Alloc.	3,184	17-7	2
3	Adam Vales	Relative	Clerical		See Attached	1.36	3.40%	Salary Alloc.	1,892	22-7	3
4	Kim Rudolph	Relative	Clerical		See Attached	1.19	3.40%	Salary Alloc.	1,041	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,117		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 38,297	\$ 161	1
2	02	Food	Patient Days	1,625,640	33	8,403	38,297	198	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	38,297	302	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	38,297	1,438	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	38,297	2,372	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	38,297	1,437	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	38,297	7,584	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	38,297	4,146	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	38,297	12,014	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	38,297	701	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	38,297	908	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	38,297	920	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	38,297	11,728	13
14	32	Interest	Patient Days	1,625,640	33	939,326	38,297	22,129	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	38,297	1,717	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	38,297	1,854	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	38,297	244	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	4,406	18
19	06	Maintenance	Direct Allocation			456,812	456,812	36,226	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	38,297	4,848	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	5,428	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	89,039	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346		23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	38,297	14,564	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 224,364	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 38,297	\$ 30	1
2	05	Utilities	Patient Days	1,625,640	32	3,307	38,297	78	2
3	06	Maintenance	Patient Days	1,625,640	32	410	38,297	10	3
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	38,297	1,297	4
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	38,297	19	5
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	38,297	76	6
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	38,297	373	7
8	26	Insurance	Patient Days	1,625,640	32	409	38,297	10	8
9	30	Depreciation	Patient Days	1,625,640	32	20,909	38,297	493	9
10	32	Interest	Patient Days	1,625,640	32	90,038	38,297	2,121	10
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	38,297	116	11
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	38,297	4	12
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	2,278	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	38,297	216	14
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	17,699	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	1,711	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	4,913	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	38,297	3,136	18
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	31,090	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	7,972	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	38,297	5,285	21
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22
23	12	Social Service Salary	Direct Allocation			8,845	8,845		23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			24
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 78,927	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 Care Centers Health Systems, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	4,431,674	33	94,358	125,277	2,667	1
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	125,277	19	2
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	125,277	535	3
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	125,277	218	4
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	125,277	58	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	125,277	331	6
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	125,277	1,145	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	125,277	250	8
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	125,277	482	9
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	125,277	377	10
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	125,277	628	11
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	125,277	71	12
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	125,277	495	13
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	125,277	121	14
15	01	Dietary	Direct Billable Income	341,879	33	112,243	24,864	8,163	15
16	02	Food	Direct Billable Income	25	33	8			16
17	03	Housekeeping	Direct Billable Income	29	33	10			17
18	10	Nursing	Direct Billable Income	69,616	33	22,856			18
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	25,925	8,511	21
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	4,382	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	6,198	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	125,277	1,749	24
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 36,400	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Therapy Works Rehabilitation Services, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 922-0702
 Fax Number (847) 905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administration	Billable Income	4,671,432	16	\$ 9,000	\$ 412,790	\$ 795	1
2	19	Professional Fees	Billable Income	4,671,432	16	7,245	412,790	640	2
3	20	Dues and Subscriptions	Billable Income	4,671,432	16	6,024	412,790	532	3
4	21	Office & Clerical	Billable Income	4,671,432	16	44,084	412,790	3,896	4
5	24	Travel and Seminar	Billable Income	4,671,432	16	15,640	412,790	1,382	5
6	26	Insurance	Billable Income	4,671,432	16	15,816	412,790	1,398	6
7	30	Depreciation	Billable Income	4,671,432	16	8,410	412,790	743	7
8	32	Interest	Billable Income	4,671,432	16	78,317	412,790	6,920	8
9	35	Rent - Equipment	Billable Income	4,671,432	16	18,231	412,790	1,611	9
10	39	Ancillary	Billable Income	4,671,432	16	211,187	412,790	18,661	10
11	17	Administrative	Billable Income	4,671,432	16	119,603	119,603	10,569	11
12	27	Emp. Ben. - Gen. Admin.	Billable Income	4,671,432	16	15,625	412,790	1,381	12
13	39	Ancillary	Billable Income	4,671,432	16	3,841,227	3,841,227	339,429	13
14	43	Emp. Ben. - Other	Billable Income	4,671,432	16	553,364	412,790	48,898	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 4,943,774	\$ 3,960,830	\$ 436,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	892,186	27	\$ 35,557	\$ 10,095	\$ 402	1
2	21	Office and Clerical	Direct Billing	892,186	27	44	10,095		2
3	30	Depreciation	Direct Billing	892,186	27	280,000	10,095	3,168	3
4	32	Interest	Direct Billing	892,186	27	23,404	10,095	265	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	38,297	464	5
6	32	Interest	Patient Days	1,625,640	33	27,081	38,297	638	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					\$ 385,762	\$	\$ 4,937	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					23,782	2
3	4	Laundry	Direct Allocation					1,932	3
4	6	Repairs & Maintenance	Direct Allocation					621	4
5	10	Nursing	Direct Allocation					107,013	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation					4	9
10	22	Employee Benefits	Direct Allocation					3,158	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					66,572	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				\$	\$		\$ 203,083	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 219,857	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				\$	\$		\$ 219,857	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Business Partners (Net)		X	Mortgage			\$	\$ 6,710,575		\$ 450,880	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	LaSalle Bank		X	Line of Credit				1,358,312		79,698	6									
7											7									
8	See Supplemental Schedule									32,701	8									
9	TOTAL Facility Related						\$	\$ 8,068,887		\$ 563,279	9									
B. Non-Facility Related*																				
10	Interest Income									(301)	10									
11	Interest Income (Bldg Co)									(306,604)	11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related						\$	\$		(306,905)	14									
15	TOTALS (line 9+line14)						\$	\$ 8,068,887		\$ 256,374	15									

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

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

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc-Care Centers Inc		X				\$	\$			\$ 22,129	8
9	Alloc-Care Centers Health Systems		X								628	9
10	Alloc-Care Centers Clinical		X								2,121	10
11	Alloc-Therapy Works Rehab		X								6,920	11
12	Alloc-Vent Lease		X								903	12
13												13
14	TOTAL Working Capital										32,701	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.)

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

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 Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046151

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Nursing & Rehab Center# 0046151 Report Period Beginning:01/01/07 Ending:12/31/07**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 34,449 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>191,664</u>	<u>2003</u>	<u>\$ 223,625</u>	<u>1</u>
2	<u>Allocated from Care Centers</u>			<u>9,892</u>	<u>2</u>
3	TOTALS	<u>191,664</u>		<u>\$ 233,517</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			2003	17,645		20	1,646	1,646	7,615	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		2,327,995	156,594		77,760	(78,834)	383,209	67
68		54,777	2,908		2,908		18,057	68
69			146,537			(146,537)		69
70		\$ 2,400,417	\$ 306,039		\$ 82,314	\$ (223,725)	\$ 408,881	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,400,417	\$ 306,039		\$ 82,314	\$ (223,725)	\$ 408,881	1
2	Rooftop Unit	2004	4,800		20	240	240	860	2
3	Chemical Kitchen System	2004	2,996		20	150	150	512	3
4	New Main Entrance	2004	2,250		20	113	113	375	4
5	Pedestrian Doors	2004	3,200		20	160	160	520	5
6	New Sidewalk	2004	3,250		20	163	163	528	6
7	Ductless A/C	2004	4,748		20	237	237	752	7
8	Construction Engineer Fees	2004	1,540		20	77	77	244	8
9	Roof Repair	2004	2,500		20	250	250	1,000	9
10	Backflow Maintenance	2004	710		20	71	71	278	10
11	Repair Potholes	2004	1,550		20	155	155	517	11
12	Fire Alarm System Repair	2004	1,516		20	152	152	493	12
13	A/C Repair	2004	1,690		20	169	169	549	13
14	Ac Work - Furnish And Install	2005	12,773		20	639	639	1,543	14
15	Reclass Peer Cabinet And Counter Top To Leasehold Imprv	2005	3,420		20	171	171	399	15
16	Reclass Peer Cabinet Adn Counter Top To Leasehold Imprv.	2005	7,705		20	385	385	899	16
17	Reclass Peer Cabinet And Counter Top To Leasehold Imprv	2005	14,240		20	712	712	1,661	17
18	Paint	2005	4,394		20	220	220	458	18
19	Blinds	2005	8,625		20	431	431	934	19
20	Home Office Salaries & Benefits - Painting	2006	12,424		20	2,071	2,071	12,424	20
21	Home Office Salaries & Benefits - Painting	2006	6,570		20	1,643	1,643	6,570	21
22	Home Office Salaries & Benefits - Painting	2006	5,347		20	1,782	1,782	5,347	22
23	Home Office Salaries & Benefits - Painting	2006	14,706		20	6,128	6,128	14,706	23
24	Home Office Salaries & Benefits - Painting	2006	6,556		20	3,278	3,278	6,556	24
25	Home Office Salaries & Benefits - Painting	2006	13,319		20	7,770	7,770	13,319	25
26	Byrne-Johnson Roofing - Re-Roof	2006	161,960		20	8,098	8,098	12,822	26
27	Inpro Corporation - Construction Supplies	2006	13,725		20	686	686	1,087	27
28	South Suburban Inv. 10970 - A/C Installation	2006	4,407		20	220	220	331	28
29	Greenview Construction Various Invoices - Remove & Replace Wir	2006	75,118		20	3,756	3,756	5,634	29
30	Home Office Salaries & Benefits - Painting	2006	7,107		20	4,738	4,738	7,107	30
31	Inpro Corp. Various Invoices - Installation Of Wall Covers (Sheet V	2006	8,384		20	419	419	489	31
32	Grainger Invoice #9193607158 - 100 Gallon Waterheater	2006	4,668		20	389	389	486	32
33	Schwartz Brothers Invoice #1316 - Install Concrete Floor, Ceramic	2006	16,000		20	800	800	1,000	33
34	TOTAL (lines 1 thru 33)		\$ 2,832,615	\$ 306,039		\$ 128,587	\$ (177,452)	\$ 509,281	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,832,615	\$ 306,039		\$ 128,587	\$ (177,452)	\$ 509,281	1
2	Painting (Transfer Expense From Home Office)	2006	10,565		20	7,924	7,924	10,565	2
3	Painting (Transfer Expense From Home Office)	2006	1,351		20	1,126	1,126	1,351	3
4	Hi-Grade Sappano'S Various Invoices - Painting Of The Facility	2006	6,846		20	5,705	5,705	6,846	4
5	Painting (Transfer Expense From Home Office)	2006	10,007		20	9,173	9,173	10,007	5
6	John Williams Interiors - Invoice #4228 - Supply & Install Carpetin	2006	11,322		20	566	566	660	6
7	Remodel 6 Shower Rooms	2007	40,905		20	1,875	1,875	1,875	7
8	Painting (Transfer Expense From Home Office)	2007	4,104		20	3,762	3,762	3,762	8
9	Painting (Transfer Expense From Home Office)	2007	4,167		20	3,473	3,473	3,473	9
10	Cubicle Curtains	2007	12,871		20	2,145	2,145	2,145	10
11	Painting (Transfer Expense From Home Office)	2007	6,782		20	5,087	5,087	5,087	11
12	Painting (Transfer Expense From Home Office)	2007	3,483		20	2,322	2,322	2,322	12
13	Blinds For Facility	2007	2,625		20	175	175	175	13
14	Parking Lot	2007	33,420		20	2,228	2,228	2,228	14
15	Painting (Transfer Expense From Home Office)	2007	3,850		20	2,246	2,246	2,246	15
16	A/C System	2007	3,250		20	158	158	158	16
17	Painting (Transfer Expense From Home Office)	2007	3,028		20	1,514	1,514	1,514	17
18	Kickplates	2007	2,897		20	72	72	72	18
19	Painting (Transfer Expense From Home Office)	2007	4,408		20	1,837	1,837	1,837	19
20	Painting (Transfer Expense From Home Office)	2007	4,056		20	1,352	1,352	1,352	20
21	Painting (Transfer Expense From Home Office)	2007	3,505		20	876	876	876	21
22	Norstar Analog Station	2007	21,384		20	1,069	1,069	1,069	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
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4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
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4									4
5									5
6									6
7									7
8									8
9									9
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,027,441	\$ 306,039		\$ 183,272	\$ (122,767)	\$ 568,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	\$	Various	\$ 50,711	\$ 50,711	\$ 247,289	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		2003		350,135		15	27,049	27,049	135,920	9
10											10
11											11
12											12
13	Book Depreciation Expense (Building Company)					156,594			(156,594)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	2,327,995	\$	156,594	\$	77,760	\$	(78,834)	\$	383,209	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	Alloc - Care Centers Inc.		2002	2002	\$ 10,491	\$ 269	39	\$ 269		\$ 1,423	4
5	Alloc - Care Centers Inc.		1996	1996	17,788	456	39	456		5,036	5
6	Alloc - Care Centers Health Systems		2002	2002	668	17	39	17		91	6
7	Alloc - Care Centers Clinical		2002	2002	1,087	28	39	28		147	7
8											8
	Improvement Type**										
9	Alloc - Care Centers Inc.			2002	8,666	792	20	792		3,968	9
10	Alloc - Care Centers Inc.			2003	10,213	933	20	933		4,676	10
11	Alloc - Care Centers Inc.			2005	507	54	20	54		129	11
12	Alloc - Care Centers Inc.			2007	106	7	20	7		7	12
13	Alloc - Care Centers Inc.			1996	300		20			300	13
14	Alloc - Care Centers Inc.			1997	1,708	55	20	55		813	14
15											15
16	Alloc - Care Centers Health Systems			2002	552	50	20	50		253	16
17	Alloc - Care Centers Health Systems			2003	650	59	20	59		298	17
18	Alloc - Care Centers Health Systems			2005	32	3	20	3		8	18
19											19
20	Alloc - Care Centers Clinical			2002	898	82	20	82		411	20
21	Alloc - Care Centers Clinical			2003	1,058	97	20	97		484	21
22	Alloc - Care Centers Clinical			2005	53	6	20	6		13	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 54,777		\$ 2,908	\$ 2,908	\$ 18,057	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 869,039	\$ 12,533	\$ 106,796	\$ 94,263	10	\$ 772,938	71
72	Current Year Purchases	16,700	119	8,557	8,438	10	8,557	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 885,739	\$ 12,652	\$ 115,353	\$ 102,701		\$ 781,495	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc-Care Centers Inc.	various	\$ 19,791	\$ 1,148	\$ 1,148		5	\$ 16,257	76
77		Alloc-Care Centers Health System	2007	357	12	12		5	12	77
78		Alloc-Care Centers Clinical	various	1,693	250	250		5	320	78
79										79
80	TOTALS			\$ 21,841	\$ 1,410	\$ 1,410			\$ 16,589	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)	\$ 4,168,538	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 320,101	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 300,035	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,066)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,366,985	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocation from Care Centers Inc.</u>				<u>1,854</u>			5
6	<u>Allocation from Care Centers Health Systems</u>				<u>495</u>			6
7	TOTAL				\$ 2,349			7

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.	<u> /2008</u>	\$ _____
13.	<u> /2009</u>	\$ _____
14.	<u> /2010</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,345 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 181,088	\$		\$ 181,088	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			78,740			78,740	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			146,892			146,892	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 prescripts				382,785		382,785	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					2,256	141,538		143,794	13
14	TOTAL			\$		\$ 408,976	\$ 524,323		\$ 933,299	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$ 18,963	1
2	Cash-Patient Deposits	29,075	29,075	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	758,519	758,519	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,027	17,027	6
7	Other Prepaid Expenses	530	530	7
8	Accounts Receivable (owners or related parties)	534,988	5,670,774	8
9	Other(specify): <u>See Attached Schedule</u>	126,567	126,567	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,467,256	\$ 6,621,455	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	590,293	590,293	15
16	Equipment, at Historical Cost	145,947	145,947	16
17	Accumulated Depreciation (book methods)	(248,602)	(1,295,316)	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): <u>See Attached Schedule</u>		23,394	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 487,638	\$ 2,724,804	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,954,894	\$ 9,346,259	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 405,390	\$ 405,392	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,751	21,751	28
29	Short-Term Notes Payable	1,358,312	1,358,312	29
30	Accrued Salaries Payable	210,800	210,800	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,993	10,993	31
32	Accrued Real Estate Taxes(Sch.IX-B)	290,545	290,545	32
33	Accrued Interest Payable		36,769	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	195,706	1,078,482	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,493,497	\$ 3,413,044	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,710,575	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,710,575	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,493,497	\$ 10,123,619	46
47	TOTAL EQUITY(page 18, line 24)	\$ (538,603)	\$ (777,360)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,954,894	\$ 9,346,259	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,305)	1
2	Restatements (describe):		2
3	<u>Late Entry - Profit Sharing Plan</u>	(5,977)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (13,282)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(242,523)	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	(282,798)	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)	\$ (525,321)	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)	\$ (538,603)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,430,717	1
2	Discounts and Allowances for all Levels	(1,865,218)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,565,499	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,467,242	6
7	Oxygen	3,196	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,470,438	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	2,359	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	383,178	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,753	19
20	Radiology and X-Ray	9,314	20
21	Other Medical Services	70,705	21
22	Laundry	3,750	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 501,059	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	301	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 301	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,751	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,751	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,545,048	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	948,382	31
32	Health Care	2,568,726	32
33	General Administration	1,446,022	33
B. Capital Expense			
34	Ownership	826,028	34
C. Ancillary Expense			
35	Special Cost Centers	935,450	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,787,571	40
41	Income before Income Taxes (line 30 minus line 40)**	(242,523)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (242,523)	43

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

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

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

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning: 01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,973	2,140	\$ 76,573	\$ 35.78	1
2	Assistant Director of Nursing	1,948	2,253	68,489	30.40	2
3	Registered Nurses	22,682	25,542	679,289	26.59	3
4	Licensed Practical Nurses	15,259	17,234	406,421	23.58	4
5	CNAs & Orderlies	65,261	71,850	779,500	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,732	10,726	151,146	14.09	8
9	Activity Director	1,865	2,066	31,765	15.38	9
10	Activity Assistants	6,550	7,153	53,541	7.49	10
11	Social Service Workers	7,434	7,989	125,913	15.76	11
12	Dietician	752	752	10,494	13.95	12
13	Food Service Supervisor	1,857	2,189	36,275	16.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,707	6,345	72,269	11.39	15
16	Dishwashers	11,661	12,721	102,029	8.02	16
17	Maintenance Workers	3,853	4,324	78,490	18.15	17
18	Housekeepers	12,836	14,529	141,000	9.70	18
19	Laundry	5,354	5,954	51,875	8.71	19
20	Administrator	1,885	2,122	98,824	46.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,095	9,071	117,555	12.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,715	2,031	25,184	12.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	186,419	206,991	\$ 3,106,632 *	\$ 15.01	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	227	\$ 9,804	01-03	35
36	Medical Director	monthly	21,000	09-03	36
37	Medical Records Consultant	20	955	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,725	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	342	11-03	44
45	Social Service Consultant	8	572	12-03	45
46	Other(specify)				46
47	<u>Therapy Program Consultant</u>		60	10A-03	47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 34,458		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,323 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT