

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0048959 Facility Name: CAMBRIDGE NURSING REHAB CTR Address: 9615 NORTH KNOX AVE SKOKIE 60076 County: COOK Telephone Number: (847) 679-4161 Fax # (847) 679-3241 HFS ID Number: Date of Initial License for Current Owners: 11/01/07 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: SANFORD BOKOR Telephone Number: (847) 675-3585 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 01/01/2016 to 12/31/2016 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) (Type or Print Name) MARK APPEL (Title) OWNER Paid Preparer (Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Print Name and Title) SANFORD BOKOR PRESIDENT (Firm Name & Address) KBKB, LTD 8140 RIVER DRIVE, MORTON GROVE, IL 60053 (Telephone) (847) 675-3585 Fax # (847) 675-5777 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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Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR

0048959 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	113	Skilled (SNF)	113	41,358	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	113	TOTALS	113	41,358	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,526	2,526	8
9	SNF/PED					9
10	ICF	27,459	2,761	2,637	32,857	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,459	2,761	5,163	35,383	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.55%

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? 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 11/01/07

J. Was the facility purchased or leased after January 1, 1978? YES X Date 11/01/07 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified and days of care provided 2,526

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL X CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	329,400	21,983	15,700	367,083		367,083		367,083			1
2	Food Purchase		186,723		186,723	(21,126)	165,597	(291)	165,306			2
3	Housekeeping	104,785	21,050		125,835		125,835		125,835			3
4	Laundry	51,358	19,513	2,739	73,610		73,610		73,610			4
5	Heat and Other Utilities			115,041	115,041		115,041		115,041			5
6	Maintenance	32,430	20,406	358,396	411,232		411,232		411,232			6
7	Other (specify):*			10,567	10,567		10,567		10,567			7
8	TOTAL General Services	517,973	269,675	502,443	1,290,091	(21,126)	1,268,965	(291)	1,268,674			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,950,726	56,100	47,769	2,054,595		2,054,595		2,054,595			10
10a	Therapy											10a
11	Activities	71,442	21,050	2,449	94,941		94,941		94,941			11
12	Social Services	80,709		5,332	86,041		86,041		86,041			12
13	CNA Training											13
14	Program Transportation			230	230		230		230			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,102,877	77,150	67,780	2,247,807		2,247,807		2,247,807			16
	C. General Administration											
17	Administrative	44,220		120,000	164,220		164,220		164,220			17
18	Directors Fees											18
19	Professional Services			161,453	161,453		161,453		161,453			19
20	Dues, Fees, Subscriptions & Promotions			62,174	62,174		62,174	(29,881)	32,293			20
21	Clerical & General Office Expenses	169,840	9,226	10,221	189,287		189,287	(2,181)	187,106			21
22	Employee Benefits & Payroll Taxes			518,589	518,589	21,126	539,715		539,715			22
23	Inservice Training & Education											23
24	Travel and Seminar			595	595		595		595			24
25	Other Admin. Staff Transportation			7,417	7,417		7,417		7,417			25
26	Insurance-Prop.Liab.Malpractice			145,950	145,950		145,950	15,438	161,388			26
27	Other (specify):*											27
28	TOTAL General Administration	214,060	9,226	1,026,399	1,249,685	21,126	1,270,811	(16,624)	1,254,187			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,834,910	356,051	1,596,622	4,787,583		4,787,583	(16,915)	4,770,668			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	11,540
	REPAIRS & MAINTENANCE		937
	OUTSIDE SERVICES		3,223
3	HOUSEKEEPING		
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
	OUTSIDE LABOR		2,739
5	HEAT & OTHER UTILITIES		
	GAS HEAT		23,871
	ELECTRICITY		63,812
	WATER		18,222
	CABLE TV - LOBBY		9,136
			115,041
6	MAINTENANCE		
	GROUNDS MAINTENANCE		12,297
	PAINTING & DECORATING		22,155
	BUILDING REPAIRS		38,609
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		28,284
	ELEVATOR MAINTENANCE & REPAIR		19,063
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,803
	FIRE SERVICE		6,520
	CONTRACTED BUILDING MAINT.		227,665
			358,396
7	OTHER		
	SCAVENGER		10,567
	SECURITY SERVICE		0
			10,567
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		9,606
	PURCHASED SERVICES		13,818
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,800
	PHARMACY CONSULTANT	XVIII B 39-2	7,505
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	12,000
	PSYCHIATRIC	XVIII B __-2	40
	RN CONSULTANT	XVIII B 38-2	0
			47,769
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	2,449
			2,449
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	5,332
			5,332
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	230	
			230
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 120,000	120,000
	DIRECTORS FEES		
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 18,741	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 142,712	
			161,453
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 19,270	
	EMPLOYEE WANT ADS	XIX F 2,090	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 31,962	
	LICENSES & PERMITS	XIX F 2,067	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 6,785	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	
	PATIENT BACKGROUND CHECKS	XIX F 0	
			62,174
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,031	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 150	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	8,040	
	MESSENGER SERVICE	0	
			10,221

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 230,737	
	UNEMPLOYMENT COMPENSATION	XIX D 0	
	WORKERS COMPENSATION INSURANCE	XIX D 44,078	
	HOSPITALIZATION INSURANCE	XIX D 208,800	
	EMPLOYEE BENEFITS - OTHER	XIX D 5,927	
	EMPLOYEE PHYSICAL EXAMS	XIX D 2,513	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 26,534	
			518,589
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 595	
	TRAVEL	XIX G 0	
			595
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	7,417	
			7,417
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	145,950	
			145,950
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

1,596,622

CAMBRIDGE NURSING REHAB CTR
SCHEDULES
12/31/2016

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

TOTAL FOOD PURCHASE	186,723
LESS SALES TAX	<u>(291)</u>
NET FOOD	186,432
TOTAL PATIENT CENSUS	35,383
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	106,149
ADD # EMPLOYEE MEALS/DAY	37
TIMES # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	13,542
PATIENT MEALS	106,149
ADD EMPLOYEE MEALS	<u>13,542</u>
TOTAL MEALS/YEAR	119,691
NET FOOD	186,432
DIVIDE TOTAL MEALS/YEAR	<u>119,691</u>
COST PER MEAL	1.56
TIMES EMPLOYEE MEALS	<u>13,542</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>21,126</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			58,666	58,666		58,666	61,824	120,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							164,515	164,515			32
33	Real Estate Taxes			289,430	289,430		289,430		289,430			33
34	Rent-Facility & Grounds			690,065	690,065		690,065	(690,065)				34
35	Rent-Equipment & Vehicles			26,380	26,380		26,380		26,380			35
36	Other (specify):*							36,440	36,440			36
37	TOTAL Ownership			1,064,541	1,064,541		1,064,541	(427,286)	637,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,482	341,710	480,192		480,192		480,192			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			230,245	230,245		230,245		230,245			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		138,482	571,955	710,437		710,437		710,437			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,834,910	494,533	3,233,118	6,562,561		6,562,561	(444,201)	6,118,360			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.)

	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,332)	30		9
10	Interest and Other Investment Income	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(291)	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	(150)	21		18
19	Entertainment		20		19
20	Contributions		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	(19,270)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,785)	20		28
29	Other-Attach Schedule	(5,857)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,836)		\$	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)	(400,365)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (400,365)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (444,201)		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

ID#0048959

Report Period Beginning:01/01/2016

Ending:12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	BANK CHARGES	\$ (2,031)	21	1
2	ILL COUNCIL LONG TERM CARE COPE	(3,826)	20	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	(5,857)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR# 0048959

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(291)	0	0	0	0	0	0	0	0	0	0	(291)	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	(291)	0	0	0	0	0	0	0	0	0	0	(291)	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	(29,881)	0	0	0	0	0	0	0	0	0	0	(29,881)	20
21	Clerical & General Office Expenses	(2,181)	0	0	0	0	0	0	0	0	0	0	(2,181)	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	15,438	0	0	0	0	0	0	0	0	0	15,438	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,062)	15,438	0	0	0	0	0	0	0	0	0	(16,624)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,353)	15,438	0	0	0	0	0	0	0	0	0	(16,915)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR # 0048959 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(11,332)	73,156	0	0	0	0	0	0	0	0	0	61,824	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(151)	164,666	0	0	0	0	0	0	0	0	0	164,515	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(690,065)	0	0	0	0	0	0	0	0	0	(690,065)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	36,440	0	0	0	0	0	0	0	0	0	36,440	36
37	TOTAL Ownership	(11,483)	(415,803)	0	0	0	0	0	0	0	0	0	(427,286)	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)	(43,836)	(400,365)	0	0	0	0	0	0	0	0	0	(444,201)	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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER 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	SKOKIE MEADOWS NURSING CENTER #2	SKOKIE	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.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 690,065	SKOKIE CAMBRIDGE REALTY LLC		\$	(690,065)	1
2	V	26	INSURANCE				15,438	15,438	2
3	V	30	DEPRECIATION				73,156	73,156	3
4	V	32	INTEREST				159,373	159,373	4
5	V	36	MIP INSURANCE				36,440	36,440	5
6	V	32	AMORT OF LOAN COST				5,293	5,293	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 690,065			\$ 289,700	\$ * (400,365)	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: 01/01/2016 Ending: 12/31/2016

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				mngmt fee	\$ 120,000	17-3	1
2											2
3	JOAN WILLEY	CFO	ADMINISTRATIV	50.00	120,000						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	\$ 120,000		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: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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	SKOKIE CAMBRIDGE REALTY, LLC						\$					\$	1			
2	CAMBRIDGE REALTY			MORTGAGE		12/21/12		6,557,538				159,373	2			
3	LOAN COST			AMORTIZE OVER LIFE OF LOAN				79,398		58,226			5,293	3		
4													4			
5													5			
	Working Capital															
6													6			
7													7			
8													8			
9	TOTAL Facility Related						\$	79,398	\$	6,615,764			\$	164,666	9	
	B. Non-Facility Related*															
10	IRS,IDR,ETC		X	LATE FEES										10		
11														11		
12														12		
13														13		
14	TOTAL Non-Facility Related						\$		\$				\$		14	
15	TOTALS (line 9+line14)							\$	79,398	\$	6,615,764			\$	164,666	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,440 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

[illegible]

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.

2015 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 SANFORD BOKOR

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 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-10-304-007-0000	NURSING HOME	\$ 48,233.88	\$ 48,233.88
2. 10-10-304-008-0000	NURSING HOME	\$ 48,239.22	\$ 48,239.22
3. 10-10-304-009-0000	NURSING HOME	\$ 48,239.22	\$ 48,239.22
4. 10-10-304-010-0000	NURSING HOME	\$ 48,239.22	\$ 48,239.22
5. 10-10-304-011-0000	NURSING HOME	\$ 48,239.22	\$ 48,239.22
6. 10-10-304-012-0000	NURSING HOME	\$ 48,239.22	\$ 48,239.22
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 289,429.98	\$ 289,429.98

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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			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	111			2007	\$ 2,365,250	\$ 60,647	39	\$ 60,647		\$ 495,284
5										
6										
7										
8										
	Improvement Type**									
9	CARPENTRY-LANDLORD			2007	83,324	2,137	39	2,137		19,589
10	WINDOWS- LANDLORD			2007	24,779	635	39	635		5,821
11	DRYWALL- LANDLORD			2007	3,685	95	39	95		871
12	FLOORING- LANDLORD			2007	80,961	2,076	39	2,076		19,030
13	PAINTING & DECORATING- LANDLORD			2007	119,994	3,076	39	3,076		28,197
14	SPECIAL EQUIPMENT- LANDLORD			2007	10,521	270	39	270		2,475
15	BLINDS & SHADES- LANDLORD			2007	6,170	158	39	158		1,448
16	CARPETS- LANDLORD			2007	6,133	157	39	157		1,439
17	SPECIAL CONSTRUCTION- LANDLORD			2007	14,852	381	39	381		3,493
18	ELECTRICAL- LANDLORD			2007	20,219	519	39	519		4,757
19	GENERAL REQUIREMENTS- LANDLORD			2007	36,552	937	39	937		8,589
20	BUILDERS OVERHEAD- LANDLORD			2007	8,143	209	39	209		1,916
21	BUILDERS PROFIT- LANDLORD			2007	40,719	1,044	39	1,044		9,570
22	ARCHITECT- LANDLORD			2007	22,320	572	39	572		5,243
23	INTEREST THRU PROJECT- LANDLORD			2007	3,698	95	39	95		871
24	CONSTRUCTION CHANGE- LANDLORD			2007	194	5	39	5		46
25	ARCHITECT- LANDLORD			2007	5,580	143	39	143		1,311
26										
27	HOT WATER LINE			2008	4,330	104	39	104		858
28	BOILER SYSTEM			2008	131,000	3,366	39	3,366		27,770
29										
30	NEW PUMPS			2009	5,837	150	39	150		1,193
31	BOILER REMOVAL & REPLACE PUMP			2009	4,730	121	39	121		963
32	NEW BASEBOARD HEATING			2009	17,028	437	39	437		3,477
33	DRAINS & CONCRETE			2009	4,850	124	39	124		987
34	NEW HOT WATER COIL			2009	2,693	69	39	69		549
35	SPRINKLER SYSTEM			2009	5,980	153	39	153		1,219
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:

01/01/2016 Ending: 12/31/2016

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		\$ 2,081	37
38	NEW SEDIMENT/AIR REMOVING DEVICE	2010	7,535	193	39	193		1,343	38
39	NEW BLATER TANKS	2010	5,023	129	39	129		897	39
40	FIRE ALARM SYSTEM	2010	18,293	469	39	469		3,264	40
41	FIRE SCAPE	2010	2,500	64	39	64		446	41
42	DISH ROOM WALLS REPAIR	2010	3,800	97	39	97		675	42
43	CAULK WINDOWS	2010	2,600	67	39	67		466	43
44	DRYER VENTING	2010	3,733	96	39	96		668	44
45	HEATING SYSTEM	2010	21,014	539	39	539		3,750	45
46									46
47	ADMINI. ASS. SUSPENDED CEILING	2011	3,188	82	39	82		492	47
48	NURSE OFFICE SUSPENDED CEILING	2011	2,929	75	39	75		450	48
49	REPAIR KITCHEN WALL	2011	3,500	90	39	90		540	49
50	remove & replaced drywall, tiling, then repaint staff bathroom	2011	3,973	102	39	102		612	50
51	remove & replaced drywall, tiling, then repaint public bathroom	2011	4,221	108	39	108		648	51
52	KITCHEN DOORS AND WALL REPLACEMENT	2011	8,934	229	39	229		1,374	52
53	WALLPAPER	2011	1,800	46	39	46		276	53
54									54
55	replace exterior kitchen door and replace wall behind stove	2012	5,228	134	39	134		665	55
56	remodeling of doorway and doors to the kitchen	2012	7,975	205	39	205		1,016	56
57									57
58	Remodeling of Dish Room and Part of Kitchen Walls	2013	11,050	284	39	284		1,123	58
59	removed 30lf of dish room wall and built new wall with metal studs								59
60	and mold resistant 5/8 drywall.installed 300 sq ft. of ceramic tiles on								60
61	the new wall. Installed 30lf base board. Removed suspended ceiling								61
62	and replaced with new fire rated grid ceiling tiles,replaced 1x4 light								62
63	fixtures with recess lights.								63
64	Dining Room Remodeling. Removed old wall and installed new	2013	13,540	347	39	347		1,374	64
65	drywall.went over the walls with new 5/8 fire rated drywalls,patched								65
66	sanded and primed for new finish. Replaced existing rotten base								66
67	cabinets,replaced with new top and botton cherry cabinets, crown								67
68	molding,and granite counter top. Installed ceramic baseboard around								68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,172,064	\$ 81,335		\$ 81,335	\$	\$ 669,126	70

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

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR

0048959

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,172,064	\$ 81,335		\$ 81,335	\$	\$ 669,126	1
2 Flooring In Therapy Room	2013	11,986	307	39	307		1,216	2
3 Tankless Water Heater	2013	25,000	641	39	641		2,537	3
4 RE-PIPING OF 3 BOILERS IN BOILER ROOM	2013	26,913	690	39	690		2,731	4
5 MODERNIZATION OF THE HYDRAULIC ELEVATORS	2014	79,550	2,040	39	2,040		6,034	5
6 REMOVED APPROXIMATELY 2,450 FT OF PAVERS ON THE WALKWAY AND PATIO SIDE. REPLACED BAD GRAVEL WITH NEW SCREENIN								6
7 LIMESTONE FOR PROPER BASE FOR NEW PAVERS. INSTALLE NEW DRAIN SYSTEM FOR BETTER STORM WATER DRAINAGE. USED								7
8 POLYMERIC SAND FOR PAVERS JOINT	2014	36,000	923	39	923		2,731	8
9 CURB AROUND THE WALKWAY, BRICK WALLS, AND 2 PILLARS FOR FLOWERPOTS FOR \$2,000. PATIO SIDE INCLUDES NEW CURB,								9
10 AND LIGHT POST WITH THE LIGHT FOR \$1,500. 2 TUSCANY FLOWER								10
11 VASES FOR \$450	2014	3,950	101	39	101		299	11
12 REQUIRED BY ASHRAE	2016	70,000	1,720	39	1,720		1,720	12
13 DISCONNECTED AND REMOVED THE EXISTING HOT WATER CIRCULATION PUMP; FURNISHED AND INSTALLED A NEW LEAD FREE								13
14 HOT WATER BRONZE RE-CIRCULATION PUMP; FURNISHED AND INSTALLED A NEW 1" BALL VALVE, 1" CHECK VALVE, AND 5'								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)		\$ 3,425,463	\$ 87,757		\$ 87,757	\$	\$ 686,394	34

**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	\$305,296	\$	\$30,530	\$30,530		\$176,550	71
72	Current Year Purchases	44,065	44,065	2,203	(41,862)	10	2,203	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$349,361	\$44,065	\$32,733	\$(11,332)		\$178,753	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	\$	\$	\$		\$40,658
77	FACILITY	2010 FORD	2010	50,811					50,811
78	ADMINISTRATOR	2011 HUNDAI	2011	35,517					35,517
79									
80	TOTALS			\$126,986	\$	\$	\$		\$126,986

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)			\$	4,177,060
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	131,822
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	120,490
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(11,332)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	992,133

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:
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:				\$690,065			3
4	Additions							4
5								5
6								6
7	TOTAL				\$690,065			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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$26,380 Description:
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

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

C. CONTRACTUAL INCOME

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)	\$			

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	\$		\$ 153,769	\$		\$ 153,769	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,584			14,584	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			173,357			173,357	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				138,482		138,482	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 341,710	\$ 138,482		\$ 480,192	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	\$ 902,730	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (112,913))	2,005,571		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)			8
9	Other(specify):	2,784,323		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,692,624	\$	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	572,369		15
16	Equipment, at Historical Cost	476,347		16
17	Accumulated Depreciation (book methods)	(553,757)		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)	\$ 494,959	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,187,583	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 198,167	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	63,421		29
30	Accrued Salaries Payable	150,676		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	295,000		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 LANDLORD</u>	2,964,041		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,671,305	\$	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)	\$ 3,671,305	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,516,278	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,187,583	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,824,509	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,824,508	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,322,770	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	(631,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 691,770	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)	\$ 2,516,278	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CAMBRIDGE NURSING REHAB CTR

0048959

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,738,184	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,738,184	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	145,525	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 145,525	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	1,471	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)	\$ 1,471	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 151	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)	\$ 7,885,331	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,290,091	31
32	Health Care	2,247,807	32
33	General Administration	1,249,685	33
	B. Capital Expense		
34	Ownership	1,064,541	34
	C. Ancillary Expense		
35	Special Cost Centers	480,192	35
36	Provider Participation Fee	230,245	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,562,561	40
41	Income before Income Taxes (line 30 minus line 40)**	1,322,770	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,322,770	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,200,870	44
45	Private Pay - Net Inpatient Revenue	523,313	45
46	Medicare - Net Inpatient Revenue	1,474,813	46
47	Other-(specify) <u>HOSPICE/INSURANCE/ETC</u>	539,188	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,738,184	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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: 01/01/2016Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,944	2,080	\$ 84,530	\$ 40.64	1
2	Assistant Director of Nursing	1,728	1,931	71,471	37.01	2
3	Registered Nurses	21,734	24,028	719,500	29.94	3
4	Licensed Practical Nurses	7,433	7,988	210,665	26.37	4
5	CNAs & Orderlies	53,078	57,276	697,288	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	960	976	15,259	15.63	9
10	Activity Assistants	4,597	4,857	56,183	11.57	10
11	Social Service Workers	3,892	4,240	80,709	19.04	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	42,894	20.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,084	25,217	286,506	11.36	15
16	Dishwashers					16
17	Maintenance Workers	1,840	2,080	32,430	15.59	17
18	Housekeepers	6,948	8,704	104,785	12.04	18
19	Laundry	3,538	4,378	51,358	11.73	19
20	Administrator	1,880	2,080	44,220	21.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,050	2,304	45,104	19.58	23
24	Clerical	7,532	8,627	124,736	14.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,900	2,147	24,314	11.32	31
32	Other Health C mds	1,893	2,221	84,368	37.99	32
33	Other(specify) <u>care plan</u>	1,880	2,080	58,590	28.17	33
34	TOTAL (lines 1 - 33)	149,903	165,294	\$ 2,834,910 *	\$ 17.15	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	\$ 11,540	1-3	35
36	Medical Director	250	12,000	9-3	36
37	Medical Records Consultant	50	4,800	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	55	7,505	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	62	2,449	11-3	44
45	Social Service Consultant	62	5,332	12-3	45
46	Other(specify) <u>PHYSICIANS</u>	250	12,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	783	\$ 55,626		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

CAMBRIDGE NURSING REHAB CTR
SCHEDULE-LEGAL
12/31/2016

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
1/21/2016	NEAL,GERBER & EISENBERG	789.5	SETTLEMENT
2/15/2016	NEAL,GERBER & EISENBERG	774.5	SETTLEMENT
7/22/2016	NEAL,GERBER & EISENBERG	163.5	GENERAL LABOR AND EMPLOYMENT COUNSELING
8/11/2016	NEAL,GERBER & EISENBERG	2,017.00	GENERAL LABOR AND EMPLOYMENT COUNSELING
9/22/2016	NEAL,GERBER & EISENBERG	5,679.55	GENERAL LABOR AND EMPLOYMENT COUNSELING
9/22/2016	NEAL,GERBER & EISENBERG	381.5	GENERAL LABOR AND EMPLOYMENT COUNSELING
4/13/2016	PAUL W. PLOTNICK	2,500.00	FILING OF CLAIM IN THE ESTATE OF VASILE NITU
5/19/2016	PAUL W. PLOTNICK	1,590.00	FILING OF CLAIM IN THE ESTATE OF VASILE NITU
7/18/2016	PAUL W. PLOTNICK	116.5	RECORDING AND CERTIFICATION OF DOCUMENTATION FEES
6/1/2016	MUCH SHELIST	977.5	BUY SELL AGREEMENT
12/7/2016	FITZGERALD LAW GROUP	38,536.95	COOK COUNTY ASSESSOR - PROPERTY TAX REDUCTION
TOTAL		53526.5	

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

YES

(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 LONG TERM CARE \$11,594

(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?

(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 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

230,245

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 benefit on Schedule V.

\$

21,126

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

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:

(18) Have all costs which do not relate to the provision of long term care been adjusted 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

HFS 3745 (N-4-99)

IL478-2471