



Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	115	Skilled (SNF)	115	41,975	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	28,126	2,058	7,129	37,313	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,126	2,058	7,129	37,313	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.89%

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

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

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

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

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 3/1/2011

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/1/2011 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 4,942

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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
	<b>A. General Services</b>										
1	Dietary	238,215	32,420	22,840	293,475		293,475	(9,651)	283,824		1
2	Food Purchase		214,023		214,023		214,023	(118)	213,905		2
3	Housekeeping	176,501	29,032		205,533		205,533		205,533		3
4	Laundry	32,569	25,787	42,000	100,356		100,356		100,356		4
5	Heat and Other Utilities			112,525	112,525		112,525	(17,056)	95,469		5
6	Maintenance	55,273	23,035	108,698	187,006		187,006	(10,144)	176,862		6
7	Other (specify):*							2,332	2,332		7
8	<b>TOTAL General Services</b>	502,558	324,297	286,063	1,112,918		1,112,918	(34,637)	1,078,281		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,918,082	218,100	42,714	2,178,896		2,178,896	(23,239)	2,155,657		10
10a	Therapy	182,427		6,845	189,272		189,272	(4,811)	184,461		10a
11	Activities	106,652	5,868	832	113,352		113,352		113,352		11
12	Social Services	45,515		11,040	56,555		56,555		56,555		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,119	2,119		15
16	<b>TOTAL Health Care and Programs</b>	2,252,676	223,968	91,431	2,568,075		2,568,075	(25,931)	2,542,144		16
	<b>C. General Administration</b>										
17	Administrative	149,444		407,807	557,251		557,251	(343,881)	213,370		17
18	Directors Fees										18
19	Professional Services			181,233	181,233	(13,132)	168,101	(98,049)	70,052		19
20	Dues, Fees, Subscriptions & Promotions			31,679	31,679		31,679	(10,618)	21,061		20
21	Clerical & General Office Expenses	131,798	20,791	310,964	463,553		463,553	(182,294)	281,259		21
22	Employee Benefits & Payroll Taxes			549,359	549,359		549,359		549,359		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,803	1,803		1,803	535	2,338		24
25	Other Admin. Staff Transportation			1,730	1,730		1,730	5,427	7,157		25
26	Insurance-Prop.Liab.Malpractice			101,436	101,436		101,436	1,098	102,534		26
27	Other (specify):*							22,870	22,870		27
28	<b>TOTAL General Administration</b>	281,242	20,791	1,586,011	1,888,044	(13,132)	1,874,912	(604,913)	1,269,999		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,036,476	569,056	1,963,505	5,569,037	(13,132)	5,555,905	(665,481)	4,890,424		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Rehabilitation Ctr

#0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			30,569	30,569	30,569	88,933	119,502				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			285	285	285	7,428	7,713				32
33	Real Estate Taxes			326,000	326,000	13,132	339,132	(3,349)	335,783			33
34	Rent-Facility & Grounds			624,378	624,378		624,378	(624,378)				34
35	Rent-Equipment & Vehicles			3,175	3,175		3,414	6,589				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			984,407	984,407	13,132	997,539	(527,952)	469,587			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		219,353	556,967	776,320	776,320	(397)	775,923				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			254,952	254,952	254,952		254,952				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		219,353	811,919	1,031,272	1,031,272	(397)	1,030,875				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,036,476	788,409	3,759,831	7,584,716	7,584,716	(1,193,829)	6,390,887				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning: 01/01/13

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(18,249)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,871	30		9
10	Interest and Other Investment Income	(15,399)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(118)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(229,801)	21		24
25	Fund Raising, Advertising and Promotional	(6,132)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,370)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,278)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (291,126)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(902,704)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (902,704)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (1,193,829)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Applewood Rehabilitation Ctr

ID# 0051359

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Collections	\$ (4,507)	19	1
2	Bank Fees	(6,034)	21	2
3	Theft & Damage	(81)	21	3
4	Capitalized R&M	(3,780)	06	4
5	Prior Year Expense - Medicare Ancillary Expense	(397)	39	5
6	Non Allowable Legal Fees	(4,228)	19	6
7	Bldg Co. - Management Fees	(5,750)	21	7
8	Bldg Co. - Accounting Fees	(1,650)	19	8
9	Bldg Co. - Miscellaneous Expenses	(310)	21	9
10	Bldg Co. - Bank Service Charges	(173)	21	10
11	Bldg Co. - Filing Fees	(250)	20	11
12	Bldg Co. - State Replacement Tax	(25)	21	12
13	COPE Dues	(3,093)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(30,278)	49

Applewood Rehabilitation Ctr

ID# 0051359

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Applewood Rehabilitation Ctr# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary				(9,651)								(9,651)	1
2	Food Purchase	(118)											(118)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(18,249)			1,193								(17,056)	5
6	Maintenance	(3,780)		(8,264)	1,900								(10,144)	6
7	Other (specify):*			343	1,989								2,332	7
8	<b>TOTAL General Services</b>	<b>(22,147)</b>		<b>(7,921)</b>	<b>(4,570)</b>								<b>(34,637)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(27,776)	4,537								(23,239)	10
10a	Therapy				(4,811)								(4,811)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			699	1,420								2,119	15
16	<b>TOTAL Health Care and Programs</b>			<b>(27,077)</b>	<b>1,146</b>								<b>(25,931)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(392,445)	48,564								(343,881)	17
18	Directors Fees													18
19	Professional Services	(10,385)	1,650	(98,100)	8,786								(98,049)	19
20	Fees, Subscriptions & Promotions	(11,125)	250	257									(10,618)	20
21	Clerical & General Office Expenses	(245,544)	6,258	56,951	41								(182,294)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			535									535	24
25	Other Admin. Staff Transportation			5,427									5,427	25
26	Insurance-Prop.Liab.Malpractice			1,013	85								1,098	26
27	Other (specify):*			13,219	9,651								22,870	27
28	<b>TOTAL General Administration</b>	<b>(267,054)</b>	<b>8,158</b>	<b>(413,143)</b>	<b>67,127</b>								<b>(604,913)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(289,201)</b>	<b>8,158</b>	<b>(448,141)</b>	<b>63,704</b>								<b>(665,481)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Rehabilitation Ctr# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	13,871	71,462		3,600								88,933	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,399)	28,345	(9,266)	3,748								7,428	32
33	Real Estate Taxes		(6,804)		3,455								(3,349)	33
34	Rent-Facility & Grounds		(624,378)										(624,378)	34
35	Rent-Equipment & Vehicles			3,414									3,414	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(1,528)</b>	<b>(531,375)</b>	<b>(5,852)</b>	<b>10,803</b>								<b>(527,952)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(397)											(397)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	<b>(397)</b>											<b>(397)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(291,126)</b>	<b>(523,217)</b>	<b>(453,993)</b>	<b>74,507</b>								<b>(1,193,829)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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 Rental Income	\$ 624,378	Applewood Property, LLC	100.00%	\$	\$ (624,378)	1
2	V	33 Property Tax	326,000	Applewood Property, LLC	100.00%		(326,000)	2
3	V	32 CIK Investments	6,000	Applewood Property, LLC	100.00%		(6,000)	3
4	V	21 Management Fee		Applewood Property, LLC	100.00%	5,750	5,750	4
5	V	19 Accounting Fee		Applewood Property, LLC	100.00%	1,650	1,650	5
6	V	21 Miscellaneous Expense		Applewood Property, LLC	100.00%	310	310	6
7	V	21 Bank Service Charge		Applewood Property, LLC	100.00%	173	173	7
8	V	20 Filing Fees		Applewood Property, LLC	100.00%	250	250	8
9	V	21 State Replacement Tax		Applewood Property, LLC	100.00%	25	25	9
10	V	30 Depreciation Expense		Applewood Property, LLC	100.00%	71,462	71,462	10
11	V	33 Real Estate Tax Expense		Applewood Property, LLC	100.00%	319,196	319,196	11
12	V	32 Interest Expense		Applewood Property, LLC	100.00%	34,345	34,345	12
13	V							13
14	Total		\$ 956,378			\$ 433,161	\$ * (523,217)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 13,800	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,536	\$ (8,264)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	343	343
17	V	10 NURSING	33,120	S.I.R. MANAGEMENT, INC.	100.00%	5,344	(27,776)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	699	699
19	V	19 PROFESSIONAL FEES	109,140	S.I.R. MANAGEMENT, INC.	100.00%	8,729	(100,411)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	257	257
21	V	21 CLERICAL & GENERAL	33,120	S.I.R. MANAGEMENT, INC.	100.00%	30,548	(2,572)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	535	535
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,427	5,427
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,013	1,013
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,294	4,294
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(9,266)	(9,266)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,414	3,414
28	V						
29	V	17 ADMINISTRATIVE	407,807	S.I.R. MANAGEMENT, INC.	100.00%	15,362	(392,445)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	2,311	2,311
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	59,523	59,523
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,925	8,925
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 596,987			\$ 142,994	\$ * (453,993)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 13,800	S.I.R. MANAGEMENT, INC.	100.00%	\$ 4,149	\$ (9,651)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	546	546	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	4,537	4,537	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	591	591	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	48,564	48,564	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	8,751	8,751	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	9,651	9,651	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	11,040	S.I.R. MANAGEMENT, INC.	100.00%	6,229	(4,811)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	829	829	25
26	V								26
27	V	6	MAINTENANCE SALARIES	8,234	S.I.R. MANAGEMENT, INC.	100.00%	9,688	1,454	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,443	1,443	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,193	1,193	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	446	446	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	35	35	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	41	41	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	85	85	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,600	3,600	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,748	3,748	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,455	3,455	37
38	V								38
39	Total		\$ 33,074				\$ 107,581	\$ * 74,507	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$ 9,996	Long Term Care Laboratory, LLC	100.00%	\$ 9,996	\$	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	<b>Total</b>		\$ 9,996			\$ 9,996	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 36,327	\$ 36,327	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	36,327	CCS Employee Benefits Group	100.00%		(36,327)	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		\$ 36,327			\$ 36,327	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES	30.600%	ALBANY CARE INC	EVANSTON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	1
2	B.G. TRUST	4.000%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	2
3	BARRISH GROUP LIMITED PARTNERSHIP	11.350%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	11.350%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	JOSEPH ABRAMCHIK	1.600%	ELMWOOD CARE, INC.	ELMWOOD PARK				5
6	L.G. TRUST	4.000%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	LOUISE BERGTHOLD	1.600%	GREENWOOD CARE, INC.	EVANSTON				7
8	PATRICIA MCDIARMID	1.600%	MAPLEWOOD CARE, INC.	ELGIN				8
9	RALPH GESUALDO	11.350%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO CHILDREN'S TRUST	11.350%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	SARAH BARRISH	1.600%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	THOMAS WINTER	1.600%	WILSON CARE, INC.	CHICAGO				12
13	UNITED TRUST #1	4.000%	WESLEY HEALTHCARE & REHABILITATION CENTER	AUBURN, IN				13
14	UNITED TRUST #2	4.000%						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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr # 0051359 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Elka Abramchick	Relative	Clerical	N/A	See Attached	1.45	4.53%	Alloc. Salary	\$ 1,983	21-7	1	
2	Joey Abramchik	Owner	Administrative	1.58%	See Attached	1.81	4.53%	Alloc. Salary	8,751	17-7	2	
3	Bryan Barrish	Relative	Administrative	N/A	See Attached	1.81	4.02%	Alloc. Salary	9,059	17-7	3	
4	Kirsten Barrish	Relative	Clerical	N/A	See Attached	2.26	4.52%	Alloc. Salary	2,283	21-7	4	
5	Sarah Barrish	Owner	Administrative	1.58%	See Attached	2.04	4.53%	Alloc. Salary	4,311	17-7	5	
6	Louise Bergthold	Owner	Administrative	1.58%	See Attached	2.72	4.53%	Alloc. Salary	9,059	17-7	6	
7	Michael Giannini	Relative	Administrative	N/A	See Attached	1.59	3.98%	Alloc. Salary	7,580	17-7	7	
8	Nenita Guzman	Relative	Dietary	N/A	See Attached	2.26	4.52%	Alloc. Salary	4,149	1-7	8	
9	Patricia Mcdiarmid	Owner	Administrative	1.58%	See Attached	2.26	4.52%	Alloc. Salary	6,215	17-7	9	
10	Tom Winter	Owner	Administrative	1.58%	See Attached	2.72	4.53%	Alloc. Salary	9,059	17-7	10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 62,449		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 Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	6	REPAIRS AND MAINT.	PATIENT DAYS	823,778	14	\$ 122,226	\$ 54,106	37,313	\$ 5,536	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581	37,313	343	2	
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	37,313	5,344	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435	37,313	699	4	
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	37,313	8,729	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665	37,313	257	6	
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	37,313	30,548	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805	37,313	535	8	
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815	37,313	5,427	9	
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368	37,313	1,013	10	
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799	37,313	4,294	11	
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)	37,313	(9,266)	12	
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364	37,313	3,414	13	
14									14	
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	37,313	15,362	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011	37,313	2,311	16	
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	37,313	59,523	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046	37,313	8,925	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 3,156,964	\$ 2,409,562		\$ 142,994	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	823,778	14	\$ 91,605	\$ 91,605	37,313	\$ 4,149	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049	37,313	546	2	
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	37,313	4,537	3	
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047	37,313	591	4	
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	37,313	48,564	5	
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200	37,313	8,751	6	
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069	37,313	9,651	7	
8									8	
9									9	
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	11,040	6,229	10	
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	293,544	14	22,047	11,040	829	11	
12									12	
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	8,234	9,688	13	
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242	8,234	1,443	14	
15									15	
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365	583	1,193	16	
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845	583	446	17	
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768	583	35	18	
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896	583	41	19	
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870	583	85	20	
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536	583	3,600	21	
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793	583	3,748	22	
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319	583	3,455	23	
24									24	
25	TOTALS					\$ 2,672,494	\$ 1,874,447	\$ 107,581	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	39	Ancillary	Direct Allocation		\$	\$		\$ 9,996	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				\$	\$		\$ 9,996	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 36,327	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				\$	\$		\$ 36,327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Business Partners, LLC		X	Mortgage			\$	\$			\$ 34,345 1					
2											2					
3											3					
4											4					
5											5					
<b>Working Capital</b>																
6	Lake Forest Bank		X	Line of Credit				50,000			285 6					
7	Alloc. S.I.R. Management	X									3,748 7					
8											8					
9	<b>TOTAL Facility Related</b>						\$	\$ 50,000			\$ 38,378 9					
<b>B. Non-Facility Related*</b>																
10	Interest Income		X								(15,399) 10					
11	Interest Income - Bldg Co.		X								(6,000) 11					
12	Alloc. S.I.R. Management	X									(9,266) 12					
13											13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (30,665) 14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 50,000			\$ 7,713 15					

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

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

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

Facility Name & ID Number

Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	<b>TOTAL Long-Term</b>																
	<b>Working Capital</b>																
8							\$	\$			\$						
9																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Working Capital</b>																
	<b>B. Non-Facility Related*</b>																
15							\$	\$			\$						
16																	
17																	
18																	
19																	
20	<b>TOTAL Non-Facility Related</b>																

\* 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.)



## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Rehabilitation Ctr COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0051359  
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda  
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>31-22-114-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>11,723.49</u>	\$ <u>11,723.49</u>
2. <u>31-22-114-024-0000</u>	<u>Long Term Care Property</u>	\$ <u>311,043.05</u>	\$ <u>311,043.05</u>
3. <u>31-22-114-025-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,148.66</u>	\$ <u>5,148.66</u>
4. <u>31-22-114-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>14,280.62</u>	\$ <u>14,280.62</u>
5. <u>See Attached</u>	<u>Allocated from SIR Management</u>	\$ <u>106,516.99</u>	\$ <u>3,776.19</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>448,712.81</u></u>	\$ <u><u>345,972.01</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359 Report Period Beginning:

01/01/13 Ending:

12/31/13

**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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>191,644</u>	<u>2003</u>	<u>\$ 223,625</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>191,644</b>		<b>\$ 223,625</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	115		2003	1967	\$ 1,977,860	\$ 71,462	39	\$ 50,714	\$ (20,748)	\$ 1,977,860	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2003		17,643		20	875	875	15,461	9
10	Various		2004		30,750		20	1,936	1,936	18,242	10
11	Various		2005		46,763		20	2,338	2,338	19,466	11
12	Various		2006		295,584		20	14,935	14,935	112,117	12
13	Various		2007		154,735		20	6,065	6,065	112,539	13
14	Various		2008		4,000		20	333	333	1,889	14
15	Various		2009		15,494		20	775	775	3,465	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 Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			82,036	2,280	3,203	923	37,046	68
69				30,569		(30,569)		69
70			\$ 2,624,864	\$ 104,311		\$ 81,174	\$ (23,137)	\$ 2,298,085 70

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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,624,864	\$ 104,311		\$ 81,174	\$ (23,137)	\$ 2,298,085	1
2	New Door Frame And Window	2010	3,500		20	175	175	685	2
3	Water Heater	2011	7,493		20	749	749	2,123	3
4	Window A/C/ Units And Sleeves	2011	39,931		20	3,993	3,993	10,316	4
5	Electric Upgrade	2011	59,662		20	2,983	2,983	7,706	5
6	Asphalt Work	2011	12,490		20	625	625	1,561	6
7	Masonry Cut-Out A/C Units	2011	32,962		20	1,648	1,648	4,258	7
8	Fire Doors	2011	22,680		20	1,134	1,134	2,363	8
9	Water Main Break	2012	16,650		20	833	833	1,041	9
10	Water Main Break	2012	34,140		20	1,707	1,707	1,992	10
11	Security Camera	2013	6,630		20	304	304	304	11
12	Front Door Alarm System	2013	6,025		20	226	226	226	12
13	Roof Top Air Conditioner	2013	8,100		20	270	270	270	13
14	Nurse Call System	2013	21,451		20	626	626	626	14
15	Asphalt In Parking Lot And Drives	2013	3,780		20	189	189	189	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	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 and Improvement Costs-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	Totals from Page 12B, Carried Forward		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	Totals from Page 12C, Carried Forward		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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 12D, Carried Forward		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,900,358	\$ 104,311		\$ 96,635	\$ (7,676)	\$ 2,331,743	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 and Improvement Costs-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	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$	\$		\$	\$	\$	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 and Improvement Costs-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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>Allocated - S.I.R. Management</u>	2009	11,317		39	290	290	1,173	3
4	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1993	20,491	650	35	585	(65)	12,002	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<u>Allocated - S.I.R. Management</u>	1993	5,195	145	20	44	(101)	5,195	9
10	<u>Allocated - S.I.R. Management</u>	1994	16		20			16	10
11	<u>Allocated - S.I.R. Management</u>	1995	119		20	6	6	109	11
12	<u>Allocated - S.I.R. Management</u>	1997	7,983	179	20	389	210	6,681	12
13	<u>Allocated - S.I.R. Management</u>	1999	628		20	31	31	447	13
14	<u>Allocated - S.I.R. Management</u>	2000	741		20	37	37	502	14
15	<u>Allocated - S.I.R. Management</u>	2007	2,381	162	20	119	(43)	737	15
16	<u>Allocated - S.I.R. Management</u>	2008	6,562	627	20	414	(213)	2,417	16
17	<u>Allocated - S.I.R. Management</u>	2009	16,306	149	20	815	666	3,460	17
18	<u>Allocated - S.I.R. Management</u>	2011	403	40	20	40		98	18
19	<u>Allocated - S.I.R. Management</u>	2012	1,291	65	20	64	(1)	91	19
20									20
21	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	2012	1,255	173	20	9	(164)	10	21
22	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	2010	1,237		20	62	62	206	22
23	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	2009	1,230	55	20	62	7	295	23
24	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	2007	359	28	20	18	(10)	126	24
25	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	2002	81		20	4	4	47	25
26	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1999	2,596		20	130	130	1,882	26
27	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1998	1,241		20	62	62	962	27
28	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1997	77		20	4	4	68	28
29	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1994	195	5	20	10	5	190	29
30	<u>Allocated- S.I.R. Properties - S.I.R. Management</u>	1993	332	2	20	8	6	332	30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>Related Party Information Continued</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (12H &amp; 12I lines 1 thru 33)</b>		\$ 82,036	\$ 2,280		\$ 3,203	\$ 923	\$ 37,046	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 152,283	\$ 1,154	\$ 15,288	\$ 14,134	10	\$ 54,817	71
72	Current Year Purchases	93,960		7,375	7,375	10	7,375	72
73	Fully Depreciated Assets	824,208		14	14	10	824,208	73
74								74
75	TOTALS	\$ 1,070,451	\$ 1,154	\$ 22,677	\$ 21,523		\$ 886,400	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated S.I.R. Management	2013	\$ 1,591	\$ 166	\$ 190	\$ 24	5	\$ 747	76
77										77
78										78
79										79
80	TOTALS			\$ 1,591	\$ 166	\$ 190	\$ 24		\$ 747	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,196,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,502	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,871	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,218,890	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning: 01/01/13

Ending: 12/31/13

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 6,589

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	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr # 0051359 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	217,574	\$		\$	217,574	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				90,241				90,241	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				249,152				249,152	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					177,344			177,344	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>							42,009			42,009	13
14	<b>TOTAL</b>			\$		\$	556,967	\$	219,353	\$	776,320	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 Rehabilitation Ctr**

# **0051359**

Report Period Beginning: **01/01/13**

Ending:

**12/31/13**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/13** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 51,340	\$ 357,601	1
2	Cash-Patient Deposits	40,954	40,954	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,415,882	1,775,188	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,712	101,712	6
7	Other Prepaid Expenses	1,162	1,162	7
8	Accounts Receivable (owners or related parties)		2,453,444	8
9	Other(specify): <u>See Attached Schedule</u>	3,965	(229,422)	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,615,015</b>	<b>\$ 4,500,639</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
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	221,653	221,653	15
16	Equipment, at Historical Cost	248,396	248,396	16
17	Accumulated Depreciation (book methods)	(55,780)	(1,573,061)	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>	815,180	815,180	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,229,449</b>	<b>\$ 2,972,654</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,844,464</b>	<b>\$ 7,473,293</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 314,769	\$ 314,769	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,029	41,029	28
29	Short-Term Notes Payable	50,000	50,000	29
30	Accrued Salaries Payable	201,420	201,420	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,426	20,426	31
32	Accrued Real Estate Taxes(Sch.IX-B)		359,306	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,200	10,200	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	49,980	2,443,938	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 687,824</b>	<b>\$ 3,441,088</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 687,824</b>	<b>\$ 3,441,088</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 2,156,640</b>	<b>\$ 4,032,205</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,844,464</b>	<b>\$ 7,473,293</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,982,081</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Partners Capital</b>	<b>20,000</b>	<b>3</b>
<b>4</b>	<b>Rounding</b>	<b>1</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,002,082</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>332,371</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(177,813)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>154,558</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,156,640</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,501,794	1
2	Discounts and Allowances for all Levels	(1,807,786)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,694,008</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,770,265	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,770,265</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,559	19
20	Radiology and X-Ray	2,734	20
21	Other Medical Services	49,326	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 238,352</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,399	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 15,399</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	199,063	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 199,063</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,917,087</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,112,918	31
32	Health Care	2,568,075	32
33	General Administration	1,888,044	33
<b>B. Capital Expense</b>			
34	Ownership	984,407	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	776,320	35
36	Provider Participation Fee	254,952	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,584,716</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>332,371</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 332,371</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,246,448	44
45	Private Pay - Net Inpatient Revenue	372,620	45
46	Medicare - Net Inpatient Revenue	849,745	46
47	Other-(specify) <u>Hospice</u>	256,136	47
48	Other-(specify) <u>HMO / Insurance</u>	(30,941)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,694,008</b>	<b>49</b>

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Applewood Rehabilitation Ctr

# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	1,918	2,029	\$ 83,723	\$ 41.26	1
2	Assistant Director of Nursing	1,994	2,122	71,296	33.60	2
3	Registered Nurses	15,910	17,202	501,644	29.16	3
4	Licensed Practical Nurses	13,668	14,554	337,472	23.19	4
5	CNAs & Orderlies	67,463	71,852	752,164	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,894	10,455	182,427	17.45	8
9	Activity Director	1,868	2,086	32,080	15.38	9
10	Activity Assistants	7,934	8,515	74,572	8.76	10
11	Social Service Workers	2,990	3,223	45,515	14.12	11
12	Dietician					12
13	Food Service Supervisor	1,805	2,086	40,697	19.51	13
14	Head Cook	6,238	7,023	88,684	12.63	14
15	Cook Helpers/Assistants	11,225	12,098	108,834	9.00	15
16	Dishwashers					16
17	Maintenance Workers	1,989	2,142	55,273	25.80	17
18	Housekeepers	13,635	15,249	176,501	11.57	18
19	Laundry	3,006	3,368	32,569	9.67	19
20	Administrator	1,844	2,086	107,288	51.43	20
21	Assistant Administrator	1,974	2,171	42,156	19.42	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,846	8,620	131,798	15.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,932	5,373	141,822	26.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,601	1,605	29,961	18.67	33
34	TOTAL (lines 1 - 33)	179,734	193,859	\$ 3,036,476 *	\$ 15.66	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	Monthly	\$ 9,040	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Monthly	1,568	10-03	37
38	Nurse Consultant	Monthly	33,120	10-03	38
39	Pharmacist Consultant	Monthly	8,026	10-03	39
40	Physical Therapy Consultant	53	2,627	10a-03	40
41	Occupational Therapy Consultant	44	2,204	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	40	2,014	10a-03	43
44	Activity Consultant	Monthly	832	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Director of Food Service	Monthly	13,800	01-03	47
48	Specialized Rehab	Monthly	11,040	12-03	48
49	TOTAL (lines 35 - 48)	137	\$ 114,271		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	\$ 107,288	Workers' Compensation Insurance	\$ 166,242	IDPH License Fee	\$ 1,990		
Patricia Swick	Asst. Admin	0	42,156	Unemployment Compensation Insurance	75,599	Advertising: Employee Recruitment	952		
				FICA Taxes	220,283	Health Care Worker Background Check			
				Employee Health Insurance	77,599	(Indicate # of checks performed <u>337</u> )	3,369		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,380		
				401K Contribution	4,764	Dues & Subscriptions	12,112		
				Other Employee Benefits	4,872	Allocated from S.I.R. Management	257		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 149,444						
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	
SIR Management - Consulting Fees			\$ 347,087				Out-of-State Travel	\$	
SIR Management - Dir. Of Admin Services			33,120						
SIR Management - Ancillary Admin Charges			27,600				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 407,807	TOTAL (agree to Schedule V, line 22, col.8)			\$ 549,359	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
Frost, Ruttenberg & Rothblatt	Accounting	\$ 14,765							
SIR Management	Dir. Of Regulatory Service	16,560							
SIR Management	Accounting Fees	36,000							
SIR Management	Bookkeeping	56,580							
Plante & Moran, LLC	Accounting	6,225							
Personnel Planners	Unemployment Consult	2,680							
Pinnacle Consulting	Customer Satisfaction	2,703							
E-Health Data	MDS Software	3,300							
Achieve Accreditation	Accreditation Consult	11,853							
The Compliance Team	WOTC Consulting	600							
Management & Network Services	Ancillary Services	750							
See Supplemental Schedule		29,218							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 181,234						

\* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Applewood Rehabilitation Ctr# 0051359

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC: \$6,281
- (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. \$ 59,422 Line 10-02
- (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. \$ 254,952  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? 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? 100% Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.