

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>22,397</u>	<u>2,878</u>	<u>9,156</u>	<u>34,431</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>22,397</u>	<u>2,878</u>	<u>9,156</u>	<u>34,431</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.03%

D. How many bed-hold days during this year were paid by the Department? 890 (Do not include bed-hold days in Section B.)

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

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

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

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 02/01/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 115 and days of care provided 8,837

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	234,403	24,958	13,699	273,060		273,060	(482)	272,578		1
2	Food Purchase		184,376		184,376		184,376	223	184,599		2
3	Housekeeping	143,076	31,735		174,811		174,811	(2,414)	172,397		3
4	Laundry	62,953	22,882		85,835		85,835	(784)	85,051		4
5	Heat and Other Utilities			97,595	97,595		97,595	1,671	99,266		5
6	Maintenance	83,851		69,979	153,830		153,830	9,888	163,718		6
7	Other (specify):*							1,443	1,443		7
8	TOTAL General Services	524,283	263,951	181,273	969,507		969,507	9,546	979,053		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,001,200	143,580	12,133	2,156,913		2,156,913	11,707	2,168,620		10
10a	Therapy	156,989			156,989		156,989	1,317	158,306		10a
11	Activities	89,972	20,781		110,753		110,753		110,753		11
12	Social Services	125,346		2,306	127,652		127,652	6,190	133,842		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,609	5,609		15
16	TOTAL Health Care and Programs	2,373,507	164,361	38,439	2,576,307		2,576,307	24,823	2,601,130		16
	C. General Administration										
17	Administrative	106,242			106,242		106,242	37,669	143,911		17
18	Directors Fees										18
19	Professional Services			362,337	362,337	(17,744)	344,593	(260,256)	84,337		19
20	Dues, Fees, Subscriptions & Promotions			38,669	38,669		38,669	(27,891)	10,778		20
21	Clerical & General Office Expenses	120,335	26,969	331,156	478,460		478,460	(174,059)	304,401		21
22	Employee Benefits & Payroll Taxes			462,864	462,864		462,864	(5,876)	456,988		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,454	7,454		7,454	722	8,176		24
25	Other Admin. Staff Transportation			5,082	5,082		5,082	379	5,461		25
26	Insurance-Prop.Liab.Malpractice			159,589	159,589		159,589	998	160,587		26
27	Other (specify):*							22,889	22,889		27
28	TOTAL General Administration	226,577	26,969	1,367,151	1,620,697	(17,744)	1,602,953	(405,425)	1,197,528		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,124,367	455,281	1,586,863	5,166,511	(17,744)	5,148,767	(371,057)	4,777,711		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: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			69,781	69,781		69,781	34,785	104,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,314	64,314		64,314	75,050	139,364			32
33	Real Estate Taxes			170,874	170,874	17,744	188,618	1,545	190,163			33
34	Rent-Facility & Grounds			377,775	377,775		377,775	(374,076)	3,699			34
35	Rent-Equipment & Vehicles			4,528	4,528		4,528	1,722	6,250			35
36	Other (specify):*											36
37	TOTAL Ownership			687,272	687,272	17,744	705,016	(260,974)	444,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		671,885	642,519	1,314,404		1,314,404	5,605	1,320,009			39
40	Barber and Beauty Shops			641	641		641	(641)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*			300	300		300	(300)				43
44	TOTAL Special Cost Centers		671,885	706,423	1,378,308		1,378,308	4,664	1,382,972			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,124,367	1,127,166	2,980,558	7,232,091		7,232,091	(627,367)	6,604,724			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

Applewood Nursing & Rehab Center

ID# 0046151

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Revenue - Jury Duty	\$ (50)	10	1
2	Barber and Beauty Income	(641)	40	2
3	Theft Loss	(1,659)	21	3
4	Collection Expense	(1,865)	21	4
5	Pharmacy - Veterans	(247)	10	5
6	Prior Period Adjustment - Computer Expense	(1,119)	21	6
7	Prior Period Adjustment - Bank Fees	(5,690)	21	7
8	Marketing & Research	(300)	43	8
9	Annual Report	(250)	20	9
10	Prior Period and Non-Allowable Legal Fees	(10,740)	19	10
11	Building Co. - Bank Charges	(223)	21	11
12	Building Co. - Filing Fees	(250)	21	12
13	Building Co. - Amortization	(11,026)	36	13
14	Prior Period Real Estate Taxes	(144,008)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(178,068)		49

Applewood Nursing & Rehab Center

ID# 0046151

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			169		2,940	(4)				(3,587)		(482)	1
2	Food Purchase	(154)		377									223	2
3	Housekeeping			352		39	(2,805)						(2,414)	3
4	Laundry						(784)						(784)	4
5	Heat and Other Utilities			1,442		92					137		1,671	5
6	Maintenance			2,239	5,484	12	(29)		2,077		105		9,888	6
7	Other (specify):*				1,017	426							1,443	7
8	TOTAL General Services	(154)		4,579	6,501	3,509	(3,621)		2,077		(3,345)		9,546	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(297)				20,014	(8,010)						11,707	10
10a	Therapy					1,151				166			1,317	10a
11	Activities													11
12	Social Services					6,190							6,190	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,609							5,609	15
16	TOTAL Health Care and Programs	(297)				32,964	(8,010)			166			24,823	16
	C. General Administration													
17	Administrative			1,651	5,988	26,107					3,923		37,669	17
18	Directors Fees													18
19	Professional Services	(10,740)		(187,096)		(62,680)			114		146		(260,256)	19
20	Fees, Subscriptions & Promotions	(29,369)		1,413		5					60		(27,891)	20
21	Clerical & General Office Expenses	(277,697)	473	11,568	90,058	5,854			(9,063)		4,748		(174,059)	21
22	Employee Benefits & Payroll Taxes				(3,081)	(2,579)	(216)						(5,876)	22
23	Inservice Training & Education													23
24	Travel and Seminar			44		678							722	24
25	Other Admin. Staff Transportation			258					9		112		379	25
26	Insurance-Prop.Liab.Malpractice			567		34			118		279		998	26
27	Other (specify):*				16,641	4,536					1,712		22,889	27
28	TOTAL General Administration	(317,806)	473	(171,595)	109,606	(28,045)	(216)		(8,822)		10,980		(405,425)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(318,257)	473	(167,016)	116,107	8,428	(11,847)		(6,745)	166	7,635		(371,057)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(53,386)	71,428	2,891		640			12,925		287		34,785	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,712)	31,259	42,499		7,735			2,269				75,050	32
33	Real Estate Taxes			1,394		151							1,545	33
34	Rent-Facility & Grounds		(377,775)	2,418							1,281		(374,076)	34
35	Rent-Equipment & Vehicles			1,708							14		1,722	35
36	Other (specify):*	(11,026)	11,026											36
37	TOTAL Ownership	(73,124)	(264,062)	50,910		8,526			15,194		1,582		(260,974)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(12,016)		(21,105)	48,708	(9,982)		5,605	39
40	Barber and Beauty Shops	(641)											(641)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(300)											(300)	43
44	TOTAL Special Cost Centers	(941)					(12,016)		(21,105)	48,708	(9,982)		4,664	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(392,322)	(263,589)	(116,106)	116,107	16,954	(23,864)		(12,656)	48,874	(765)		(627,367)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
1	V	34 Rent	\$ 377,775	Applewood Property LLC	100.00%	\$	\$ (377,775)	1
2	V	33 Real Estate Taxes	314,882	Applewood Property LLC	100.00%	314,882		2
3	V	32 Interest Income	306,521	Applewood Property LLC	100.00%	337,780	31,259	3
4	V	21 Bank Charges		Applewood Property LLC	100.00%	223	223	4
5	V	21 Filing Fees		Applewood Property LLC	100.00%	250	250	5
6	V	30 Depreciation		Applewood Property LLC	100.00%	71,428	71,428	6
7	V	36 Amortization		Applewood Property LLC	100.00%	11,026	11,026	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 999,178			\$ 735,589	\$ * (263,589)	14

* 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 169	\$	169	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	377		377	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	352		352	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,442		1,442	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,239		2,239	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,651		1,651	20
21	V	19 Professional Fees	194,239	Extended Care Consulting, LLC	100.00%	7,143		(187,096)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,413		1,413	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	11,568		11,568	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	44		44	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	258		258	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	567		567	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	2,891		2,891	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	42,499		42,499	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,394		1,394	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	2,418		2,418	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,708		1,708	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 194,239			\$ 78,133	\$ *	(116,106)	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 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,484	\$	5,484	15
16	V	06 Maintenance (Direct)	932	Extended Care Consulting, LLC	100.00%	932			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	938		938	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	79		79	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	5,988		5,988	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	90,058		90,058	20
21	V	21 Office and Clerical (Direct)	14,472	Extended Care Consulting, LLC	100.00%	14,472			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,409		15,409	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,232		1,232	23
24	V	22 Employee Benefits	3,081	Extended Care Consulting, LLC	100.00%			(3,081)	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		\$ 18,485			\$ 134,592	\$ *	116,107	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 39	\$	39	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	92		92	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	12		12	17
18	V	19 Professional Fees	63,483	Extended Care Clinical, LLC	100.00%	803		(62,680)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	5		5	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	683		683	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	678		678	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	34		34	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	640		640	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	7,735		7,735	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	151		151	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	2,940		2,940	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	426		426	27
28	V	10 Nursing Salary	10,408	Extended Care Clinical, LLC	100.00%	30,422		20,014	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,151		1,151	29
30	V	12 Social Service Salary	2,306	Extended Care Clinical, LLC	100.00%	8,496		6,190	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,609		5,609	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	26,107		26,107	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,171		5,171	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	4,536		4,536	34
35	V	22 Employee Benefits	2,579	Extended Care Clinical, LLC	100.00%			(2,579)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 78,776			\$ 95,730	\$ *	16,954	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	1 Dietary	\$ 40	Xcel Supply, LLC	100.00%	\$ 36	\$ (4)
16	V	3 Housekeeping	30,540	Xcel Supply, LLC	100.00%	27,736	(2,805)
17	V	4 Laundry	8,538	Xcel Supply, LLC	100.00%	7,754	(784)
18	V	6 Repairs & Maintenance	315	Xcel Supply, LLC	100.00%	286	(29)
19	V	10 Nursing	87,227	Xcel Supply, LLC	100.00%	79,217	(8,010)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	2,353	Xcel Supply, LLC	100.00%	2,137	(216)
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	130,853	Xcel Supply, LLC	100.00%	118,836	(12,016)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 259,865			\$ 236,002	\$ * (23,864)

* 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%	\$ 209,837	\$ 209,837	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	209,837	CCS Employee Benefits Group	100.00%		(209,837)	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		\$ 209,837			\$ 209,837	\$ *	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%	\$ 2,077	\$ 2,077
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	114	114
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	176	176
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	9	9
19	V	26 Insurance		Vent Lease, LLC.	100.00%	118	118
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	5,405	5,405
21	V	32 Interest		Vent Lease, LLC.	100.00%	910	910
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	7,520	7,520
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,359	1,359
24	V	21 Office and Clerical	9,239	Vent Lease, LLC.	100.00%		(9,239)
25	V	39 Ancillary	21,105	Vent Lease, LLC.	100.00%		(21,105)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 30,344			\$ 17,688	\$ * (12,656)

* 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	39 THERAPY	\$ 579,269	TRICARE REHAB		\$ 627,977	\$ 48,708	15
16	V	10A REHAB				166	166	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		\$ 579,269			\$ 628,143	\$ * 48,874	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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,806	\$	1,806	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	137		137	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	105		105	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	146		146	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	60		60	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	743		743	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	112		112	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	279		279	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	287		287	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%				26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	1,281		1,281	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	14		14	28
29	V	01 Dietary	8,977	Care Centers Health Systems, Inc.	100.00%	3,584		(5,393)	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	22 Employee Benefits		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	16,615	Care Centers Health Systems, Inc.	100.00%	6,633		(9,982)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	3,923		3,923	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	4,005		4,005	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,712		1,712	38
39	Total		\$ 25,592			\$ 24,827	\$ *	(765)	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Applewood Nursing & Rehab Center # 0046151 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	0.75	2.50%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.38	2.50%	Alloc. Salary	4,167	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	1.22	3.00%	Alloc. Salary	2,201	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,368		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	30	\$ 6,770	\$	34,431	\$ 169	1
2	02	Food	Patient Days	30	15,058		34,431	377	2
3	03	Housekeeping	Patient Days	30	14,059		34,431	352	3
4	05	Utilities	Patient Days	30	57,646		34,431	1,442	4
5	06	Maintenance	Patient Days	30	89,465		34,431	2,239	5
6	17	Administrative	Patient Days	30	66,000		34,431	1,651	6
7	19	Professional Fees	Patient Days	30	285,482		34,431	7,143	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		34,431	1,413	8
9	21	Office and Clerical	Patient Days	30	462,313		34,431	11,568	9
10	24	Seminar and Travel	Patient Days	30	1,768		34,431	44	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		34,431	258	11
12	26	Insurance	Patient Days	30	22,668		34,431	567	12
13	30	Depreciation	Patient Days	30	115,549		34,431	2,891	13
14	32	Interest	Patient Days	30	1,698,489		34,431	42,499	14
15	33	Real Estate Taxes	Patient Days	30	55,709		34,431	1,394	15
16	34	Rent - Building	Patient Days	30	96,636		34,431	2,418	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		34,431	1,708	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 78,133	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

1	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	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	34,431	5,484	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		932	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		34,431	938	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		79	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	34,431	5,988	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	34,431	90,058	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			14,472	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	34,431	15,409	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	34,431	1,232	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529		\$ 134,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

Extended Care Clinical LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

1	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	30	\$ 1,549	\$	34,431	\$ 39	1
2	05	Utilities	Patient Days	30	3,693		34,431	92	2
3	06	Maintenance	Patient Days	30	477		34,431	12	3
4	19	Professional Fees	Patient Days	30	32,105		34,431	803	4
5	20	Dues and Subscriptions	Patient Days	30	213		34,431	5	5
6	21	Office & Clerical	Patient Days	30	27,296		34,431	683	6
7	24	Travel and Seminar	Patient Days	30	27,079		34,431	678	7
8	26	Insurance	Patient Days	30	1,342		34,431	34	8
9	30	Depreciation	Patient Days	30	25,586		34,431	640	9
10	32	Interest	Patient Days	30	309,136		34,431	7,735	10
11	33	Real Estate Taxes	Patient Days	30	6,053		34,431	151	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	34,431	2,940	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		34,431	426	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	34,431	20,014	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	34,431	1,151	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	34,431	6,190	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		34,431	3,967	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	34,431	26,107	18
19	21	Office Salary	Patient Days	30	206,680	206,680	34,431	5,171	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		34,431	4,536	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	34,431	10,408	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		2,306	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			1,642	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 95,730	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

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			\$		\$ 36	1
2	3	Housekeeping	Direct Allocation					27,736	2
3	4	Laundry	Direct Allocation					7,754	3
4	6	Repairs & Maintenance	Direct Allocation					286	4
5	10	Nursing	Direct Allocation					79,217	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					2,137	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					118,836	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					\$	\$	\$ 236,002	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 209,837	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				\$	\$		\$ 209,837	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	821,185	26	\$ 80,807	\$ 21,105	\$ 2,077	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	21,105	114	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	21,105	176	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	21,105	9	4
5	26	Insurance	Direct Billing	821,185	26	4,573	21,105	118	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	21,105	5,405	6
7	32	Interest	Direct Billing	821,185	26	35,420	21,105	910	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	34,431	7,520	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	34,431	1,359	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					\$ 706,114	\$	\$ 17,688	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 627,977	1
2	10A	REHAB	DIRECT ALLOCATION					166	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				\$	\$		\$ 628,143	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/09Ending: 12/31/09

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 Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 612-5662

Fax Number

(224) 612-5862

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	85,083	1,806	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		85,083		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	85,083	137	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	85,083	105	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	85,083	146	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	85,083	60	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	85,083	743	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	85,083	112	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	85,083	279	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	85,083	287	10	
11	32	Interest	Gross Billable Income	3,421,940	26		85,083		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		85,083		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	85,083	1,281	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	85,083	14	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	8,977	3,584	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18	
19	22	Employee Benefits	Direct Billable Income	411	26	164			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	16,615	6,633	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	85,083	3,923	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	85,083	4,005	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	85,083	1,712	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 24,827	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending:

12/31/09

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										
										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			\$	\$ 4,248,646		\$ 337,780	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	LaSalle Bank		X	Line of Credit				1,472,544		64,215	6								
7	Xerox		X	Copier Purchase Financing				8,582		99	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 5,729,772		\$ 402,094	9								
B. Non-Facility Related*																			
10	Interest Income									(8,712)	10								
11	Allocated from EC Consulting		X							42,499	11								
12	Allocated from EC Clinical		X							7,735	12								
13	See Supplemental Schedule									(304,252)	13								
14	TOTAL Non-Facility Related						\$	\$		\$ (262,730)	14								
15	TOTALS (line 9+line14)						\$	\$ 5,729,772		\$ 139,364	15								

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

* 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:

01/01/09

Ending:

12/31/09

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15	Allocated from Vent Lease		X				\$	\$			\$ 2,269	15								
16	Interet Income (Bldg Co)		X								(306,521)	16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			
											(304,252)	20								

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (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).

None

F. 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>191,644</u>	<u>2003</u>	<u>\$ 223,625</u>	<u>1</u>
2	<u>Allocated from EC Consulting/EC Clinical 2201 Main</u>			<u>9,183</u>	<u>2</u>
3	TOTALS	191,644		\$ 232,808	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		17,645		20	1,415	1,415	10,563	9
10	Various		2004		30,750		20	1,937	1,937	10,499	10
11	Various		2005		51,157		20	2,558	2,558	11,010	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:

01/01/09

Ending:

12/31/09

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		1,977,860	71,428		50,714	(20,714)		67
68		36,333	2,482		2,482		14,547	68
69			69,781			(69,781)		69
70		\$ 2,113,745	\$ 143,691		\$ 59,106	\$ (84,585)	\$ 46,619	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:

01/01/09

Ending:

12/31/09**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		\$ 2,113,745	\$ 143,691		\$ 59,106	\$ (84,585)	\$ 46,619	1
2	Home Office Salaries & Benefits - Painting	2006	12,424		20			12,424	2
3	Home Office Salaries & Benefits - Painting	2006	6,570		20			6,570	3
4	Home Office Salaries & Benefits - Painting	2006	5,347		20			5,347	4
5	Home Office Salaries & Benefits - Painting	2006	14,706		20			14,706	5
6	Home Office Salaries & Benefits - Painting	2006	6,556		20			6,556	6
7	Home Office Salaries & Benefits - Painting	2006	13,319		20			13,319	7
8	Byrne-Johnson Roofing - Re-Roof	2006	161,960		20	8,098	8,098	29,018	8
9	Inpro Corporation - Construction Supplies	2006	13,725		20	686	686	2,459	9
10	South Suburban Inv. 10970 - A/C Installation	2006	4,407		20	220	220	771	10
11	Greenvue Construction Various Invoices - Remove & Replace W	2006	75,118		20	3,756	3,756	13,146	11
12	Home Office Salaries & Benefits - Painting	2006	7,107		20			7,107	12
13	Inpro Corp. Various Invoices - Installation Of Wall Covers (Sheet	2006	8,384		20	419	419	1,328	13
14	Grainger Invoice #9193607158 - 100 Gallon Waterheater	2006	4,668		20	389	389	1,264	14
15	Schwartz Brothers Invoice #1316 - Install Concrete Floor, Cerami	2006	16,000		20	800	800	2,600	15
16	Painting (Transfer Expense From Home Office)	2006	10,565		20			10,565	16
17	Painting (Transfer Expense From Home Office)	2006	1,351		20			1,351	17
18	Hi-Grade Sappano'S Various Invoices - Painting Of The Facility	2006	6,846		20			6,846	18
19	Painting (Transfer Expense From Home Office)	2006	10,007		20			10,007	19
20	John Williams Interiors - Invoice #4228 - Supply & Install Carpet	2006	11,322		20	566	566	1,793	20
21	Remodel 6 Shower Rooms	2007	40,905		20	2,045	2,045	5,965	21
22	Painting (Transfer Expense From Home Office)	2007	4,104		20			4,104	22
23	Painting (Transfer Expense From Home Office)	2007	4,167		20			4,167	23
24	Cubicle Curtains	2007	12,871		20	2,574	2,574	7,294	24
25	Painting (Transfer Expense From Home Office)	2007	6,782		20			6,782	25
26	Painting (Transfer Expense From Home Office)	2007	3,483		20			3,483	26
27	Blinds For Facility	2007	2,625		20	263	263	700	27
28	Parking Lot	2007	33,420		20	3,342	3,342	8,912	28
29	Painting (Transfer Expense From Home Office)	2007	3,850		20			3,850	29
30	A/C System	2007	3,250		20	271	271	700	30
31	Painting (Transfer Expense From Home Office)	2007	3,028		20			3,028	31
32	Kickplates	2007	2,897		20	145	145	362	32
33	Painting (Transfer Expense From Home Office)	2007	4,408		20			4,408	33
34	TOTAL (lines 1 thru 33)		\$ 2,629,917	\$ 143,691		\$ 82,680	\$ (61,011)	\$ 247,551	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,629,917	\$ 143,691		\$ 82,680	\$ (61,011)	\$ 247,551	1
2	Painting (Transfer Expense From Home Office)	2007	4,056		20			4,056	2
3	Painting (Transfer Expense From Home Office)	2007	3,505		20			3,505	3
4	Norstar Analog Station	2007	21,384		20	4,277	4,277	9,623	4
5	A/C Condensing Unit	2008	4,000		20	333	333	556	5
6	Valve Repair	2009	6,100		20	102	102	102	6
7	Painting	2009	5,494		20	183	183	183	7
8	Replacement Door And Frame	2009	3,900		20	81	81	81	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)		\$ 2,678,356	\$ 143,691		\$ 87,656	\$ (56,035)	\$ 265,657	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,678,356	\$ 143,691		\$ 87,656	\$ (56,035)	\$ 265,657	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)		\$ 2,678,356	\$ 143,691		\$ 87,656	\$ (56,035)	\$ 265,657	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	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		\$ 2,678,356	\$ 143,691		\$ 87,656	\$ (56,035)	\$ 265,657	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)	\$ 2,678,356	\$ 143,691		\$ 87,656	\$ (56,035)	\$ 265,657	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Applewood Property LLC - 115 Bed Facility	1967	1,977,860	71,428	39	50,714	(20,714)		3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Nursing & Rehab Center

0046151

Report Period Beginning:

01/01/09

Ending:

12/31/09

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
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 1,977,860	\$ 71,428		\$ 50,714	\$ (20,714)	\$

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main	2002	11,399	292	39	292		2,131	3
4	Allocated from Extended Care Clinical 2201 Main	2002	1,256	32	39	32		235	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	115	2	20	2		13	9
10	Allocated from Extended Care Consulting	2009	69	3	20	3		3	10
11									11
12	Allocated from Extended Care Consulting 2201 Main	2002	9,416	861	20	861		5,172	12
13	Allocated from Extended Care Consulting 2201 Main	2003	11,097	1,014	20	1,014		6,095	13
14	Allocated from Extended Care Consulting 2201 Main	2005	551	59	20	59		199	14
15	Allocated from Extended Care Consulting 2201 Main	2009	99	5	20	5		5	15
16									16
17	Allocated from Extended Care Clinical 2201 Main	2002	1,037	95	20	95		671	17
18	Allocated from Extended Care Clinical 2201 Main	2003	1,222	112	20	112		22	18
19	Allocated from Extended Care Clinical 2201 Main	2005	61	6	20	6		1	19
20	Allocated from Extended Care Clinical 2201 Main	2009	11	1	20	1			20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 36,333	\$ 2,482		\$ 2,482	\$	\$ 14,547	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:

01/01/09

Ending:

12/31/09

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	\$ 93,722	\$ 13,422	\$ 15,998	\$ 2,576	10	\$ 69,050	71
72	Current Year Purchases	10,805	209	282	73	10	282	72
73	Fully Depreciated Assets	802,745				10	802,745	73
74								74
75	TOTALS	\$ 907,272	\$ 13,631	\$ 16,280	\$ 2,649		\$ 872,077	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Extended Care Consult.	2009	\$ 8,046	\$ 126	\$ 126		5	\$ 7,669	76
77		Alloc. Extended Care Clinical	2009	1,799	360	360		5	1,059	77
78		Alloc. EC Health Systems	2009	729	146	146		5	219	78
79										79
80	TOTALS			\$ 10,574	\$ 632	\$ 632			\$ 8,947	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,829,010	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,568	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (53,386)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,146,681	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	BUILDING IMPROVEMENTS - 2003	\$ 350,135	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 350,135	\$	\$	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.

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>Allocated from EC Consulting</u>			<u>2,418</u>			5
6	<u>Allocated from EC Health Systems</u>			<u>1,281</u>			6
7	TOTAL			\$ <u>3,699</u>			7

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

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

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

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: \$ 6,249 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

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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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		Contract	Total
		1	2		
		Drop-outs	Completed		
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	\$		\$ 244,930	\$		\$ 244,930	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			96,151			96,151	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			298,274			298,274	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				438,589		438,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					3,164	233,296		236,460	13
14	TOTAL			\$		\$ 642,519	\$ 671,885		\$ 1,314,404	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

0046151

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 1,381,423	1
2	Cash-Patient Deposits	40,678	40,678	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	599,748	599,748	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,756	154,756	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	471,621	1,801,362	8
9	Other(specify): <u>See Attached Schedule</u>	43,956	43,956	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,311,309	\$ 4,021,923	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	609,787	609,787	15
16	Equipment, at Historical Cost	163,303	163,303	16
17	Accumulated Depreciation (book methods)	(409,190)	(1,640,693)	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>		1,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 363,900	\$ 2,393,967	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,675,209	\$ 6,415,890	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 582,308	\$ 582,309	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,258	23,258	28
29	Short-Term Notes Payable	1,481,126	1,481,126	29
30	Accrued Salaries Payable	116,305	116,305	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,524	3,524	31
32	Accrued Real Estate Taxes(Sch.IX-B)	311,672	311,672	32
33	Accrued Interest Payable		11,064	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	3,959	299,636	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,522,152	\$ 2,828,894	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,248,646	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)	\$	\$ 4,248,646	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,522,152	\$ 7,077,540	46
47	TOTAL EQUITY(page 18, line 24)	\$ (846,943)	\$ (661,650)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,675,209	\$ 6,415,890	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (899,078)	1
2	Restatements (describe):		2
3	Dividends - Prior Year Reversed in Late AJE	274,234	3
4	Rounding	(6)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (624,850)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,720)	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	(218,373)	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)	\$ (222,093)	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)	\$ (846,943)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 7,124,053	1
2	Discounts and Allowances for all Levels	(2,754,787)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,369,266	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,252,263	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,252,263	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	1,017	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	445,960	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,606	19
20	Radiology and X-Ray	6,435	20
21	Other Medical Services	99,622	21
22	Laundry	3,440	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 598,080	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,712	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,712	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	50	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 50	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,228,371	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	969,507	31
32	Health Care	2,576,307	32
33	General Administration	1,620,697	33
B. Capital Expense			
34	Ownership	687,272	34
C. Ancillary Expense			
35	Special Cost Centers	1,315,345	35
36	Provider Participation Fee	62,963	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,232,091	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,720)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,720)	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:

01/01/09

Ending:

12/31/09

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	1,724	2,018	\$ 79,288	\$ 39.29	1
2	Assistant Director of Nursing	1,828	2,003	59,534	29.72	2
3	Registered Nurses	14,465	17,551	491,839	28.02	3
4	Licensed Practical Nurses	21,425	24,076	581,864	24.17	4
5	CNAs & Orderlies	61,099	69,838	756,720	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,238	10,291	156,989	15.25	8
9	Activity Director	1,856	2,102	29,136	13.86	9
10	Activity Assistants	6,771	7,381	60,836	8.24	10
11	Social Service Workers	6,698	7,469	125,346	16.78	11
12	Dietician	652	660	9,605	14.55	12
13	Food Service Supervisor	1,988	2,361	41,383	17.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,728	6,597	76,842	11.65	15
16	Dishwashers	10,666	12,047	106,573	8.85	16
17	Maintenance Workers	3,859	4,277	83,851	19.61	17
18	Housekeepers	12,079	13,701	143,076	10.44	18
19	Laundry	2,583	2,933	62,953	21.46	19
20	Administrator	1,846	2,133	106,242	49.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,828	8,684	120,335	13.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,120	2,359	31,955	13.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	174,453	198,481	\$ 3,124,367 *	\$ 15.74	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	275	\$ 13,699	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>See Attached - Extended Care Allocation</u>		12,714		47
48					48
49	TOTAL (lines 35 - 48)	275	\$ 52,138		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dianne O'Connor	Administrator	0	\$ 106,242	Workers' Compensation Insurance	\$ 79,984	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	24,695	Advertising: Employee Recruitment	609	
				FICA Taxes	228,344	Health Care Worker Background Check		
				Employee Health Insurance	109,015	(Indicate # of checks performed <u>362</u>)	4,424	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,895	
				Employee Physicals	8,628	Licenses & Fees	382	
				Other Employee Welfare	4,817	Allocated from EC Consulting	1,413	
				Holiday Expense	1,504	Allocated from EC Clinical	5	
						See Supplemental Schedule	60	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,242	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 456,987		\$ 10,778		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	7,454
							Allocated from EC Consulting	44
							Allocated from EC Clinical	678
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 8,176
C. Professional Services								
Vendor/Payee	Type	Amount						
Frost, Ruttenberg & Rothblatt	Accounting	\$ 20,267						
Paycor	Payroll Processing	9,061						
ADP	Payroll Processing	18,536						
Ehealth Data Solutions	MDS Software	3,180						
XKZero	IT Consulting	168						
IIT/Sourcetechn	Computer Support	440						
National Datacare Corporation	Data Processing	773						
Personnel Planners	Unemployment Tax Cons.	2,340						
Pinnacle Consulting	Customer Satisfaction	2,540						
Chad Cournaya	Medicare Consultant	156						
Prospect Resources	Natural Gas Procurement	650						
See Supplemental Schedule		304,228						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 362,339					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Nursing & Rehab Center# 0046151Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,924 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.