FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051359

Facility Name: Applewood Rehabilitation Center, Llc

Address: 21020 Kostner Avenue (Number) Matteson (City) 60443 (Zip Code)

County: Cook

Telephone Number: (708) 747-1300 **Fax #** (708) 747-6282

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,235	2,449	11,189	34,873	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,235	2,449	11,189	34,873	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.08%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 115 and days of care provided 4,428

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,432	46,924	22,452	309,808		309,808	(9,226)	300,582			1
2	Food Purchase		202,375		202,375		202,375	(141)	202,234			2
3	Housekeeping	184,822	31,604		216,426		216,426		216,426			3
4	Laundry	32,528	21,945	52,000	106,473		106,473		106,473			4
5	Heat and Other Utilities			140,489	140,489		140,489	(21,980)	118,509			5
6	Maintenance	55,145	27,816	107,241	190,202		190,202	(9,838)	180,364			6
7	Other (specify):*							3,699	3,699			7
8	**TOTAL General Services**	512,927	330,664	322,182	1,165,773		1,165,773	(37,486)	1,128,287			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,878,078	238,110	39,436	2,155,624		2,155,624	(6,901)	2,148,723			10
10a	Therapy	175,363		21,180	196,543		196,543	(5,266)	191,277			10a
11	Activities	92,255	4,676	832	97,763		97,763		97,763			11
12	Social Services	44,651		551	45,202		45,202		45,202			12
13	CNA Training											13
14	Program Transportation			186	186		186		186			14
15	Other (specify):*							3,699	3,699			15
16	**TOTAL Health Care and Programs**	2,190,347	242,786	92,185	2,525,318		2,525,318	(8,468)	2,516,850			16
	C. General Administration											
17	Administrative	123,403		423,819	547,222		547,222	(355,749)	191,473			17
18	Directors Fees											18
19	Professional Services			286,142	286,142	(53,275)	232,867	(147,637)	85,230			19
20	Dues, Fees, Subscriptions & Promotions			46,682	46,682		46,682	(13,873)	32,809			20
21	Clerical & General Office Expenses	200,977	24,147	375,399	600,523		600,523	(263,282)	337,241			21
22	Employee Benefits & Payroll Taxes			544,727	544,727		544,727		544,727			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,759	2,759		2,759	737	3,496			24
25	Other Admin. Staff Transportation			1,560	1,560		1,560	4,360	5,920			25
26	Insurance-Prop.Liab.Malpractice			105,827	105,827		105,827	1,453	107,280			26
27	Other (specify):*							24,627	24,627			27
28	**TOTAL General Administration**	324,380	24,147	1,786,915	2,135,442	(53,275)	2,082,167	(749,364)	1,332,803			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,027,654	597,597	2,201,282	5,826,533	(53,275)	5,773,258	(795,318)	4,977,941			29

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc #0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,368	46,368		46,368	36,779	83,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,701	9,701		9,701	(9,701)				32
33	Real Estate Taxes			424,500	424,500	53,275	477,775	46,811	524,586			33
34	Rent-Facility & Grounds			687,341	687,341		687,341	(687,341)				34
35	Rent-Equipment & Vehicles			2,820	2,820		2,820	4,144	6,964			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,170,730	1,170,730	53,275	1,224,005	(609,308)	614,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		222,452	616,345	838,797		838,797	(1,308)	837,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,876	248,876		248,876		248,876			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		222,452	865,221	1,087,673		1,087,673	(1,308)	1,086,365			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,027,654	820,049	4,237,233	8,084,936		8,084,936	(1,405,933)	6,679,003			45

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(23,448)	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	(60,429)	30		9
10	Interest and Other Investment Income	(4,957)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(141)	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	(1,033)	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	(325,469)	21		24
25	Fund Raising, Advertising and Promotional	(7,390)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(59)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(43,509)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (466,435)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(939,498)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (939,498)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,405,933)		37

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

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

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

Applewood Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Fees - Collections	$ (5,455)	19	1
2	Office Expense - Bank Fees	(6,640)	21	2
3	Theft & Damage	(1,366)	21	3
4	PAC Dues	(6,466)	20	4
5	Additional R&M	1,378	06	5
6	Capitalized R&M	(5,866)	06	6
7	Bldg Co. - Management Fees	(5,750)	21	7
8	Bldg Co. - Accounting Fees	(800)	19	8
9	Bldg Co. - Filing Fees	(250)	21	9
10	Bldg Co. - Bank Service Charges	(71)	21	10
11	Miscellaneous Income	(17)	10	11
12	Non-allowable Legal	(12,206)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(43,509)		49

Applewood Rehabilitation Center, Llc

ID# 0051359

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(9,226)								(9,226)	1
2	Food Purchase	(141)											(141)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(23,448)			1,468								(21,980)	5
6	Maintenance	(4,488)		(13,484)	8,134								(9,838)	6
7	Other (specify):*				3,699								3,699	7
8	**TOTAL General Services**	(28,077)		(13,484)	4,075								(37,486)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)		(11,883)	5,044	(45)							(6,901)	10
10a	Therapy				(5,266)								(5,266)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,188	1,511								3,699	15
16	**TOTAL Health Care and Programs**	(17)		(9,695)	1,289	(45)							(8,468)	16
	C. General Administration													
17	Administrative			(407,422)	51,673								(355,749)	17
18	Directors Fees													18
19	Professional Services	(18,461)	800	(139,798)	9,822								(147,637)	19
20	Fees, Subscriptions & Promotions	(14,889)		1,016									(13,873)	20
21	Clerical & General Office Expenses	(339,605)	6,071	70,187	65								(263,282)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			737									737	24
25	Other Admin. Staff Transportation			4,360									4,360	25
26	Insurance-Prop.Liab.Malpractice			1,311	142								1,453	26
27	Other (specify):*			13,481	11,146								24,627	27
28	**TOTAL General Administration**	(372,955)	6,871	(456,128)	72,848								(749,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(401,049)	6,871	(479,307)	78,212	(45)							(795,318)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Applewood Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(60,429)	92,666		4,542								36,779	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,957)		(8,783)	4,039								(9,701)	32
33	Real Estate Taxes		41,568		5,243								46,811	33
34	Rent-Facility & Grounds		(687,341)										(687,341)	34
35	Rent-Equipment & Vehicles			4,144									4,144	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(65,386)	(553,107)	(4,639)	13,824								(609,308)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(1,263)		(45)					(1,308)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**					(1,263)		(45)					(1,308)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(466,435)	(546,236)	(483,946)	92,036	(1,307)		(45)					(1,405,933)	45

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 687,341	Applewood Property, LLC	100.00%	$	$ (687,341)	1
2	V	33	Property Tax	424,500	Applewood Property, LLC	100.00%		(424,500)	2
3	V	21	Management Fee		Applewood Property, LLC	100.00%	5,750	5,750	3
4	V	19	Accounting Fee		Applewood Property, LLC	100.00%	800	800	4
5	V	21	Filing Fees		Applewood Property, LLC	100.00%	250	250	5
6	V	21	Bank Service Charge		Applewood Property, LLC	100.00%	71	71	6
7	V	30	Depreciation Expense		Applewood Property, LLC	100.00%	92,666	92,666	7
8	V	33	Real Estate Tax Expense		Applewood Property, LLC	100.00%	466,068	466,068	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,111,841			$ 565,605	$ * (546,236)	14

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 16,560	S.I.R. MANAGEMENT, INC.	100.00%	$ 3,076	$ (13,484)	15
16	V								16
17	V	10	NURSING	35,880	S.I.R. MANAGEMENT, INC.	100.00%	23,997	(11,883)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,188	2,188	18
19	V	19	PROFESSIONAL FEES	142,560	S.I.R. MANAGEMENT, INC.	100.00%	2,483	(140,077)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,016	1,016	20
21	V	21	CLERICAL & GENERAL	16,560	S.I.R. MANAGEMENT, INC.	100.00%	77,815	61,255	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	737	737	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,360	4,360	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,311	1,311	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,120	4,120	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,783)	(8,783)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,523	3,523	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	621	621	28
29	V								29
30	V	17	ADMINISTRATIVE	423,819	S.I.R. MANAGEMENT, INC.	100.00%	16,397	(407,422)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	279	279	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	8,932	8,932	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,361	9,361	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 635,379			$ 151,433	$ * (483,946)	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 13,800	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,574	$ (9,226)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	638	638	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,044	5,044	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	698	698	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	51,673	51,673	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	9,774	9,774	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,146	11,146	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	11,040	S.I.R. MANAGEMENT, INC.	100.00%	5,774	(5,266)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	813	813	25
26	V								26
27	V	6	MAINTENANCE SALARIES	13,145	S.I.R. MANAGEMENT, INC.	100.00%	20,455	7,310	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,061	3,061	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,468	1,468	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	824	824	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	48	48	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	65	65	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	142	142	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,542	4,542	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,039	4,039	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,243	5,243	37
38	V								38
39	Total			$ 37,985			$ 130,021	$ * 92,036	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 3,385	MAC Rx, LLC	100.00%	$ 3,341	$ (45)	15
16	V	39	Ancillary	95,610	MAC Rx, LLC	100.00%	94,348	(1,263)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,995			$ 97,688	$ * (1,307)	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	4	Laundry	$ 52,000	Chateau Nursing & Rehab Center		$ 52,000	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,000			$ 52,000	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary	$ 5,456	Long Term Care Laboratory, LLC	100.00%	$ 5,411	$ (45)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,456			$ 5,411	$ * (45)	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	30.60%	ALBANY CARE INC	EVANSTON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	1
2	B.G. TRUST	4.00%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	2
3	BARRISH GROUP LIMITED PARTNERSHIP	11.35%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	11.35%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	JOSEPH ABRAMCHIK	1.60%	ELMWOOD CARE, INC.	ELMWOOD PARK	CHATEAU NURSING & REHAB	WILLOWBROOK	LAUNDRY	5
6	L.G. TRUST	4.00%	OAKTON PAVILION	DES PLAINES	MAC RX, LLC	DES PLAINES	PHARMACY CONSULT	6
7	LOUISE BERGTHOLD	1.60%	GREENWOOD CARE, INC.	EVANSTON				7
8	PATRICIA MCDIARMID	1.60%	WESLEY HEALTHCARE & REHABILITATION CENTER	AUBURN, IN				8
9	RALPH GESUALDO	11.35%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO CHILDREN'S TRUST	11.35%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	SARAH BARRISH	1.60%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	THOMAS WINTER	1.60%	WILSON CARE, INC.	CHICAGO				12
13	UNITED TRUST #1	4.00%						13
14	UNITED TRUST #2	4.00%						14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Elka Abramchick	Relative	Clerical	N/A	See Attached	1.55	4.84%		$ 2,076	21-7	1
2	Joey Abramchik	Owner	Administrative	1.60%	See Attached	1.93	4.83%		9,774	17-7	2
3	Bryan Barrish	Relative	Administrative	N/A	See Attached	1.93	4.83%		9,671	17-7	3
4	Kirsten Schloss	Relative	Maintenance	N/A	See Attached	2.42	4.84%		4,657	6-7	4
5	Sarah Barrish	Owner	Administrative	1.60%	See Attached	2.18	4.84%		5,094	17-7	5
6	Louise Bergthold	Owner	Administrative	1.60%	See Attached	2.90	4.83%		9,671	17-7	6
7	Michael Giannini	Relative	Administrative	N/A	See Attached	1.69	4.23%		8,267	17-7	7
8	Nenita Guzman	Relative	Dietary	N/A	See Attached	2.42	4.84%		4,574	1-7	8
9	Patricia Mcdiarmid	Owner	Administrative	1.60%	See Attached	2.42	4.84%		7,980	17-7	9
10	See Supplemental Schedule								11,670		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	$ 73,434		13

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	721,222	14	$ 63,617	$	34,873	$ 3,076	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	34,873	23,997	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		34,873	2,188	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		34,873	2,483	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		34,873	1,016	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	34,873	77,815	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		34,873	737	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		34,873	4,360	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		34,873	1,311	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		34,873	4,120	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		34,873	(8,783)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		34,873	3,523	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		34,873	621	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	34,873	16,397	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		34,873	279	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	34,873	8,932	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		34,873	9,361	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 151,433	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	721,222	14	$ 94,587	$ 94,587	34,873	$ 4,574	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		34,873	638	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	34,873	5,044	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		34,873	698	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	34,873	51,673	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		34,873	9,774	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		34,873	11,146	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	11,040	5,774	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		11,040	813	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	13,145	20,455	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		13,145	3,061	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		623	1,468	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		623	824	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		623	48	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		623	65	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		623	142	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		623	4,542	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		623	4,039	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		623	5,243	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 130,021	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 3,341	1
2	39	Ancillary	Direct Allocation						94,348	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					$	$		$ 97,688	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Chateau Nursing & Rehab Center
Street Address: 7050 Madison Street
City / State / Zip Code: Willowbrook IL 60521
Phone Number: (630-323-6380
Fax Number: (630-323-5342

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry	Direct Allocation			$	$		$ 52,000	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					$	$		$ 52,000	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Direct Allocation			$	$		$ 5,411	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					$	$		$ 5,411	25

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				160,000			9,701	6
7	Allocated from SIR Managemen	X									4,039	7
8												8
9	TOTAL Facility Related						$	$ 160,000			$ 13,740	9
	B. Non-Facility Related*											
10	Interest income										(4,957)	10
11	Allocated from SIR Managemen	X									(8,783)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,740)	14
15	TOTALS (line 9+line14)						$	$ 160,000			$ 0	15

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 199,144	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 436,594	2
3. Under or (over) accrual (line 2 minus line 1).		$ 237,450	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 215,676	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$ 53,275	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 53,641 **For** 2011 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 506,401	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	316,375	8
	2011	364,100	9
	2012	342,196	10
	2013	398,288	11
	2014	431,351	12

2015 accrual = 2014 tax $431,351 x 1.05 = $452,919 - 1st installment of 2015 tax $237,243 = $215,676

2014 real estate taxes are 431,351, however the facility paid the 2nd installment of the 2014 and the 1st installment of the 2015 in 2015.

The total actually paid in 2015 was $449,535. This is the reason for the variance on line 7 above, and line 33 on page 4.

Allocated from SIR Management = $5,243

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051359

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	31-22-114-023-0000	Long Term Care Property	$ 13,194.27	$ 13,194.27
2.	31-22-114-024-0000	Long Term Care Property	$ 396,184.46	$ 396,184.46
3.	31-22-114-025-0000	Long Term Care Property	$ 5,822.58	$ 5,822.58
4.	31-22-114-026-0000	Long Term Care Property	$ 16,149.74	$ 16,149.74
5.	See Attached	Allocated from SIR Management	$ 118,674.75	$ 4,496.21
6.	See Attached	Allocated from Regency Property LLC	$ 862,948.02	$ 506.80
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,412,973.82	$ 436,354.06

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Applewood Rehabilitation Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051359

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	191,644	2003	$ 223,625	1
2					2
3	TOTALS	191,644		$ 223,625	3

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		2003	1967	$ 1,977,860	$ 92,666	39	$	$ (92,666)	$ 1,977,860	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	17,643		20	455	455	16,677	9
10	Various			2004	30,750		20	1,139	1,139	20,870	10
11	Various			2005	46,763		20	2,338	2,338	24,142	11
12	Various			2006	295,584		20	14,935	14,935	141,987	12
13	Various			2007	154,735		20	6,065	6,065	124,670	13
14	Various			2008	4,000		20	333	333	2,556	14
15	Various			2009	15,494		20	775	775	5,014	15
16	Various			2010	3,500		20	175	175	1,035	16
17	Various			2011	175,218		20	11,132	11,132	50,590	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		99,961	2,820		3,671	851	48,191	68
69	Financial Statement Depreciation			46,368			(46,368)		69
70	TOTAL (lines 4 thru 69)		$ 2,821,507	$ 141,854		$ 41,019	$ (100,835)	$ 2,413,593	70

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,821,507	$ 141,854		$ 41,019	$ (100,835)	$ 2,413,593	1
2	Water Main Break	2012	16,650		20	833	833	2,706	2
3	Water Main Break	2012	34,140		20	1,707	1,707	5,406	3
4	Security Camera	2013	6,630		20	332	332	967	4
5	Front Door Alarm System	2013	6,025		20	301	301	828	5
6	Roof Top Air Conditioner	2013	8,100		20	405	405	1,080	6
7	Nurse Call System	2013	21,451		20	1,073	1,073	2,771	7
8	Asphalt In Parking Lot And Drives	2013	3,780		20	189	189	504	8
9	Condensing Unit	2014	3,525		20	176	176	353	9
10	Dvr - Security System	2014	3,119		20	156	156	273	10
11	Wi-Fi Wiring Upgrade	2014	12,230		20	612	612	1,070	11
12	Concrete Sidewalk & Asphalt Work	2014	17,416		20	871	871	1,451	12
13	Sprinkler System (263 Heads)	2014	15,345		20	767	767	1,087	13
14	Annuciator Panel For Fire Alarm	2014	3,845		20	192	192	272	14
15	Asphalt Work	2015	7,281		20	273	273	273	15
16	Carpeting - Various Offices	2015	9,228		20	461	461	461	16
17	Cooling System (2 Units)	2015	5,245		20	175	175	175	17
18	Carrier Roof-Top Unit	2015	6,825		20	256	256	256	18
19	Video Camera & Monitors	2015	2,792		20	23	23	23	19
20	Handrails Installation - All Halls	2015	100,886		20	2,102	2,102	2,102	20
21	Installed Rigid Vinyl Flooring	2015	2,731		20	137	137	137	21
22	Installed Wood Tile Flooring For Front Lobby Lounge	2015	3,135		20	157	157	157	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,111,887	$ 141,854		$ 52,215	$ (89,639)	$ 2,435,944	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - S.I.R. Management	2009	24,189	620	39	620		3,747	3
4	Allocated- S.I.R. Properties - S.I.R. Management	1993	21,899	695	35	626	(69)	14,077	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	5,552	155	20		(155)	5,552	9
10	Allocated - S.I.R. Management	1994	17		20			17	10
11	Allocated - S.I.R. Management	1995	127		20	4	4	127	11
12	Allocated - S.I.R. Management	1997	8,531	191	20	416	225	7,972	12
13	Allocated - S.I.R. Management	1999	671		20	34	34	545	13
14	Allocated - S.I.R. Management	2000	792		20	40	40	615	14
15	Allocated - S.I.R. Management	2007	2,545		20	127	127	1,043	15
16	Allocated - S.I.R. Management	2008	7,013	701	20	442	(259)	3,467	16
17	Allocated - S.I.R. Management	2009	17,426	159	20	871	712	5,441	17
18	Allocated - S.I.R. Management	2011	431	43	20	43		190	18
19	Allocated - S.I.R. Management	2012	1,380	69	20	69		236	19
20	Allocated - S.I.R. Management	2014	194	19	20	10	(9)	15	20
21									21
22	Allocated - S.I.R. Properties - S.I.R. Management	2012	1,341	94	20	5	(89)	24	22
23	Allocated - S.I.R. Properties - S.I.R. Management	2010	1,321		20	66	66	352	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2009	1,315	59	20	66	7	447	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2007	383	8	20	19	11	173	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2002	87		20	4	4	59	26
27	Allocated - S.I.R. Properties - S.I.R. Management	1999	2,775		20	139	139	2,289	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1998	1,326		20	66	66	1,160	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1997	82		20	4	4	79	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1994	209	5	20		(5)	209	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1993	355	2	20		(2)	355	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 99,961	$ 2,820		$ 3,671	$ 851	$ 48,191	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 99,961	$ 2,820		$ 3,671	$ 851	$ 48,191	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 99,961	$ 2,820		$ 3,671	$ 851	$ 48,191	34

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 289,573	$ 1,572	$ 29,240	$ 27,668	10	$ 112,299	71
72	Current Year Purchases	20,728		1,506	1,506	10	1,506	72
73	Fully Depreciated Assets	832,787		3	3	10	832,787	73
74								74
75	TOTALS	$ 1,143,088	$ 1,572	$ 30,749	$ 29,177		$ 946,593	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	2015	$ 1,701	$ 149	$ 182	$ 33	5	$ 1,162	76
77										77
78										78
79										79
80	TOTALS			$ 1,701	$ 149	$ 182	$ 33		$ 1,162	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)	$ 4,480,301	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,575	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,146	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (60,429)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,383,699	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	Construction Project	$ 351,147	92
93			93
94			94
95		$ 351,147	95

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 3,441 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	Allocated from SIR Management		$	$ 3,523	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,523	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.

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 249,537	$		$ 249,537	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			129,616			129,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,192			237,192	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				204,089		204,089	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						18,363		18,363	13
14	TOTAL			$		$ 616,345	$ 222,452		$ 838,797	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.

STATE OF ILLINOIS

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,442	$ 240,435	1
2	Cash-Patient Deposits	37,644	37,644	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,056,175	1,271,851	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,697	93,697	6
7	Other Prepaid Expenses	4,458	4,458	7
8	Accounts Receivable (owners or related parties)	200,000	2,913,444	8
9	Other(specify):		61,995	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,426,416	$ 4,623,524	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		223,625	13
14	Buildings, at Historical Cost		3,036,861	14
15	Leasehold Improvements, at Historical Cost	391,250	391,250	15
16	Equipment, at Historical Cost	337,583	337,583	16
17	Accumulated Depreciation (book methods)	(140,667)	(2,073,803)	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):	1,340,878	765,878	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,929,044	$ 2,681,394	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,355,460	$ 7,304,918	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 645,479	$ 645,480	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,669	37,669	28
29	Short-Term Notes Payable	160,000	160,000	29
30	Accrued Salaries Payable	187,822	187,822	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,465	9,465	31
32	Accrued Real Estate Taxes(Sch.IX-B)		215,676	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,300	6,300	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	30,156	937,404	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,076,891	$ 2,199,816	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,076,891	$ 2,199,816	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,278,569	$ 5,105,102	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,355,460	$ 7,304,918	48

*(See instructions.)

Facility Name & ID Number Applewood Rehabilitation Center, Llc **#** 0051359 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,223,627	1
2	Restatements (describe):		2
3	Rounding	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,223,632	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	329,937	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(275,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 54,937	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,278,569	24 *

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,836,975	1
2	Discounts and Allowances for all Levels	(2,035,316)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,801,659	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,091,889	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,091,889	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	158,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,230	19
20	Radiology and X-Ray	2,997	20
21	Other Medical Services	48,279	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 220,533	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,947	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,947	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	290,845	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 290,845	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,414,873	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,165,773	31
32	Health Care	2,525,318	32
33	General Administration	2,135,442	33
	B. Capital Expense		
34	Ownership	1,170,730	34
	C. Ancillary Expense		
35	Special Cost Centers	838,797	35
36	Provider Participation Fee	248,876	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,084,936	40
41	**Income before Income Taxes (line 30 minus line 40)****	329,937	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 329,937	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,590,630	44
45	Private Pay - Net Inpatient Revenue	444,702	45
46	Medicare - Net Inpatient Revenue	679,217	46
47	Other-(specify) Hospice	403,999	47
48	Other-(specify) Managed Care/Insurance	683,111	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,801,659	49

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

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

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

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,959	2,086	$ 91,374	$ 43.80	1
2	Assistant Director of Nursing	1,859	1,985	69,598	35.06	2
3	Registered Nurses	11,393	12,766	403,814	31.63	3
4	Licensed Practical Nurses	17,815	18,771	446,659	23.80	4
5	CNAs & Orderlies	64,146	67,723	713,395	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,329	9,372	175,363	18.71	8
9	Activity Director					9
10	Activity Assistants	8,111	8,982	92,255	10.27	10
11	Social Service Workers	2,728	3,225	44,651	13.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,306	20,526	240,432	11.71	15
16	Dishwashers					16
17	Maintenance Workers	1,693	2,127	55,145	25.93	17
18	Housekeepers	15,217	16,258	184,822	11.37	18
19	Laundry	2,135	2,428	32,528	13.40	19
20	Administrator	1,772	2,086	123,403	59.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,675	12,241	200,977	16.42	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	4,828	5,540	153,238	27.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,966	186,116	$ 3,027,654 *	$ 16.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,652	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Monthly	2,392	10-03	37
38	Nurse Consultant	Monthly	35,880	10-03	38
39	Pharmacist Consultant	Monthly	1,164	10-03	39
40	Physical Therapy Consultant	86	3,995	10a-03	40
41	Occupational Therapy Consultant	51	3,858	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	2,287	10a-03	43
44	Activity Consultant	Monthly	832	11-03	44
45	Social Service Consultant	Monthly	551	12-03	45
46	Other(specify)				46
47	Director of Food Service	Monthly	13,800	01-03	47
48	Consultant -Socialized Rehab	Monthly	11,040	10a-03	48
49	TOTAL (lines 35 - 48)	196	$ 114,451		49

C. CONTRACT NURSES

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

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dianne O'Connor	Administrator	0	$ 123,403
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 123,403

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 363,099
SIR Management - Dir. of Admin. Services	33,120
SIR Management - Ancillary Admin Charges	27,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 423,819
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir. Of Regulatory Service	$ 16,560
SIR Management	Bookkeeping	56,580
SIR Management	Dir of Financial Serv	43,200
PayChex	Payroll Services	11,931
Pinnacle Consulting	Customer Satisfaction	2,784
E-Health Data	MDS Software	3,300
HK Payroll	WOTC Program	1,415
Archieve Accrediation	Accrediation Consult	10,802
Burke Warren	RE Tax Assessment	35,235
Legat Architects	Architect Consulting	353
See Supplemental Schedule		103,984
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 286,142

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,678
Unemployment Compensation Insurance	56,406
FICA Taxes	223,946
Employee Health Insurance	85,554
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Contributions	5,675
Other Employee Benefits	10,468
TOTAL (agree to Schedule V, line 22, col.8)	$ 544,727

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	1,000
Health Care Worker Background Check	
(Indicate # of checks performed 131)	1,312
Patient Background Checks 140	1,399
Licenses & Permits	4,015
Dues & Subscriptions	22,076
Allocated from SIR Management	1,016
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,759
Allocated from SIR Management	737
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,496

**See instructions.

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
9													
10													
11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Applewood Rehabilitation Center, Llc # 0051359 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: $19,593.42**

(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. $ **48,522** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **248,876**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **None** 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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.