

		FOR BHF USE					

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

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: <u>0048959</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>CAMBRIDGE NURSING REHAB CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> 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.																																															
Address: <u>9615 N KNOX AVE</u> <u>SKOKIE</u> <u>60076</u>																																																	
Number City Zip Code																																																	
County: <u>COOK</u>																																																	
Telephone Number: <u>(847) 679-4161</u> Fax # <u>(847) 679-3241</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>MARK APPEL</u></td></tr><tr><td>(Title) <u>OWNER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>BOB KAGDA</u></td></tr><tr><td>and Title) <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u></td></tr><tr><td colspan="2" rowspan="4">In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</td><td colspan="2">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</td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr><tr><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARK APPEL</u>	(Title) <u>OWNER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)	Paid Preparer	(Date) _____	(Print Name <u>BOB KAGDA</u>	and Title) <u>VICE PRESIDENT</u>	(Firm Name <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u>	In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____		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																																	
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Date of Initial License for Current Owners: <u>11/1/07</u>																																																	
Type of Ownership:																																																	
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		☐	Other _____																																														

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,358</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>113</u>	TOTALS	<u>113</u>	<u>41,358</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,824</u>	<u>2,824</u>	8
9	SNF/PED					9
10	ICF	<u>26,911</u>	<u>3,584</u>	<u>2,036</u>	<u>32,531</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,911</u>	<u>3,584</u>	<u>4,860</u>	<u>35,355</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.49%

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

0 (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?

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

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

YES ☐NO ☒

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

Date started 11/01/07

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

YES ☒Date 11/01/07NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified _____ and days of care provided 2,824Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	331,950	18,287	13,888	364,125		364,125		364,125		1
2	Food Purchase		203,718		203,718	(25,210)	178,508	(224)	178,284		2
3	Housekeeping	112,044	21,181		133,225		133,225		133,225		3
4	Laundry	201,085	16,589		217,674		217,674		217,674		4
5	Heat and Other Utilities			70,230	70,230		70,230		70,230		5
6	Maintenance	32,430	16,152	75,840	124,422		124,422		124,422		6
7	Other (specify):*			9,331	9,331		9,331		9,331		7
8	TOTAL General Services	677,509	275,927	169,289	1,122,725	(25,210)	1,097,515	(224)	1,097,291		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,869,016	77,335	56,038	2,002,389		2,002,389		2,002,389		10
10a	Therapy										10a
11	Activities	106,828	14,298	1,540	122,666		122,666		122,666		11
12	Social Services	118,598		6,697	125,295		125,295		125,295		12
13	CNA Training										13
14	Program Transportation			5,456	5,456		5,456		5,456		14
15	Other (specify):* CARE PLAN	62,110			62,110		62,110		62,110		15
16	TOTAL Health Care and Programs	2,156,552	91,633	81,731	2,329,916		2,329,916		2,329,916		16
	C. General Administration										
17	Administrative	44,052		258,000	302,052		302,052		302,052		17
18	Directors Fees										18
19	Professional Services			44,845	44,845		44,845		44,845		19
20	Dues, Fees, Subscriptions & Promotions			49,887	49,887		49,887	(26,912)	22,975		20
21	Clerical & General Office Expenses	177,074	11,128	7,316	195,518		195,518	(1,430)	194,088		21
22	Employee Benefits & Payroll Taxes			581,011	581,011	25,210	606,221		606,221		22
23	Inservice Training & Education			2,170	2,170		2,170		2,170		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			6,298	6,298		6,298		6,298		25
26	Insurance-Prop.Liab.Malpractice			67,729	67,729		67,729	11,219	78,948		26
27	Other (specify):*										27
28	TOTAL General Administration	221,126	11,128	1,017,256	1,249,510	25,210	1,274,720	(17,123)	1,257,597		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,055,187	378,688	1,268,276	4,702,151		4,702,151	(17,347)	4,684,804		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	11,478
	REPAIRS & MAINTENANCE		2,410
			0
			13,888
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		14,802
	ELECTRICITY		26,271
	WATER		19,184
	CABLE TV - LOBBY		9,973
			0
			70,230
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,723
	PAINTING & DECORATING		14,177
	BUILDING REPAIRS		9,039
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		19,507
	ELEVATOR MAINTENANCE & REPAIR		12,496
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,435
	FIRE SERVICE		7,200
	CONTRACTED BUILDING MAINT.		5,263
			0
			0
			0
			75,840
7	OTHER		
	SCAVENGER		9,331
	SECURITY SERVICE		0
			0
			0
			9,331
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		8,540
	PURCHASED SERVICES		23,786
	PSYCHO-SOCIAL CONSULTANT	XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,512
	PHARMACY CONSULTANT	XVIII B 39-2	1,800
	UTILIZATION REVIEW FEES	XVIII B -2	0
	PHYSICIANS	XVIII B -2	17,000
	PSYCHIATRIC	XVIII B -2	0
	RN CONSULTANT	XVIII B 38-2	0
	PROGRAM CONSULTANT		225
	DENTAL		175
			56,038
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,540
			0
			1,540
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	6,697
			6,697
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		5,456
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	258,000
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	1,745
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	43,100
			0
			44,845
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,846
	EMPLOYEE WANT ADS	XIX F	7,754
	CONTRIBUTIONS	VI 20 XIX F	150
	DUES & SUBSCRIPTIONS	XIX F	12,339
	LICENSES & PERMITS	XIX F	2,882
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	3,900
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,016
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0
	PATIENT BACKGROUND CHECKS	XIX F	0
			49,887
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		30
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		0
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,430
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		5,856
	MESSENGER SERVICE		0
			0
			7,316

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	231,590
	UNEMPLOYMENT COMPENSATION	XIX D	20,214
	WORKERS COMPENSATION INSURANC	XIX D	71,756
	HOSPITALIZATION INSURANCE	XIX D	212,857
	EMPLOYEE BENEFITS - OTHER	XIX D	8,479
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,290
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	33,825
	CHICAGO HEAD TAX	XIX D	0
			0
			581,011
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		2,170
			2,170
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		6,298
			6,298
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		67,729
			67,729
			67,729
27	OTHER		
	BAD DEBTS	VI 24	0
			0

GRAND TOTAL COLUMN 3 OTHER

1,268,276

CAMBRIDGE NURSING REHAB CTR
SCHEDULES
12/31/2012

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	203,718
LESS SALES TAX	<u>(224)</u>
NET FOOD	203,494
TOTAL PATIENT CENSUS	35,355
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	106,065
ADD # EMPLOYEE MEALS/DAY	41
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	15,006
PATIENT MEALS	106,065
ADD EMPLOYEE MEALS	<u>15,006</u>
TOTAL MEALS/YEAR	121,071
NET FOOD	203,494
DIVIDE TOTAL MEALS/YEAR	<u>121,071</u>
COST PER MEAL	1.68
TIMES EMPLOYEE MEALS	<u>15,006</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>25,210</u></u>

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,110	44,110		44,110	139,717	183,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,153	8,153		8,153	736,801	744,954			32
33	Real Estate Taxes			242,406	242,406		242,406		242,406			33
34	Rent-Facility & Grounds			1,213,215	1,213,215		1,213,215	(1,213,215)				34
35	Rent-Equipment & Vehicles			75,185	75,185		75,185		75,185			35
36	Other (specify):*							36,504	36,504			36
37	TOTAL Ownership			1,583,069	1,583,069		1,583,069	(300,193)	1,282,876			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		110,319	259,498	369,817		369,817		369,817			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			360,942	360,942		360,942		360,942			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		110,319	620,440	730,759		730,759		730,759			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,055,187	489,007	3,471,785	7,015,979		7,015,979	(317,540)	6,698,439			45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	753	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment		20		19
20	Contributions	(5,166)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(17,846)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,900)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,813)		\$	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)	(289,727)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (289,727)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (317,540)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
CAMBRIDGE NURSING REHAB CTR

Report Period Beginning: ID# 0048959
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(224)	0	0	0	0	0	0	0	0	0	0	(224)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(224)	0	0	0	0	0	0	0	0	0	0	(224)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(26,912)	0	0	0	0	0	0	0	0	0	0	(26,912)	20
21	Clerical & General Office Expenses	(1,430)	0	0	0	0	0	0	0	0	0	0	(1,430)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	11,219	0	0	0	0	0	0	0	0	0	11,219	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,342)	11,219	0	0	0	0	0	0	0	0	0	(17,123)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(28,566)	11,219	0	0	0	0	0	0	0	0	0	(17,347)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	753	138,964	0	0	0	0	0	0	0	0	0	139,717	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	736,801	0	0	0	0	0	0	0	0	0	736,801	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,213,215)	0	0	0	0	0	0	0	0	0	(1,213,215)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	36,504	0	0	0	0	0	0	0	0	0	36,504	36
37	TOTAL Ownership	753	(300,946)	0	0	0	0	0	0	0	0	0	(300,193)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(27,813)	(289,727)	0	0	0	0	0	0	0	0	0	(317,540)	45

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.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARK APPEL	50	SKOKIE MEADOWS NURSING CENTER #2	SKOKIE	SKOKIE CAMBRIDGE	SKOKIE	REAL ESTATE
JOAN WILLEY	50			REALTY, LLC		

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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 1,213,215	SKOKIE CAMBRIDGE REALTY LLC		\$	(1,213,215)	1
2	V	26	INSURANCE				11,219	11,219	2
3	V	30	DEPRECIATION				138,964	138,964	3
4	V	32	INTEREST				736,801	736,801	4
5	V	36	MIP INSURANCE				36,504	36,504	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,213,215			\$ 923,488	\$ * (289,727)	14

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

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 CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARK APPEL	CFO	FINANCIAL	50.00				MGMT FEES	\$ 258,000	17-3	1
2											2
3	JOAN WILLEY	CEO	ADMINISTRATIVE	50.00	258,000						3
4					SKOKIE MEADOWS NURSING CENTER #2						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 258,000		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 CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 SKOKIE CAMBRIDGE REALTY, LLC
Street Address 9615 N. KNOX
City / State / Zip Code SKOKIE IL 60076
Phone Number (847)679-4161
Fax Number (847)679-3241

	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	26	INSURANCE	DIRECT	1	1	\$	\$		0	1
2	30	DEPRECIATION	DIRECT	1	1				0	2
3	32	INTEREST	DIRECT	1	1				0	3
4	36	MIP INSURANCE	DIRECT	1	1				0	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CAMBRIDGE REALTY			MORTGAGE		12/21/12	\$	7,239,800	11/01/42	2.4000	\$	5,309	1
2	CAMBRIDGE REALTY		X	MORTGAGE	\$37,760.00	10/17/07	6,822,050					650,412	2
3	CAMBRIDGE REALTY		X	2ND MORTGAGE		7/24/07	835,500					80,197	3
4	JACOB GRAF		X	WORKING CAPITAL									4
5	DIAMOND BANK		X	WORKING CAPITAL								883	5
	Working Capital												
6													6
7	DIAMOND BANK		X	WORKING CAPITAL	INT. ONLY	4/15/11		412,190		6.0000		8,153	7
8													8
9	TOTAL Facility Related				\$37,760.00		\$	7,657,550	\$	7,651,990			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	7,657,550	\$	7,651,990			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,504 Line # 36

* 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	250,000	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.)			\$	242,406	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(7,594)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	250,000	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.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	242,406	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 221,368 8			
		2008 227,079 9			
		2009 175,021 10			
		2010 235,114 11			
		2011 242,406 12			
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED					
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.					

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
CAMBRIDGE NURSING REHAB CTR
COUNTY
COOK

FACILITY IDPH LICENSE NUMBER
0048959

CONTACT PERSON REGARDING THIS REPORT
BOB KAGDA

TELEPHONE
(847) 675-3585
FAX #:
(847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	10-10-304-007-0000	NURSING HOME	\$ 40,397.22	\$ 40,397.22
2.	10-10-304-008-0000	NURSING HOME	\$ 40,401.72	\$ 40,401.72
3.	10-10-304-009-0000	NURSING HOME	\$ 40,401.72	\$ 40,401.72
4.	10-10-304-010-0000	NURSING HOME	\$ 40,401.72	\$ 40,401.72
5.	10-10-304-011-0000	NURSING HOME	\$ 40,401.72	\$ 40,401.72
6.	10-10-304-012-0000	NURSING HOME	\$ 40,401.72	\$ 40,401.72
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 242,405.82	\$ 242,405.82

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 X NO

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048

B. General Construction Type: Exterior Frame

Number of Stories

C. Does the Operating Entity?

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING		2007	\$ 275,250	1
2					2
3	TOTALS			\$ 275,250	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	113			2007	\$ 2,365,250	\$ 60,647	39	\$ 60,647	\$	\$ 313,343
5										
6										
7										
8										
	Improvement Type**									
9	CARPENTRY-LANDLORD			2007	83,324	2,137	39	2,137		11,041
10	WINDOWS- LANDLORD			2007	24,779	635	39	635		3,281
11	DRYWALL- LANDLORD			2007	3,685	95	39	95		491
12	FLOORING- LANDLORD			2007	80,961	2,076	39	2,076		10,726
13	PAINTING & DECORATING- LANDLORD			2007	119,994	3,076	39	3,076		15,893
14	SPECIAL EQUIPMENT- LANDLORD			2007	10,521	270	39	270		1,395
15	BLINDS & SHADES- LANDLORD			2007	6,170	158	39	158		816
16	CARPETS- LANDLORD			2007	6,133	157	39	157		811
17	SPECIAL CONSTRUCTION- LANDLORD			2007	14,852	381	39	381		1,969
18	ELECTRICAL- LANDLORD			2007	20,219	519	39	519		2,681
19	GENERAL REQUIREMENTS- LANDLORD			2007	36,552	937	39	937		4,841
20	BUILDERS OVERHEAD- LANDLORD			2007	8,143	209	39	209		1,080
21	BUILDERS PROFIT- LANDLORD			2007	40,719	1,044	39	1,044		5,394
22	ARCHITECT- LANDLORD			2007	22,320	572	39	572		2,955
23	INTEREST THRU PROJECT- LANDLORD			2007	3,698	95	39	95		491
24	CONSTRUCTION CHANGE- LANDLORD			2007	194	5	39	5		26
25	ARCHITECT- LANDLORD			2007	5,580	143	39	143		739
26										
27	HOT WATER LINE			2008	4,330	104	39	104		442
28	COILER SYSTEM			2008	131,000	3,366	39	3,366		14,306
29										
30	NEW PUMPS			2009	5,837	150	39	150		593
31	BOILER REMOVAL & REPLACE PUMP			2009	4,730	121	39	121		479
32	NEW BASEBOARD HEATING			2009	17,028	437	39	437		1,729
33	DRAINS & CONCRETE			2009	4,850	124	39	124		491
34	NEW HOT WATER COIL			2009	2,693	69	39	69		273
35	SPRINKLER SYSTEM			2009	5,980	153	39	153		607
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 CAMBRIDGE NURSING REHAB CTR

0048959

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	NEW MOTORIZED VALVE BODY AND MOTOR	2010	\$ 11,686	\$ 299	39	\$ 299	\$	\$ 885	37
38	NEW SEDIMENT/AIR REMOVING DEVICE	2010	7,535	193	39	193		571	38
39	NEW BLATER TANKS	2010	5,023	129	39	129		381	39
40	FIRE ALARM SYSTEM	2010	18,293	469	39	469		1,388	40
41	FIRE SCAPE	2010	2,500	64	39	64		190	41
42	DISH ROOM WALLS REPAIR	2010	3,800	97	39	97		287	42
43	CAULK WINDOWS	2010	2,600	67	39	67		198	43
44	DRYER VENTING	2010	3,733	96	39	96		284	44
45	HEATING SYSTEM	2010	21,014	539	39	539		1,594	45
46									46
47	ADMINI. ASS. SUSPENDED CEILING	2011	3,188	82	39	82		164	47
48	NURSE OFFICE SUSPENDED CEILING	2011	2,929	75	39	75		150	48
49	REPAIR KITCHEN WALL	2011	3,500	90	39	90		180	49
50	remove & replaced drywall, tiling, then repaint staff bathroom	2011	3,973	102	39	102		204	50
51	remove & replaced drywall, tiling, then repaint public bathroom	2011	4,221	108	39	108		216	51
52	KITCHEN DOORS AND WALL REPLACEMENT	2011	8,934	229	39	229		458	52
53	WALLPAPER	2011	1,800	46	39	46		92	53
54									54
55	replace exterior kitchen door and replace wall behind stove	2012	5,228	129	39	129		129	55
56	remodeling of doorway and doors to the kitchen	2012	7,975	196	39	196		196	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,147,474	\$ 80,690		\$ 80,690	\$	\$ 404,460	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$196,305	\$27,944	\$19,631	\$ (8,313)	10	\$67,775	71
72	Current Year Purchases	8,632	8,632	432	(8,200)	10	432	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		65,808	65,808				74
75	TOTALS	\$204,937	\$102,384	\$85,871	\$ (16,513)		\$68,207	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	ADMINISTRATOR	2008 LEXUS ES 350	2008	\$ 40,658	\$	\$	\$	5	\$ 40,658	76
77	FACILITY	2010 FORD	2010	50,811		10,163	10,163	5	30,489	77
78	ADMINISTRATOR	2011 HUNDAI	2011	35,517		7,103	7,103	5	14,206	78
79										79
80	TOTALS			\$ 126,986	\$	\$ 17,266	\$ 17,266		\$ 85,353	80

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	3,754,647
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	183,074
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	183,827
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	753
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	558,020

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
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

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.
13.
14.

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$75,185
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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
☒ 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_____

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	39-3	hrs	\$		\$ 81,244	\$		\$ 81,244	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,568			47,568	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			130,686			130,686	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				110,319		110,319	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 259,498	\$ 110,319		\$ 369,817	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.

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	\$ (27,346)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,500))	1,280,523		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(482,967)		8
9	Other(specify): skokie 1 & 2 elimination	241,919		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,012,129	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	294,380		15
16	Equipment, at Historical Cost	331,923		16
17	Accumulated Depreciation (book methods)	(328,105)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 298,198	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,310,327	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 278,417	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	412,190		29
30	Accrued Salaries Payable	117,466		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO SKOKIE 2</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,058,073	\$	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)	\$ 1,058,073	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 252,254	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,310,327	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 427,696	1
2	Restatements (describe):		2
3	SKOKIE 1 & 2 ELIMINATION	(109,424)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 318,272	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	501,982	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	(568,000)	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)	\$ (66,018)	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)	\$ 252,254	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959Report Period Beginning: 01/01/2012Ending: 12/31/2012**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,434,013	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,434,013	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,714	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 82,714	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,234	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,234	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,517,961	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,122,725	31
32	Health Care	2,329,916	32
33	General Administration	1,249,510	33
	B. Capital Expense		
34	Ownership	1,583,069	34
	C. Ancillary Expense		
35	Special Cost Centers	369,817	35
36	Provider Participation Fee	360,942	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,015,979	40
41	Income before Income Taxes (line 30 minus line 40)**	501,982	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 501,982	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,036,954	44
45	Private Pay - Net Inpatient Revenue	554,214	45
46	Medicare - Net Inpatient Revenue	1,497,968	46
47	Other-(specify) <u>VETERAN</u>	344,877	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,434,013	49

**TAX RETURN PREPARED ON CASH BASIS

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? NO** 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 CAMBRIDGE NURSING REHAB CTR# 0048959Report Period Beginning: 01/01/2012Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,132	\$ 75,158	\$ 35.25	1
2	Assistant Director of Nursing	1,968	2,080	78,085	37.54	2
3	Registered Nurses	23,802	26,081	758,088	29.07	3
4	Licensed Practical Nurses	6,714	7,175	179,535	25.02	4
5	CNAs & Orderlies	63,219	66,832	709,805	10.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,976	2,080	40,248	19.35	9
10	Activity Assistants	5,744	6,250	66,580	10.65	10
11	Social Service Workers	5,680	6,264	118,598	18.93	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,080	42,894	20.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,282	26,898	289,056	10.75	15
16	Dishwashers					16
17	Maintenance Workers	1,944	2,080	32,430	15.59	17
18	Housekeepers	9,122	10,155	112,044	11.03	18
19	Laundry	15,804	17,524	201,085	11.47	19
20	Administrator	1,920	2,072	44,052	21.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,683	3,900	48,486	12.43	23
24	Clerical	5,925	6,634	128,588	19.38	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					31
32	Other Health Care MDS	1,916	2,080	68,345	32.86	32
33	Other(specify) <u>CARE PLANS</u>	1,696	1,861	62,110	33.37	33
34	TOTAL (lines 1 - 33)	179,403	194,178	\$ 3,055,187 *	\$ 15.73	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	54	\$ 11,478	1-3	35
36	Medical Director	250	12,000	9-3	36
37	Medical Records Consultant	47	4,512	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	55	1,800	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	59	1,540	11-3	44
45	Social Service Consultant	59	6,697	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	524	\$ 38,027		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

